# How do clients experience intensive EMDR for PTSD? A phenomenological analysis

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# Abstract

There is a dearth of qualitative research exploring the benefits and challenges of intensive Eye Movement Desensitisation and Reprocessing (EMDR) from the clients' perspective. Currently, research into intensive EMDR, which involves multiple therapy sessions over consecutive days, is dominated by quantitative research seeking to explore its efficacy among different population. However, these studies indicate that intensive treatment for PTSD may offer an improved clients' experience, faster reduction in symptoms, greater symptom reduction, and reduced dropout rates (Najavits, 2015). The aim of this study is to understand what might be lost and gained from intensive delivery of EMDR from the participants' perspective, and to explore participants' experiences whilst considering contextual factors such as culture, society, and environment. The study also aims to understand the impact of intensive EMDR on the participants' sense of self. Interpretative phenomenological analysis (IPA) was used to analyse data generated from 10 individual interviews with participants who had experienced intensive EMDR treatment for PTSD. The participants were selected through purposeful sampling and data gathered from interviews conducted via video conferencing software. Two Personal Experiential Themes (PETs) were identified: (1) 'The importance of psychological safety' and (2) 'The changing self'. The PET of the importance of psychological safety generated two emergent themes of 'A protected space' defined as a protected bubble segregated from participants' usual lives, and 'The importance of a continued connection', a connection with a part of the process which felt safe and reassuring. The PET of 'the changing self' generated two emergent themes of a 'Wow! moment', a sudden and visceral moment of insight which was pleasing, and 'Living the way I always wanted' a sense of feeling and behaving in a way which is closer to the authentic self.

Intensive EMDR can be experienced as safe, facilitating agency and engagement, and affecting a meaningful change, which was valued by participants. These findings concur with Shapiro's (2001) assertion that EMDR is a humanistic and integrative psychotherapy, and correspond with established humanistic theories such as Maslow's (1954) hierarchy of needs. Implications for practice are that intensive EMDR may offer a safe, efficient, and cost-effective approach to the treatment of PTSD.

## Introduction

This study is the first to explore intensive delivery of EMDR for the treatment of post-traumatic stress disorder (PTSD) symptoms using interpretive phenomenological analysis (IPA) of interviews with ten people.

Eye Movement Desensitisation and Reprocessing (EMDR) is a model of psychotherapy used for the relief of psychological distress caused by traumatic experiences. EMDR comprises of an 8-phase treatment protocol which includes (1) History taking, (2) Emotional regulation skills, (3-6) Target identification and memory processing, (7) Closure, and (8) Re-evaluation of target memory. Phases 3-6 involve the use of Bilateral Stimulation (BLS) in the form of saccadic eye movements, alternate hand-tapping, or alternative audio beats to facilitate access to, and processing of traumatic memories in a way that is tolerable to clients. The understanding of how EMDR works is based on the Adaptive Information Processing (AIP) model which posits that simultaneously accessing the trauma memory and more adaptive memories or information available to the client, will lead to a spontaneous reconsolidation of memories and a reduction in distress (Solomon and Shapiro, 2008b). EMDR is considered one psychotherapy that has a ’bottom up’ approach which accesses the limbic system, responsible for affect and autonomic regulation (Taylor et al., 2010). EMDR is currently one

of two psychotherapeutic approaches recommended by the National Institute of Care Excellence (NICE) for the treatment of PTSD (NICE, 2018), therefore it is worth exploring how it may be applied in different circumstances and contexts.

Intensive EMDR is defined in this study as the delivery of the standard protocol (Shapiro, 2001), at a higher frequency than the common practice of once per week sessions. Currently, there is no standardised definition or criteria across the literature for what intensive EMDR is or how it should be delivered. Thus, it has been previously described as 'massed' 'condensed' and 'intensive' interchangeably (Ragsdale et al., 2020). If the efficacy of EMDR is unchanged by the increase in session frequency, intensive EMDR may provide timelier relief to people who are experiencing PTSD symptoms.

Post-Traumatic Stress Disorder (PTSD) is described as a psychiatric disorder resulting from direct exposure to or witnessing a traumatic event such as natural disaster, sexual violence or serious accident, or learning about a loved-one's violent death (American Psychiatric Association [APA], 2013). For a diagnosis to be made, symptoms must fall under four categories; (1) intrusions of memories, thoughts, images, emotions, and sensations of the traumatic event, (2) avoidance of reminders of the traumatic event, (3) alterations in cognition and mood, including changes in beliefs about the self, other people, and the world, and (4) alterations in arousal and reactivity, including hypervigilance and being easily startled (APA, 2013).

Prevalence of PTSD is high, with over 70% of the global population having been exposed to more than three traumatic events in their lifetime (Kessler et al., 2017). In the United

Kingdom (UK), approximately one third of adults have been exposed to a traumatic event, and many go on to develop symptoms of post-traumatic stress (McManus, Bebbington and Brugha, 2014).

Recommended treatments for PTSD commonly involve a phased-based protocol which can include psycho-education, managing distressing memories, processing trauma memories, overcoming avoidance, and re-establishing adaptive functioning (NICE, 2018). These phases are each completed in sequence, before progressing onto the next phase (De Jongh et al., 2016a).

Evidence based treatments for PTSD are limited, and show variability in efficacy (NICE, 2018), with dropout rates ranging between 0% and 30% (Lewis et al., 2020), and lower recovery rates when compared to other mental health conditions (Baker, 2018). Existing guidance for single event trauma recommends between 8-12 sessions of either CBT or EMDR (NICE, 2018) however, there is a lack of consensus in the number of sessions required for multiple traumas, with estimates ranging from 4 months to several years for the most severely impaired clients (Cloitre et al., 2012). Therefore, when we apply the existing guidance to multiple traumas, delivered at a pace of once per week, this could equate to a commitment of several months of therapy. Previous PTSD research has mainly focused on quantitative studies to measure treatment efficacy, and few studies used qualitative methods to explore the individuals' experiences of treatment for PTSD.

IPA

IPA (Smith, Flowers and Larkin, 2022) is a qualitative research methodology located within a qualitative paradigm. The IPA methodology seeks to examine the phenomenology of human

experience, which supposes that human experience, and the world, appears to us through meaning-making or phenomenon via various relationships and activities.

IPA focuses on the individual, lived experience. It conceptualises the self as contextual, intersubjective and relational – a 'being-in-the-world' (Heidegger, 1962, p.154), and therefore unable to be understood in isolation. IPA is idiographic, meaning it is concerned with detail and the perspective of particular people in a particular context (Smith, Flowers and Larkin, 2022). IPA retains a sensitivity and curiosity about what it is to be human. IPA is a qualitative research methodology that aims to understand the meaning and significance of an event in the context of a personal and social world (Smith and Osborn, 2007). It takes both an empathic and a critical view of the data, and research outcomes of IPA can be applied by the informed reader to their own experiential knowledge (Smith, Flowers and Larkin, 2022).

Although there are very few phenomenological studies into PTSD, these studies have given valuable insight into people's experiences of living with PTSD, their carers' experiences, and those of clinicians working in the field. These studies show the importance of being listened to and feeling safe in the treatment of trauma among people with intellectual difficulties (Stenfert Kroese et al., 2016), and a conflict between the wish to avoid the trauma memory and the therapist's advice to revisit the memory (Vincent et al., 2013). Other studies have given us an understanding of clients' difficulties in giving up their inner critic, when selfcompassion has felt aversive (Lawrence and Lee, 2014), and a changing relationship with the world during treatment from mistrust to trust, "from sceptic to convert" (Gilkinson, 2010, p.147).

Furthermore, while overall there is a dearth of phenomenological studies on EMDR for

PTSD, there are a few that provide valuable insight into how clients experience treatment. For example, Blore (2011) found that clients experience post-traumatic growth as an appreciation of life, and as a spiritual and philosophical development. Similarly, Marich (2010) found that the existence of safety was paramount for women receiving EMDR during an addiction recovery programme, and that accessing the emotional core was vital to recovery. Overall, however, phenomenological studies into EMDR and PTSD are scant; therefore, there is an opportunity to contribute valuable insights to the field.

The following section presents literature review on the literature relating to EMDR, including efficacy research, the proposed mechanisms of change, and the role of the therapeutic relationship in EMDR. The recent increase in quantitative studies in intensive EMDR for PTSD is also presented and the need for the clients' experiences to be represented is highlighted.

## Literature review

### Historical overview of PTSD

Records reveal references to what would now be considered PTSD symptoms in a variety of literature dating back as early as the Epic of Gilgamesh (2100BC) and the battle of Marathon (440BC). Without exception, they pertain to soldiers returning from battle (Crocq and Crocq, 2000). The assumption that only soldiers suffered from trauma symptoms was challenged during the industrial revolution however, when casualties from industrial accidents and the developing railway networks increased. It is no coincidence that at the same time a scepticism and stigma grew towards sufferers as corporate organisations resisted compensation claims with accusations of malingering and constitutional weakness (Crocq and Crocq, 2000).

The subsequent development of various international wars renewed interest in categorising and conceptualising trauma related symptoms, as a result most of the research from the mid-twentieth century pertains to soldiers (Lasiuk and Hegadoren, 2006). Alongside the research, the debate between the physical and psychological origins of the symptoms continued until the 1960s when theorists finally began to consider the interrelatedness of the psychological, physical, somatic and emotional components of trauma (Friedman, Keane and Resick, 2007).

## Psychoanalytic theories of traumas

A view proposed by Freud (1986) explained trauma symptoms as disassociated unconscious memories, where treatment required the unearthing of unconscious desires and conflict and the retelling of the traumatic information which resulted in emotional catharsis. However, Ferenczi (1949) argued that the magnitude of a traumatic experience would overwhelm a person's internal psychic life and challenged Freud's theory, which positions the victim as the unwitting instigator of the trauma. At a similar time, interest in psychoanalytic theory and intrapsychic processes began to wane and made way for more empirical approaches to research, such as behaviourism (Friedman, Keane and Resick, 2007).

## Behaviourism and exposure

Behaviourism (Watson, 1913) drew the attention of professionals treating PTSD (Lasiuk and Hegadoren, 2006). Behaviourism attributes anxiety symptoms (and PTSD) to a conditioned fear response (Mowrer, 1960; Pavlov, 1927) combined with the negative reinforcement of unhelpful escape strategies such as avoidance (Skinner, 1953). Behaviourism gave rise to manualised exposure techniques which require prolonged contact with the feared object or memory, to habituate (Leahy, Holland and McGinn, 2009) and de-couple paired stimuli (Foa,

Hembree and Rothbaum, 2007; Foa and Rothbaum, 1998). In a recent literature review, Dawson et al. (2021) identified exposure therapy as highly effective in clinical populations. Efficacy has also been found for specific populations such as refugees (Adenauer et al., 2011), and via novel modes of delivery such as video platform (Foa et al., 2018), and using virtual reality (Beidel et al., 2019). However, exposure treatment has been criticised for the level of distress that is evoked during exposure to the feared object or memory (Olatunji, Deacon and Abramowitz, 2009; Feeny, Hembree and Zoellner, 2003) and this is reflected in dropout rates as high as 51% (Arntz, Tiesema and Kindt, 2007). The literature also reveals significant resistance from therapists who fear they would experience vicarious trauma or re-traumatise the client ( Zoellner et al., 2011; Olatunji, Deacon and Abramowitz, 2009; Becker, Zayfert and Anderson, 2004 ). Therefore, although apparently effective, exposure therapy is not easily tolerated by clients or therapists. Yet, exposure therapy for PTSD has led to the understanding that the trauma memory can be the feared object and therefore, the person's internal world can be a trigger to distress (Rauch and Mclean, 2021). This recognition initiated the idea of a cognitive component in the development and maintenance of PTSD.

## Cognitive Therapy

At the time that Skinner (1953) was laying the foundations for behavioural treatments for anxiety, Beck (1967) was formulating Cognitive Behavioural Therapy (CBT) for depression and emotional disorders (Beck, 1976). In CBT it is proposed that the meaning attached to a traumatic event (or appraisal of the traumatic event) is responsible for its impact and the maintenance of distress (Fairbrother and Rachman, 2006; Beck, Emery and Anderson, 1985). Subsequently, Foa and Kozak (1986) proposed a model for processing emotional information and the multiple maintaining factors in PTSD. From the CBT perspective, treatment of PTSD

requires exposure and cognitive restructuring techniques to process emotions, contextualise the traumatic experience, and update maladaptive beliefs (Ehlers and Clark, 2000). Alongside CBT efficacy research, there is a significant amount of literature exploring the mechanism of action and moderating and mediating components of CBT (Arntz, Tiesema and Kindt, 2007; Salkovskis et al., 2006).

Proponents of exposure therapy have argued that it is the exposure component to CBT which is responsible for change. However, this argument was countered in a key dismantling study by Jacobson et al. (1996) and other studies which showed that cognitive change was the mediator of change during exposure therapy (Lee et al., 2021; Smits et al., 2006). Studies show that CBT is superior to exposure therapy for PTSD (Bryant et al., 2008), and with improved relapse prevention (Felmingham and Bryant, 2012). CBT has also shown to be effective treatment in treating other conditions such as panic disorder (Salkovskis et al., 2006), social anxiety disorder (Mattick and Peters, 1988), obsessive compulsive disorder (Butler et al., 1991), and generalised anxiety disorder (Starcevic and Brakoulias, 2008). Given CBT's efficacy it is understandable that it is the treatment most utilised in the NHS England and Ministry of Defence.

## Eye Movement Desensitisation and Reprocessing

EMDR emerged in the late 1980s at a time when people were keen to find alternative ways of treating veterans returning from the Vietnam war with PTSD (Wessely and Jones, 2004). EMDR is difficult to categorise, as it appears to combine elements of exposure, cognitive restructuring and somatic processing, with the addition of bilateral stimulation (Solomon & Shapiro, 2008a). Shapiro (2001) has described EMDR as a humanistic approach which harnesses the body's natural ability to heal.

Shapiro's (2001) theory of Adaptive Information Processing (AIP) was informed by Pavlov's (1927) concept of information processing. The theory which underpins EMDR, posits that the human brain has an innate tendency to integrate stressful experiences (Shapiro, 2001). However, when the brain is overwhelmed, the stressful information is not integrated, and the event remains unprocessed, in a state-specific form. This dysfunctionally stored memory is susceptible to current day triggers which re-activate the state from before, resulting in a present day re-experiencing of the memory. EMDR has evolved into an evidenced-based psychological treatment for PTSD, and its use in the NHS and internationally is growing (Murphy et al., 2013).

The World Health Organization (2018), and the latest guidelines from the NICE (2018) recommend EMDR, Trauma Focussed-CBT or Narrative Exposure Therapy (NET; a derivative of exposure therapy) for the treatment of PTSD. In the NICE (2018) update of the treatment guidelines for PTSD, EMDR was no longer recommended for the military population due to a lack of supporting evidence. However, a new publication of an EMDR Competency Framework (Roth, Dudley and Pilling, 2021) published in partnership with Health Education England, recognises that EMDR has utility with many presenting issues derived from trauma, and not just PTSD. This will inevitably mean a broadening scope of practice and greater interest in research as highlighted by Valiente-Gómez et al.'s (2017) systematic review on further applications of EMDR.

## Desired outcomes and components of therapy

The guidelines for the identification and treatment of PTSD naturally lead to consideration of the desired outcomes of therapy. How we define and quantify the desired outcome of therapy

is a long-standing challenge for theorists and researchers, due to the difficulty in defining and quantifying such subjective concepts as growth and wellbeing (Krueger and Stone, 2014). These limitations mean that often-well-established theories have little empirical evidence. Furthermore, these theories have been criticised for having an ethnocentric bias, with Western conceptions of self and identity (Christopher and Hickinbottom, 2008). Yet, their credibility prevails because of their pervasive applicability and utility in practice.

Two such theories are Maslow's (1954) theory of self-actualisation and Rogers' (1959) theory of a fully functioning person (Kaufman, 2018). These theories are humanistic in nature, and concord with the standards of conduct, performance, and ethics outlined by the Health Care Professionals Council (Health Care Professionals Council, 2016). This study is interested in participants' experiences of intensive EMDR for PTSD considering such theories of growth and wellbeing.

## Self-actualisation

Maslow's (1954) theory of motivation and personality is one of the foundations of humanistic psychology. Maslow (1954) proposed that humans are motivated by deficit and growth needs. Once these needs are met, a person can achieve the full realisation of their potential, or self-actualisation. Self-actualisation suggests that each person has idiosyncratic talents or competencies that can be developed and realised, which implies a continuous process of growth.

The characteristics of self-actualisation described by Maslow (1954) are openness to experience and a willingness to try out new things, learn new ideas and new skills. Selfactualised people have an accurate perception of reality which is undistorted by defences and prejudices. This openness leads to a freshness of appreciation, and appreciation of beauty. The second characteristic is an open attitude towards problem solving: which leads to spontaneity, general creativity, a playful attitude towards problem solving, and self-expression. The third characteristic in Maslow's description of a self-actualised person is autonomy: this person does not rely on the opinions of others or on the social conventions imposed by society. Maslow (1954) said that for self-actualisation to be achieved, basic needs such as physiological and safety needs must be met by interpersonal means. However, the optimal stance of the therapist is not defined in the theory given this should be in accordance with the individual's requirements. Regarding the therapeutic relationship,
Maslow stated that a good relationship is a precondition for therapy, however it is a means to an end, not the end in itself (Maslow, 1954). Maslow's theory is a popular framework of understanding human growth and may help us understand the potential growth inhibiting effects of trauma, however, it has been criticised for lacking guidance on how to operationalise his ideas and of being representative only of White Western culture. Therefore, the theory is vulnerable to misinterpretation and misapplication among anyone who wishes to use it.

The 'fully functioning person'

The centrality of the subjective human experience is emphasised in Rogers' (1959) theory of psychotherapy. He proposed that the self is fluid, and the world is experienced through perception and associated values (Rogers, 1959). He argued that the individual has the innate

and universal potential to change and develop, or an actualisation tendency (Rogers, 1959). He believed that the right environment, such as a strong therapeutic relationship, can stimulate the actualisation tendency, which promotes the realisation of a fully functioning person (Rogers, 1959). These ideas encapsulate some of the fundamentals to humanistic psychology. Rogers' description of the characteristics of a fully functioning person shares similarities with Maslow's (1954) theory of self-actualisation. First, the client has an increasing openness to experience, which is the opposite to defensiveness. This increased openness promotes a personal awareness of feelings and attitudes, and a more objective reality which is independent of influence from expectations or pre-conceived categories. Second, the 'fully functioning person' possesses a willingness to be a process; the client is content in the understanding that they are not a problem to be solved or product but a process. They accept they are not a fixed entity, but in a process of becoming, ''a continually changing constellation of potentialities'' (Rogers, 1959, p.122). Third, Rogers uses gendered language typical of this period, when he describes ''an increasing trust in his organism'' (p.118). This means the fully functioning person trusts that they will behave in a way that will satisfy their needs for a particular situation. Several studies have attempted to quantify and operationalise the optimal outcome of therapy (Burnett and Van Dorssen, 2000; Connolly and Strupp, 1996; Rogers, 1957). However, in a recent literature review Renger, Macaskill and Naylor (2020) reviewed 10 studies and analysed 10 interviews with personcentred therapists. The authors identified as many as 71 perceived characteristics of a fully functioning person. These findings indicate that beyond the theory, the definition of desired outcomes of psychotherapy are highly subjective (Renger, Macaskill and Naylor, 2020). This study recognises the subjective nature of experience and seeks to understand how participants in intensive EMDR experience and view desirable outcomes and growth from

their own perspective. Although Rogers'(1957) theory has been criticised for excluding the influence of socio-cultural mechanisms which can inhibit self-actualisation and for its lack of empirical evidence (Kensit, 2000), it has proven its utility among the counselling profession through the value of its guiding principles which humanise the client, and provide explicit instructions for the therapist. Once the desired outcome of therapy is agreed, attention naturally turns to how this is instigated in psychotherapy.

## Mechanisms of change in psychotherapy

Understanding how and why change is achieved in psychotherapy is the subject of much theoretical discussion (Lane et al., 2020, 2015). Several hypotheses regarding mechanisms of change have been proposed, some of which are specific to a particular therapeutic approach and others span several approaches.

## Insights as a conduit to change

Research suggests that moments of insight into behaviours correlate with positive outcomes, and are a valuable experience in psychotherapy (Angus and Greenberg, 2011; Hill and Knox, 2008). Moments of insight have been defined as a conscious meaning shift involving new connections (Timulak and McElvaney, 2013), and an Aha! moment (Wampold et al., 2007). It has also been suggested that insights may take several weeks or months to occur (Castonguay and Hill, 2012). However, the literature has been criticised for the lack of agreement in definition of insight across studies (Castonguay and Hill, 2012).

Several studies show a moderate correlation between insight moments and therapeutic outcomes (Connolly Gibbons et al., 2013; Johansson et al., 2010) indicating that moments of insight in therapy could be as central to therapeutic change as the therapeutic relationship (Flückiger et al., 2012) and positive regard (Farber and Doolin, 2011; Horvath et al., 2011) A meta-analysis of 23 quantitative studies attempted to assess the magnitude of the insight-outcome relationship (Jennissen et al., 2018). This analysis used a psychodynamic definition of insight ‘’making links between past and present experiences, relationships, and patterns.’’ (Hovarth et al., 2011, p.10) to select studies which used objective and subjective measures of insights. The analysis revealed a moderate effect size (r=0.31) between insight and treatment outcome. These findings are comparable to the effect sizes of other treatment factors such as therapeutic alliance (Flückiger et al., 2012), positive regard (Farber and Doolin, 2011), and empathy (Elliott et al., 2011). Limitations of these studies are that they generally confirm correlation rather than a causal relationship between insights and outcomes, and they do not address confounding factors or the mediating effects of other variables. Therefore, the research outcomes are inconclusive but indicative of interest in insight across the field of neuropsychology and psychotherapy.

Developments in neuroscience have identified correlations between insight, cognitive and somatic processes, and their implications for psychotherapy (Kounios and Beeman, 2009). Several studies using MRI and EEG have uncovered neurological processes where brain activity precedes conscious awareness of an insight moment, in terms of arousal in the amygdala prior to conscious awareness of a negative stimuli (Killgore and Yurgelun-Todd, 2004; Critchley, Mathia and Dolan, 2002). Faustino (2022) proposed that these findings show the unconscious processes responsible for repression, where painful experiences are hidden

out of awareness. Therefore, moments of insight in therapy are when disconnected elements of an experience become connected (Faustino, 2022).

Kounios and Beeman (2009) suggested the possibility of creating the right preconditions which invoke spontaneous therapeutic insight. In this study, Kounios and Beeman (2009) explored the intercorrelates and antecedents of Aha! moments. Two randomly assigned groups of adult participants were provided with either problems which required insight, or problems which required analysis. They found neurological processes were active prior to the insight experience, which were absent in the analysis group. The findings suggest that even though insight is experienced as sudden, there is a prior preparatory state which precedes it. It is therefore possible that a preparatory state for insight could be accessed to enhance or improve outcomes in intensive EMDR therapy.

Moment-to-moment emotional processes effect shifts in organisation and meaning, and resolve various psychological difficulties (Greenberg, Rice and Elliot, 1996).

In a meta-analysis of qualitative studies into insight events in psychotherapy, Timulak and McElvaney (2013) examined 7 studies that used an interpersonal process recall (IPR) interview method with clients and therapists, thus the authors claim both objective and subjective reports were obtained through analysing transcripts of actual therapeutic sessions and interview data with clients and therapists afterwards, regarding their experiences of the sessions. They explored insights according to three domains of context, key intervention, and impact. They found two types of insight events in the studies analysed, painful/poignant and

self-asserting/powerful. Both types of insights occurred when working on core issues such as low self-worth. Insights were instigated by collaborative, supportive and validating interventions. The impact was experienced as making associations between session content, a fuller awareness of personal needs or wants, and feeling understood and supported by the therapist. This study reveals that both painful and empowering insight events are experienced as helpful by clients. The limitation of research into insights is the variability in the definition of insights across studies and the variation in how authors qualify these. Thus, qualitative studies offer a more nuanced perspective on insight moments, however, the body of research remains small.

## EMDR and mechanisms of change

There have been several theories proposed which attempt to account for the mechanism of change in EMDR and include neurological (Rauch et al., 1996), psychophysiological (Elofsson et al., 2008), and psychological accounts ( Baddeley and Andrade, 2000; Andrade, Kavanagh and Baddeley, 1997). Furthermore, the addition of BLS (Shapiro, 2001), often in the form of saccadic eye movements (EMs), is unique to the field of psychotherapy and has stimulated much interest (Nieuwenhuis et al., 2013). Several hypothesis were examined in a systematic review of the literature, where the working memory hypothesis seemed the most likely explanation (Landin-Romero et al., 2018).

## The working memory hypothesis as a proposed mechanism of change in EMDR

Research studies have established a link between PTSD and working memory (Blanchette and Caparos, 2016; Morey et al., 2009). Gunter and Bodner (2009) proposed that creating a demand on the working memory in the form of eye movements or other tasks while recalling an unpleasant memory, decreased vividness, emotionality and recall of the unpleasant memory. The working memory model proposed by Baddeley (1986) suggested three major components to working memory: a limited capacity attentional control system, the central executive, and two slave systems named the visuospatial sketchpad (VSSP) and phonological loop (Baddeley, 1986). The VSSP is responsible for the maintenance and manipulation of visual imagery and the phonological loop has the same function for auditory and verbal material (Baddeley and Andrade, 2000). This model has been supported by several experimental studies which involve dual task procedures which isolate and disrupt components of working memory (Van Den Hout et al., 2014; Smith et al., 1995; Baddeley, 1992). However, these studies are limited to non-clinical participants, therefore it cannot be confirmed if similar findings would be replicated with participants with PTSD. Furthermore, they do not examine the effects of experimental demand and affective priming (Van den Hout et al., 2011) which could account for the positive results.

After several years of theoretical debate, a recent systematic review concluded that the working memory hypothesis is the most likely explanation for change in EMDR therapy (Landin-Romero et al., 2018). The limitations to the working memory hypothesis are that it is not supported in non-clinical groups (Navarroet et al., 2013) and does not explain why eye movements are shown to reduce vividness and emotionality with both visual and audio memories (Matthijssen, van Schie and van den Hout, 2019; Kristjánsdóttir and Lee, 2011).

Furthermore, the working memory hypothesis does not account for the degradation of unpleasant memory and not neutral memory found in Van den Hout et al.'s (2014) study. Therefore, it appears that we cannot draw conclusions regarding the mechanisms of change, whilst a definitive explanation for the specific contribution of eye movements or other bilateral stimulation remains unavailable. In light of the difficulty in establishing a mechanism of change in psychotherapy, there are other components of therapy which may contribute to progress which are of interest to researchers and practitioners, namely providing a context of safety and the therapeutic relationship.

## Context as safety

Psychological safety during psychotherapy is of primary concern to practitioners and clients (British Association of Counselling and Psychotherapy, 2018) as a mechanism or contributor to change. The therapeutic frame is a conceptual idea said to be a containing vessel for therapeutic work to be conducted and the basis of safety and trust in therapy (Gray, 2013) and intensive EMDR presents a possible deviation from the traditional frame of once weekly sessions. Thus, clients' experience of safety is of interest to this study. The therapeutic frame is a metaphorical container where therapeutic activity takes place, which provides consistency and continuity for the client and process (Gray, 2013). The frame can include practical arrangements, an attitude of mind of the therapist, relationship boundaries (Lemma, 2013), physical environment, and organisational context. Safety in the frame has been found to increase a sense of agency for clients, engagement with therapy and to predict outcomes (Huber et al., 2021; Jennissen et al., 2018; Bandura, 2006).

Intensive EMDR for PTSD constitutes a re-organisation of the therapeutic frame, which involves comparatively long, consecutive days in one venue. Therefore, it is possible that various elements of the frame, including the physical environment and facilities, will be integral to the participants' experiences of intensive EMDR. The therapeutic environment can affect individuals physically, psychologically, emotionally, and spiritually (Pressly and Heesacker, 2001). Literature pertaining to public spaces and facilities in psychiatric wards shows that ward design can improve staff and patients' sense of wellbeing, safety, and comfort (Gross et al., 1998; Remen, 1991; Whitehead et al., 1984). However, these studies are limited in their reliance on survey data and observations and exclude the clients' experiences of these spaces.

Deeper insight into the impact of the physical environment is provided by Backhaus (2008) and Long (2001). Backhaus (2008) used a mixed methods approach to explore 153 clients' experiences of the physical environment in counselling. They found that clients derived a sense of safety, comfort, and relaxation from the counselling room and that this comfort went on to improve retention.

Similarly, a recent mixed methods study by Sinclair (2021) used interviews to survey 24 counselling clients and 23 therapists regarding 22 elements of the physical environment. They found that being uninterrupted and having comfortable seating and room temperature during therapy were of highest priority for both clients and therapists. Interestingly, clients reported a preference for a more 'homely' rather than a clinical environment. These qualitative studies

show that the physical environment retains meaning for clients and can embody crucial factors which contribute to a sense of safety and wellbeing during therapy. The findings of the above studies indicate that extended contact with the physical environment during intensive EMDR, will likely feature in participants' experience of safety.

There is general agreement across the EMDR literature that adverse effects such as dissociation, freeze response, fear, panic, shut down, collapse and fainting and adverse events such as suicidal ideation, suicide attempts, homicidal ideation and self -harm, do not occur during EMDR or intensive EMDR for PTSD (Pérez et al., 2020; Smyth-Dent, Fitzgerald and Hagos, 2019; Wachen et al., 2019; Zepeda Méndez et al., 2018). However, a direct comparison of adverse events between weekly administered EMDR, and intensive EMDR has not been reported, therefore, it remains that we have little understanding of the potential differences between the two methods of delivery. Furthermore, these studies are dominated by the clinicians' perspective on the treatment and how it progressed meaning the participants' experience of the intervention is unrepresented. More literature is needed on the clients' experience of intensive EMDR to corroborate such claims.

Two phenomenological studies by (Marich, 2012; Marich, 2010) offer an alternative perspective and provide rare insight into clients' experiences of safety in EMDR therapy. Ten interviews were conducted with women in recovery from addiction, and a phenomenological analysis was employed to analyse the data. Participants' fears of being belittled and being controlled were identified and the authors credited several factors as contributing to a sense

of safety. These factors included features of the setting, the milieu of women in similar circumstances and staff attitudes towards them. The analysis also found education, preparation, orientation, and session closure procedures as helpful in providing a sense of safety. Thus, as suggested by these studies' findings, therapists and clients differ in their conceptualisation of safety. It seems that therapists conceptualise safety as a mitigation of risk of self-harm or dissociation. This differs from the clients' experience of safety which appears more complex, is derived from an array of contextual elements such as the environment, how they are welcomed to the facility, and their confidence in the therapist. Thus, it is difficult to draw conclusions about context as safety when the current and limited research is heavily weighted towards the clinicians' perspective.

## The therapeutic relationship

The therapeutic relationship has been proposed to account for 30% of outcomes in psychotherapy (Cuijpers, Reijnders and Huibers, 2019). Theories regarding the nature and purpose of the therapeutic relationship vary across modalities, and in their positioning of the therapist's role and technique.

Bordin (1979) posited a collaborative therapeutic alliance, and Buber and Smith (1958), an IThou relationship, where client and therapist are siblings in incomprehension and discovery. Rogers (1957) proposed a similar egalitarian relationship that provides three core conditions necessary to foster a good therapeutic relationship: congruence, genuineness and unconditional positive regard. This was followed by Reich (1897-1957) who suggested

empathy, awareness of feelings and ability to make sense of feelings as essential to form a relationship. Alternatively, several studies have identified a process of therapeutic rupture and subsequent repair as key to the building of the therapeutic relationship consisting of exploring rupture experiences and avoidance, and emergence of wish or need (Safran and Muran, 2000; Rennie, 1994; Rhodes et al., 1994; Safran et al., 1990). Evidence also reveals that when ruptures go unaddressed, it can increase dropout rates in CBT (Castonguay et al., 1996) and in psychoanalytic therapy (Piper et al., 1999; Piper et al., 1991).

It is possible that the extended nature of intensive EMDR with fewer interruptions and more momentum, will give rise to a novel relational experience of therapy. Freeman, Olesen and Hjortdahl (2003) suggested that continuity of care is crucial to patient care and outlined three conditions for continuity of care, specifically continuity of experience, where the patient experiences coordinated and a smooth progression of care, longitudinal continuity, where contact is with as few professionals as possible, and relational continuity, where patient sees the same health professional for each of their appointments. In other studies, continuity of care is rated as 'highly important' by service users and associated with increased patient satisfaction (Biringer et al., 2017; Sudhakar-Krishnan and Rudolf, 2007; Gulliford, Naithani and Morgan, 2006;) and is considered crucial in preventative care and in reducing hospitalisations (Saultz and Albedaiwi, 2004). However, studies which make the link between continuity of care and outcomes in mental health settings have been criticised for inconsistent results and underdeveloped outcome measures (Puntis et al., 2015; Adair et al., 2003). Therefore, more research is needed into what continuity of care means to patients, and which explores how this can be translated into psychotherapy practice.

Clients' experiences of secondary care mental health services show that the experience of continuity can be influenced by the structure and administration of care and professionals' characteristics (Parker, Corden and Heaton, 2011). In the few psychotherapy studies that explore continuity of care, discontinuity of therapists has been shown to double the likelihood of client dropout (Nielsen et al., 2009). In a data analysis study of 1420 psychotherapy patients, Wise and Rinn (1983) found that dropout rates are reduced if the same person who assessed the client went on to deliver the therapy. It is possible that the perpetual nature of intensive EMDR may provide a continuity of care and reduce dropout rates much valued by clients and practitioners therefore, this study hopes to explore if continuity is part of the participants' experiences.

## EMDR and the therapeutic relationship

The EMDR literature regarding the therapeutic relationship reveals that EMDR incorporates several relational concepts from the broader field of psychotherapy, including transference and countertransference phenomenon, mirror neurons, the value of rupture and repair (Clarkson, 1994), and co-regulation (Porges, 2011; Taylor et al., 2010). The theory that underpins EMDR proposes that difficulties can be addressed by identifying their origins and the adapting interweaves to manage these (Dworkin and Errebo, 2010).

Dworkin (2013) suggested that the therapeutic alliance positions the client and therapist 'shoulder to shoulder' and although this is necessary in EMDR therapy, it is not sufficient in the case of the traumatised client. In the case of trauma and PTSD, the client has experienced

tremendous fear and isolation, and therefore, requires a greater level of connectedness with the therapist. Thus, the therapist's role is to provide safety and an anchor to the present, particularly during trauma processing sessions. Dworkin highlighted that this connection can only be attained through a face-to-face orientation that a therapeutic relationship, as opposed to alliance provides. Thus the safety of the real relationship reflected in the degree to which each is genuine with the other (Gelso et al., 2005; Gelso and Carter, 1994), has the emphasis in the EMDR session rather than the transferential one, an anticipated relationship in which the experience of unconscious fears and desires regarding the relationship takes place (Freud, 1915).

The literature regarding EMDR and the therapeutic relationship in EMDR is limited. Dworkin (2013) suggested that EMDR is particularly vulnerable to ruptures in the therapeutic relationship. They suggested that the structured nature of EMDR, which requires certain tasks to be completed, may trigger negative beliefs about the self, for both the client and therapist. Also, the unpredictable nature of EMDR processing can create fear in the client and therapist, increasing the risk of relationship rupture. Furthermore, rapid shifts in emotional arousal may result in an abrupt exit from the therapeutic window. Dworkin (2013) suggested that the therapist refers to their mirror neurons, neurons which fire in the brain and which correspond with the client's actions, to understand the client's process. Dworkin (2013) also suggested the use of adapted interweaves, therapist's interjection designed to jump-start blocked processing to repair ruptures. Similarly, Piedfort-Marin (2018) proposed the use of countertransference based interweaves to release the AIP when countertransference issues block processing. Rosoff (2019) suggested the main purpose of the therapeutic relationship in

EMDR is co-regulation, being sensitive to dysregulation, and regulating the patient's state during resource development and memory processing leading to trauma resolution and reduction of trauma symptoms. EMDR appears to be no different to many other approaches in recognising the value to the therapeutic relationship in coregulation, however there is continued scope in understanding the unique relational features and challenges that EMDR presents.

EMDR and the therapeutic relationship-the client's perspective.

Marich et al., (2020) found that clients perceived the relationship as contributing to EMDR success and found safety and encouragement in the therapeutic alliance. Feeling they were in capable hands facilitated a positive experience of EMDR (Wise and Marich, 2016; Marich, 2012, 2010). Similarly, Skinner (2017) found clients' experiences of safety, a confidence in the therapist's abilities, feeling understood and feeling cared for were attributed to the therapeutic relationship. In contrast, a study by Edmond, Sloan and McCarthy (2004) compared experiences of clients who received either eclectic therapy or EMDR and found that clients who received eclectic therapy placed much more importance on the relationship than those who received EMDR. EMDR patients rarely mentioned their therapist during the interviews unless asked specifically. The slim amount of evidence available regarding EMDR and the therapeutic relationship means it is not currently possible to draw conclusions about its potential unique features, nor of its similarities and differences with other modalities. Thus, there is scope to explore these factors in future studies.

## Efficacy of EMDR for PTSD

Besides debate regarding the proposed mechanism of change in EMDR, the efficacy of EMDR has been the focus of much investigation using quantitative methodology. For a treatment to be suitable for therapists and clients, it needs to be effective, structured, measurable, and tolerable for both. The early research literature indicates that the use of EMDR for PTSD is effective, well tolerated, maintained at follow-up when compared to other evidenced based (Abbasnejad, Mahani and Zamyad, 2007; Högberg et al., 2007; van der Kolk et al., 2007; Soberman, Greenwald and Rule, 2002). The evidence is less prolific regarding its use with veterans (Carlson et al., 1998) and with other difficulties such as Generalised Anxiety Disorder (GAD; Gauvreau and Bouchard, 2008) and depression (Uribe and Ramírez, 2006). Similarly, the evidence for intensive delivery of EMDR for PTSD is scant and therefore presents a gap in the research literature. In all, the research shows that EMDR is a legitimate contender in the field as it is equally effective or superior to other treatments (Bisson et al., 2013; Ho and Lee, 2012), is well tolerated by clients (De Haan et al., 2020) and wholistic (Dworkin, 2013). In addition, the broader scope for EMDR outlined in the EMDR competency framework of practice and supervision (Roth, Dudley and Pilling, 2021), means that research in this area could rise exponentially. Thus, there is scope for new research into clients' personal experiences of EMDR when delivered to different populations and using innovative modes of delivery.

Alongside the efficacy studies, there is a body of research which continues to be generated by EMDR practitioners and includes numerous case studies, case series ; (Bongaerts, Van Minnen and de Jongh, 2017; Blount, Ford and Peterson, 2014), and data evaluations

(Wachen et al., 2019). This ongoing research interest combined with the new Competence Framework for EMDR (Roth, Dudley and Pilling, 2021), indicates an enthusiasm for the treatment. Going forward, good quality RCTs combined with qualitative research are needed to build a dynamic picture of EMDR as a whole, from both a quantitative and experiential perspective.

## Intensive EMDR

The rationale for intensive treatment of PTSD is that it is equal in efficacy when compared to once weekly sessions (Hurley, 2018; Ehlers et al., 2014; Ehlers et al., 2010), and therefore provides a quicker recovery and potentially less disruption to clinicians and clients. It is hypothesised that intensive therapy builds on momentum, provides additional safety and mitigates avoidance of reminders of the trauma which is a maintaining feature of PTSD (Foa et al., 2018). There is currently no consensus regarding the definition of intensive EMDR. This omission may explain the variety and disparity of procedures between studies. For example, there is a huge variation in dosage across studies, which range from a single session (D'Antoni et al., 2022; Jarero, Artigas and Luber, 2011) up to several sessions over several days for 4 weeks (Wibbelink et al., 2021), with most studies reporting an average length of treatment between five and ten days (Bongaerts et al., 2021; Blount, Ford and Peterson, 2014;). In the same vein, a rationale for the use of a condensed version of the original protocol (Shapiro, 2001) versus an abridged version of the treatment in some studies is not provided. There is also great variability and experimentation in procedures, some advocating lengthy assessments, periods of stabilisation, several follow up treatment sessions or intensive therapy as an adjunct to regular weekly sessions. Gutner et al. (2016) have attempted to examine the impact of session frequency and consistency on outcomes and found that

frequency and consistency have a significant correlation with a reduction in PTSD symptoms. Furthermore, they found that a longer period between sessions 4 and 5 correlated with a smaller reduction in symptoms. Thus, the treatment of PTSD is sensitive to session timing and consistency. There is evidence to suggest that treatment chronicity has a positive correlation with outcomes in studies of survivors of natural disasters, with the more recent the trauma, the greater likelihood of recovery (Zepeda Méndez et al., 2018; Murray,

El-Leithy and Billings, 2017; Jarero, Artigas and Luber, 2011; Chemtob, Nakashima and Carlson, 2002). A limitation in terms of establishing the treatment efficacy of intensive EMDR is that it is common for treatment programmes to combine other activities such as yoga (Thoresen et al., 2022; Wachen et al., 2019; Zepeda Méndez et al., 2018), exercise, psychoeducation ( Wagenmans et al., 2018; Bongaerts, Van Minnen and de Jongh, 2017; Blount, Ford and Peterson, 2014), equine assisted therapy (Steele et al., 2018), and mindfulness (Roque-Lopez et al., 2021) with EMDR. The potential additive effects of these components are acknowledged in the literature; however, they present a problem in treatment and research validity and thus questions the value of these additional activities. Overall, studies of intensive EMDR indicate chronicity and frequency have a role in outcomes, however they give very little consideration of confounding variables, the therapeutic relationship, the optimum timing of treatment, adequate dosage and who might benefit the most from this format of delivery. This leaves opportunity for further research to explore the experience of intensive EMDR from the clients' perspective.

In a rare qualitative study of intensive EMDR, Thoresen et al. (2022) interviewed eight participants of an intensive therapy programme for PTSD. The programme combined EMDR,

prolonged exposure (PE), physical activity, and psychoeducation, over eight days and used therapist rotation. The authors identified five major themes: (1) terrible but worth it, (2) continuous pressure through therapist rotation, (3) physical activity as a necessary break from mental marathon, (4) sense of unity in an intensive treatment program, and (5) the whole is greater than the sum of its parts. Thoresen et al. (2022) showed that participants experienced intensive therapy as easier to stay tuned into, and easier to get back into, when they compared it to their previous experiences of weekly therapy. They also said that the format reduced avoidance as it was more difficult to cancel the sessions. The participants experienced the therapist rotation as enabling different perspectives and new relational experiences which they felt contributed to change. They also reported a sense of being cared for by the therapists as a collective, rather than each therapist one by one. Participants revealed that after the therapy they felt the two-week gap before a follow up call was too long, and they wished to reach out to their therapists in that time. Thoresen et al. (2022) and the current study stand alone as qualitative explorations of client experience in a research landscape dominated by quantitative studies of intensive EMDR for PTSD.

## Intensive EMDR Efficacy

Most of the current efficacy research is from one institution in the Netherlands (Psytrek) that reports outcome data for a residential intensive treatment program consisting of regular EMDR, a prolonged exposure (PE) session with exercise and therapist rotation. The outcomes show that intensive EMDR is effective among various clinical populations such as older and younger people (Gielkens et al., 2021), patients with dissociative symptoms (Zoet, de Jongh and van Minnen, 2021), adolescents (van Pelt et al., 2021), and people with

complex PTSD ( Voorendonk et al., 2020; Bongaerts, Van Minnen and de Jongh, 2017). However, these studies like many others, lack treatment control groups and do not account for the additive effects of wellbeing activities during the programme.

Other studies are consistent in showing treatment efficacy, although across various participant groups and timelines, indicating a level of flexibility in the approach but inconsistency in research parameters. A significant reduction in distress in veterans was found in studies varying from a 7-day (Steele et al., 2018) to 12 days (Ragsdale et al., 2020) treatment programme for veterans. Zepeda Méndez et al. (2018) showed that 2 EMDR sessions over 4 days significantly reduced symptoms in adults with PTSD, and Arabia, Manca and Solomon (2011) and Wanders, Serra and de Jongh (2008) showed that four sessions of EMDR is effective with children with behavioural problems.

Furthermore, research shows that three sessions of EMDR is effective amongst civilians with multiple trauma (Wilson, Becker and Tinker, 1995). Two studies show one session of EMDR as helpful in reducing symptoms among survivors of a natural disaster (Jarero, Artigas and Luber, 2011), geopolitical crisis (Adúriz, Bluthgen and Knopfler, 2009) and human massacre (Molero, Jarero and Givaudan, 2019). The current research in intensive EMDR is promising but has some significant issues relating to the quantitative research paradigm, including validity in that the study participants are so specific, they do not reflect real-world clients, and generalisability as the findings cannot be applied to other situations.

## RCT for intensive EMDR

There are three randomised controlled trials of intensive EMDR, all of which are for EMDR group protocols. First, Molero, Jarero and Givaudan (2019) delivered the Integrated Group Treatment Protocol (IGTP) designed for administration to groups of trauma survivors, three times per day over three days to young refugees and found the programme was well tolerated and was culturally sensitive. Second, Pérez et al. (2020) successfully delivered online, intensive, group EMDR to health workers exposed to multiple patients' deaths during the COVID-19 pandemic and showed a significant positive effect on PTSD, anxiety, and depression measures. The limitation of both these studies is that participants were not formally diagnosed with PTSD, therefore results cannot be generalised to the PTSD population. Finally, Jiménez et al.'s (2020) study population met the criteria for PTSD. Jiménez et al. (2020) delivered the EMDR-PRECI protocol to 32 survivors of sexual and/or physical violence aged between 12 and 17 years old and compared outcomes to a treatment as usual (TAU) group. The treatment was delivered three times per week according to participants' availability. The outcomes showed significant reduction in PTSD, anxiety, and depression in the treatment group. The strength of this study is that the outcomes may be generalised to people with PTSD of a similar age, however the authors recognised that the sample size was small. The few RCTs regarding intensive EMDR highlight a need for more studies investigating Shapiro's (2001) original protocol used for intensive EMDR, delivered on a one to one or group basis.

## Treatment dosage

Twelve sessions of EMDR for a single incident trauma are recommended by the NICE guidelines, however, the frequency of the sessions or the number of sessions required for

multiple traumas in not stated. Not surprisingly, the research shows a huge variation and little consideration of the dosage and frequency of sessions during the intensive treatment of PTSD. Despite this variability, the findings from the few studies that highlight this are interesting. A study by Hurley (2018) found that weekly EMDR sessions compared to twice daily sessions for 10 days were equally beneficial to participants. However, they suggested that the intensive approach offers the following additional benefits: any reactivity may be immediately addressed, reduced dropout rates, increased engagement, and circumventing interruptions such as holidays and sickness. In other studies of intensive PTSD treatments (CBT and prolonged exposure), the higher frequency and greater consistency of treatment sessions correlated with greater symptom reduction (Gutner et al., 2016). Furthermore, Van Minnen et al. (2020) explored the sequencing of intensive EMDR and exposure sessions during intensive treatment for PTSD. They found that participants who received an exposure session in the morning followed by an EMDR session in the afternoon, showed significantly more progress than when the delivery sequence was reversed. This suggests that the benefits of treatment are sensitive to session frequency, consistency, and sequencing and therefore, should be considered more carefully in the treatment guidelines and research. A further limitation to these studies is that it remains unclear if stabilisation measures such as symptom management techniques were necessary or implemented prior to, or during the intervention. These studies show that research into intensive EMDR is in its infancy. However, what remains is great opportunity for research in many directions including RCTs, qualitative studies which access clients' and therapists' perspectives, and for theoretical debate exploring the definition and guidelines for intensive EMDR.

## Research Rationale

The literature shows that EMDR is effective for the treatment of PTSD (Bisson et al., 2013). With regards to intensive EMDR, there is little consistency between study procedures and what constitutes intensive treatment, with terms such as condensed, massed, and intensive being used interchangeably. There is some consideration of confounding variables, including the therapeutic relationship, the optimum timing of treatment, adequate dosage and who might benefit the most from this format of delivery. Furthermore, only Thoresen et al. (2022) explored intensive EMDR from the participants' perspective. However, there is a growth in interest in intensive EMDR, which could stimulate research using both qualitative and quantitative methodologies. Given the limited understanding of what makes EMDR work, and how other factors such as safety and the therapeutic relationship contribute to this, it is likely that intensive EMDR has unknown implications and consequences worth exploring from the clients' perspective, and which go beyond the existing efficacy and theoretical research.

## Research questions

1. What is the clients' experience of intensive EMDR for PTSD and the therapeutic relationship, how did these work best for them?
2. What is there to be lost or gained from intensive EMDR therapy from the clients' perspective?
3. What is the role of contextual, factors in the clients' experience of therapy?
4. How clients make meaning of their experience of therapy considering the wider context of their lives, their diagnosis and their sense of self?

# Methodology

## Reflexivity

Reflexivity recognises the subjective nature of qualitative research, and that data collection and analysis are always influenced by the researcher (McLeod, 2001). Reflexivity understands that knowledge is generated not discovered and is concerned with the interpersonal and co-constructed nature of experience between researcher and participant (Dodgson, 2019; Etherington, 2007; Ponterotto, 2005). Thus, it is necessary and appropriate to outline the researcher's context below.

I am a psychological therapist who has worked with Post Traumatic Stress Disorder (PTSD) since 2014, in the NHS and Ministry of Defence (MOD) settings. In 2016 I embarked on EMDR training where I learnt EMDR was reputed for gaining rapid results and being appropriate for more complex clients. I completed my EMDR training in 2017 and was disappointed when my EMDR practice fell short of my expectations. This left me with a curiosity regarding how, why, and with whom EMDR worked. In particular, I wanted to see how clients experienced intensive EMDR, and if they experienced the variability in effectiveness and outcomes that I did.

During my practice, I have observed services under pressure to see clients with increasing complexity when more appropriate services do not exist, or services have waiting lists of more than 12 months. The length of PTSD treatment, which can be up to 20 sessions in some

services, is also often derailed by life events, deployment, sickness, and annual leave. I came to this research topic because I am passionate that service users receive the best care in a timely fashion. For this reason, intensive EMDR appeared to offer a solution.

## Insider/outsider

My relationship with intensive EMDR began in 2018, when I travelled to the Netherlands and visited a government-funded trauma service where I observed an intensive, residential treatment programme, which consisted of two treatment sessions per day for 5 to 10 days. The programme incorporated daily EMDR and CBT sessions book-ended by physical activity with rotating therapists. This visit and what I saw, challenged many of my assumptions about PTSD treatment, including the importance of the therapeutic relationship, and adherence to protocols.

As a researcher, practitioner, and recipient of EMDR therapy considering my assumptions about the participants' experiences can provide rich material for reflection (McLeod, 2001), and is in keeping with the counselling psychology value of recognising the subjective experience (British Psychological Society [BPS], 2017). My assumptions were that some of the interviews would confirm my experience of EMDR and that some participants would be dissatisfied with the treatment. I also assumed that the therapeutic relationship would feature highly because of the volume of literature that supports this (Norcross, 2002). Finally, I assumed that participants would attribute their recovery to the therapist or treatment. IPA recognises that my own experience, culture, and societal context will influence my

assumptions about participants and the world. In knowing my assumptions, I attempted to bracket these while the research and analysis was undertaken, and I was open to these being questioned by the data. This practice of reflexivity is underpinned by the theoretical foundations of IPA.

## Theoretical foundations of IPA

This study is located in the epistemological and ontological assumptions of IPA in that it takes the view that the researcher and participants are situated within a cultural and social context which holds meaning and influences what can be known. Thus, this study takes a critical realist position which makes the distinction between the independent characteristics of reality and the observations and theorisations made by researchers (Pilgrim 2014). Critical realism extends beyond what is observable and theorises about the context and values inherent in research and understands that these elements fluctuate and change over time (Pilgrim, 2014). The critical realist stance was selected for this study as it aligns with IPA (Larkin, Eatough and Osborn, 2011) and pursues the participant's reality while recognising that contextual and historical meanings overlay reality. The epistemological position of IPA is existential phenomenology, the origins of which can be found in the writings of Husserl (1859-1937) and Heidegger (1889-1976). Heidegger (1962) suggested that knowledge of the world and who we are is located in our consciousness and is revealed to us through our relationship with external objects such as beliefs, society, behaviours and culture (Smith, Flowers and Larkin, 2022). For Husserl, no person exists in isolation of the world, but rather is in constant directedness (intentionality) towards the object outside itself (Smith, Flowers and Larkin, 2022). For Husserl, to be phenomenological, we stand back and reflect on these

processes. Heidegger disagreed with this assertion and suggested that knowledge is never free from interpretation and meaning; therefore, we cannot detach entirely from it (Smith, Flowers and Larkin, 2022). IPA is appropriate for this research project because it recognises the interrelatedness and intersubjectivity of the individual with their world and builds on the assumption that knowledge is never free from interpretation (Heidegger, 1962). In doing so, it allows for context, and the role of the researcher as interpreter.

IPA recognises that phenomena arise from and is subject to interpretation. Interpretation begins with the participants generating an interpretation of their own, as they narrate and reflect on their experiences. This phenomenon is then interpreted by the researcher. This two-fold process is referred to as a double hermeneutic, and accounts for the researcher who reflects and engages with the material on various levels, moving from the whole to viewing the part, and returning to the whole again several times in the process of analysis. Thus, the analysis is a result of two interpretations - that of the participant, and that of the researcher. It is influenced by prior experiences, assumptions and preconceptions or forestructures of both participant and researcher (Smith, Flowers and Larkin, 2022).

Husserl (2012) argued that there are core structures and features of the human experience. The researcher carries assumptions and expectation to the research, which require suspending before engaging in data collection and analysis. However, following Heidegger (1962) and an interpretative phenomenological approach, it is acknowledged that a complete exclusion of these is not possible. Bracketing is used throughout the process of data generation and

analysis, when researcher's pre-existing concerns are suspended as far as possible, and during data analysis, when moving from one interview transcript to another.

IPA is concerned with the particular, and a detailed, in-depth analysis. Its concern is with particular experiences in a particular context. IPA uses purposive 'samples' and focusses on a particular meaning for a particular person. However, it does not seek to learn about the individual alone - rather, it seeks to learn about the individual as they are embedded in the interpersonal and contextual, relational, worldly phenomena.

Since its beginnings, there has been phenomenal interest in the use of IPA in qualitative research (Smith, Flowers and Larkin, 2022). The most likely explanation for this is that IPA's methodology is easily implemented and that it has the capacity to honour the lived experience across a diverse range of people, research topics and issues. The role of the researcher is to create the context where the participant can share their experience and thus, provides us with access to the phenomenon (Smith, Flowers and Larkin, 2022). The researcher attempts to enter the participant's lifeworld in the knowledge that it is not possible to eliminate their own experiences from the process. Consequently, an inherent part of conducting IPA research is to acknowledge and reflect upon the researcher's subjectivity and interest in the research. During the interview and once the data collection is complete, the researcher pays attention to the story being told, from a reflective stance, whilst remaining close to the experience to make sense of what is appearing (Smith, Flowers and Larkin, 2022). As discussed earlier, the

analysis is approached with an open mind, with bracketed preconceptions and assumptions (Willig, 2007).

The qualitative methodology was selected because it is in keeping with the research question, aims of the study and is aligned with the researcher's values. It reflects upon the intersubjective nature of a phenomenon between the researcher and research participant during the narrative, and it positions the individual's account at the heart of the project. Furthermore, given the rarity of intensive EMDR, an idiographic approach can offer knowledge which is unique and individual.

## Development of the interview schedule

Developing an interview schedule was an opportunity to consider and anticipate possible sensitive issues that may arise, to frame questions in a way that would illicit the most rich and comprehensive data, and to identify probes and prompts which could facilitate the process should it become stuck (Smith, 2022). The careful construction of an interview schedule can help to put the participants at ease, avoid leading questions and help identify and 'bracket' any researcher assumptions that may be inherent in the draft questions (Smith, 2022).

The interview schedule for this study was developed according to Smith (2022). The questions were informed by the research questions, and created so that the participants' responses would answer these research questions. The broad subjects for coverage were identified as the participants' experiences of intensive EMDR for PTSD. Under this, several topics of interest

were identified, including emotional experiences, how the intervention fitted into their lives, and the impact of the experience. Once a draft form of the interview schedule was completed, questions were re-ordered to create a coherent sequence, moving from preparing and anticipating the treatment, to experiences during the treatment and to looking back at the experience. It was also important to begin the interview with narrative questions, where the participant recounts some knowledge, to help the participant feel at ease. The phrasing of the questions and prompts was also reviewed to ensure they were intentionally open and informal, to support a relaxed conversation and the collection of rich data. Once this iterative process was complete, feedback was sought from a supervisor to identify questions which may be too direct, too abstract, or inhabit researcher assumptions. The interview was then finalized and to hand during the interviews. See table 1 for the interview schedule.

Table 1: Interview schedule

| | |
|---|---|
| | *Thank the participant for participating in the study. Begin with some introductory questions and building rapport (Have you ever participated in research before? Do you use Skype a lot? What is the weather like there?)*<br>*Introduce myself as a researcher*<br>*Give a short brief around the intention of the study.*<br>*I am interested in your story.* |
| Q1 | How did you find out about the programme?<br><br>• How did you feel / mean to you when you realised you could attend the programme? |
| Q2 | When you found out that it was condensed/intensive over a week or two rather than once per week, what ran through your mind?<br><br>How did you manage the time commitments?<br>How did it fit in with your life and existing commitments?<br>Prompt: How did you feel?<br>Away from work?<br>Away from family?<br><br>Were you anticipating any advantages or disadvantages to the intensive therapy vs once weekly sessions? |
| Q3 | What role did your support network have? /How did they respond? |
| Q4 | So, pretend I don't know anything about the programme, how would you describe it to me? |

| | |
|---|---|
| Q5 | What was the treatment like for you?<br>Set up, process and procedures<br>And the several sessions per day, per week? |
| Q6 | During that time, what was most important/meaningful to you? (Relationship with therapist/facilities/access/choices). |
| Q7 | What was it that you think was the biggest contributor to you feeling better? The therapist, the eye movements, the environment, the format?<br>Prompt: How did this contribute? |
| Q8 | Looking back what do you think the intensive format 'did' for you that perhaps weekly did not?<br>What sticks in your mind? |
| Q9 | Looking back is there anything that you would have liked done differently?<br>Prompt: are you glad you went for an intensive treatment vs weekly session?<br>Why is that? |
| Q10 | Looking back, what impact has the experience had on you as a person?<br>Prompt: and your family/situation<br>How do you make sense of that?<br>Would you do it again or recommend it to anyone? |
| Q11 | Anything you would like to add? |
| | *Draw the interview to a close:*<br>*Thankyou for participating*<br>*What has the experience of participating today been like?*<br>*Repeat right to withdraw*<br>*Any questions?*<br>*Give contact details for any further questions.* |

## Recruitment

Participants for the study were sourced through two organisations. The organisations were selected because of their extensive experience in delivering intensive EMDR for PTSD, and their access to previous clients. The first was The Trauma Institute, Massachusetts (MA), a state funded organisation which provides intensive trauma therapy to victims of crime. The second source of recruitment was Access Wellness, an independent practice in Ireland, which provides intensive EMDR to private clients.

Six participants were recruited from an American, state-funded compensation programme for victims of crime for state residents. Participants did not have to meet the diagnostic criteria for PTSD to access the service. These victims of crime were referred via the victim support programme, and would attend the treatment programme at no cost, for at least 5 consecutive days with a further 1-2 days offered if required. The participants spent the whole day at the centre, engaged with EDMR therapy between the hours of 9am and 5pm.They were allocated to one therapist throughout this period.

The second setting was in a private centre in Ireland offering intensive therapy to private fee-paying clients. Most of the participants lived out of town and travelled in for the intensive therapy. They often opted to stay overnight in a hotel, sometimes travelling with a partner for support. The arrangement meant that participants would receive several hours of EMDR therapy per day, and in between appointments, were free to pursue their own activities. In general, this was sightseeing, or relaxing in the hotel. Without exception, these clients had experienced therapy with the therapist prior to agreeing an intensive format, and therefore intensive EMDR was an extension of regular therapy.

This study did not seek to distinguish between the sources of participants; however, there was no perceptible difference in type of trauma, severity of symptoms, age, work or social status or personal histories.

Therapists within each organisation were requested to contact previous clients who they deemed appropriate for the study according to the criteria outlined below. The identified participants were contacted by email. informing them of the scope of the study and invited to contact the researcher via email should they wish to participate in an interview. The therapists within each organisation were unaware of which of their clients responded. An initial online video call was scheduled to discuss the study, to help the participant to feel more relaxed in advance of the interview, to test the technology, and to answer any questions the potential participant had.

The primary reason for choosing video interviews for data collection was because it facilitated access to the small group of people who had experienced intensive EMDR (Salmons, 2016). Other benefits of this approach included equal access to non-verbal and social cues (Stewart and Willaims, 2005) and a relative anonymity for the participant (Bargh, McKenna and Fitzsimons, 2002). Anonymity occurs because the participant remains in their social context which is detached from the researcher's context. This detachment may facilitate further authenticity during the interviews (Bargh, McKenna and Fitzsimons, 2002). In contrast to video interviews, face to face interviews are considered synchronous in that both the space and time is shared between the researcher and participant (Janghorban, Roudsari and Taghipour, 2014) when often online interviews usually retain the shared time

but not space. However in the case of this study, most of the interviews were conducted across differing time zones thus displacing both time and space (Janghorban, Roudsari and Taghipour, 2014).

Several measures were taken in case risk was identified during correspondence or video contact with the participant. For example, the location and contact details of the participants were taken in advance of the interview, and I had the contact details of the local police department and child protection services. As a clinician who has worked with PTSD and other difficulties, I have experience and expertise in managing people who present with risk. No risk was identified during any of the participants' interviews.

Participants were encouraged to be as comfortable as possible and bring along a drink if they wished. The interviews opened with a reiteration of consent and confidentiality, lasted approximately 1 hour, and closed with a de-briefing period where the participant was checked for wellbeing and encouraged to do something fun or comforting after the interview. All participants reported feeling well at the end of the interview.

Individuals diagnosed with PTSD have an increased risk of suicide, reporting high levels of suicidal ideation (51.9%), suicide attempts (36.9%; LeBouthillier et al., 2015) and self-harm (Dyer et al., 2013). Therefore, I was vigilant for signs of risk during correspondence and video contact with participants, according to the Joiner et al.'s (2007) risk assessment model. Only participants who were considered low risk were contacted about the study.

‘Sampling‘ considerations

A purposive sampling method (Etikan, Musa and Alkassim, 2016) was utilised as participants were identified and selected because of their participation in an intensive EMDR for PTSD. A diagnosis of PTSD was not required for acceptance into treatment.

Inclusion criteria:

- Over 18 years old
- Having completed the trauma treatment program 3 months prior to participation in the research
- Conversant in English
- Deemed to be low risk by the treating practitioner
- Agreeable to the use of online conferencing software

Exclusion criteria:

- Participants considered to be at risk of their recovery being destabilised by participation in the interview were excluded from the recruitment process
- Participants undergoing treatment for the same difficulty at the time of interview (within or outside of the organisation)

Characteristics of the participant group

The final sample size was ten, which is in keeping with recommendation for IPA research for practitioner doctorates and enabled a concentrated focus and in-depth analysis of the individual phenomena (Smith, Flowers and Larkin, 2022). The group of participants age ranged between 18 and 64 years old and consisted of 6 females and 4 males. Nine participants identified as White, and 1 as Asian, 3 identified as working class, 5 as middle class and 2 as upper class. Six participants identified as heterosexual, 1 as gay, 1 lesbian, 1 bisexual and 1 identified as another sexuality. Five were single and 5 were in a relationship. (see table 2)

After each interview a participant number was assigned to the audio recording, before it was sent via a secure network to a professional transcription service. A confidentiality agreement was put in place between UWE and the transcription service (see appendix F).

Table 2: Participant demographics

| Pseudo-nym | Gender | Age | Employment | Sexuality | Racial /ethnic background | Social class | Disability | Marital status | Children |
|---|---|---|---|---|---|---|---|---|---|
| Mia | Female | 18-24 | Full time employed | Other | White | Middle | no | Single | No |
| Honoka | Female | 25-34 | Full time employed | Lesbian | White | Upper middle | no | Partnered | No |
| Harper | Female | 25-34 | Full time student | Bisexual | White | Upper middle | no | Single | No |
| Emma | Female | 45-54 | Full time employed | Heterosexual | Asian | Working | no | Single | Yes |
| Lucas | Male | 35-44 | Part time student | Gay | White | Middle | no | Partnered | No |
| James | Male | 55-64 | Part time student | Heterosexual | White | Middle | no | Married | Yes |
| Noah | Male | 55-64 | Full time | Heterosexual | White | Working | no | Single | No |
| Grace | Female | 45-54 | Part time | Heterosexual | White | Middle | no | Married / civil partnership | Yes |
| Fiadh | Female | 35-44 | Full time | Heterosexual | White | Middle | no | Partnered | No |
| Jack | Male | 25-34 | Full time | Heterosexual | White | Working | no | Single | No |

## Analysis

The process of data analysis in IPA is intended to be a reflexive one, with the focus of the analysis on making sense of the individual's experience (Smith, Flowers and Larkin, 2022). The analysis was guided by the steps outlined in Smith, Flowers and Larkin (2022), as they provide a clear outline of execution which can be applied flexibly. The process is iterative and inductive (Smith, Flowers and Larkin, 2022).

Each interview was transcribed by a professional and confidential transcription service. One page from each transcription was cross checked with the original recording to check for errors and quality. Furthermore, if any additional anomalies were apparent in the transcription during reading, further cross checking with the original recording and corrections were made.

By way of preparation for the analysis, two short extracts from the data set were selected to be analysed separately and then conjointly between the researcher and the study's supervisors. Both supervisors had expertise in qualitative research and have published several peer-reviewed articles. This process provided guidance in the depth and breadth of analysis required for an IPA research study before the full analysis commenced.

Each transcript was analysed in turn. Analysis began with making initial notations of my first impressions on the transcript, oscillating from broad to detailed observations. This was followed by noting semantic, linguistic, and conceptual elements of the text, including hesitations and repetitions. Chunks of text were then isolated and reviewed for convergence, divergence, and relationships across the transcript. Mapping statements that fit together followed with clustering related statements, through a process of abstraction, creating personal experiential themes and through subsumption, when a statement within the text is promoted to a Personal Experiential Theme (PET). Moving to the next participant transcript and bracketing what has been learned before allowed new experiential themes to present themselves from each case. Finally, patterns were looked for across all cases by looking for connections and relationships between experiential statements and PETs, while noticing individual cases which could represent those themes. Supervisors were used throughout to ensure the analysis remained close to the data and adhered to the research questions and aims. An external supervisor was also engaged to guide and quality check the final themes.

## Ethical considerations

Participants' wellbeing was of primary concern to the researcher. The research was guided by the British Psychological Society practice guidelines (British Psychological Society, 2017), and the UWE Code of Good Research Conduct (University of the West of England, 2015), which uphold participants' rights to respect, confidentiality and self-determination. All participants' correspondence, including signed consent forms took place according to the Data Protection Act 2018 (Information Commissioner's Office, 2019).

## Participants' wellbeing

Participants were invited to share their experiences of the intensive treatment and informed that there was no requirement to disclose the trauma at any time. If the participant became distressed during the interview, it was planned that the interview would end, and an extended time for the debriefing would be allowed. I am an experienced EMDR and trauma therapist and could call on these skills should the participant become upset. An information sheet was also provided with relevant signposting to avenues of support. Participants were interviewed in their own homes; therefore, they did not face any out of the ordinary risks other than those encountered in everyday life.

A three-month exclusion period between completing therapy and participation in the study allowed participants the time to reintegrate into their lives following their psychological

therapy, while preventing interference with any residual processing and memory reconsolidation. The gap also supported a clear demarcation between the treatment process and the research.

# Analysis

In the following analysis I will present an overview and interpretation of the meaning and significance attached to the experience of undergoing intensive EMDR. Using excerpts from each of the participants, interpretations, convergences, and divergences are presented. The intention of the analysis is to represent and interpret the participants' experiences of intensive EMDR from their own perspective. Two PETs were identified: The importance of psychological safety and The changing self. Each PET encompasses two experiential statements. Table 3 below outlines the thematic structure.

Table 3: An overview of the thematic structure

| Personal Experiential Theme | | Experiential Statement |
|---|---|---|
| The importance of psychological safety | 1a | A protected space |
| | 1b | The importance of a continued connection |
| The changing self | 2a | Wow! moment |
| | 2b | Living the way I always wanted |

### Personal Experiential Theme 1: The importance of psychological safety

The importance of psychological safety during intensive EMDR was apparent as a key theme across the interviews. For the participants, psychological safety was defined as a sense of support and comfort during the process of intensive EMDR. This theme encompasses two experiential statements. First, the participants derived safety from a continued connection, and a sense of an ongoing link with the process. The nature and meaning of the link varied between participants. Second, the participants derived safety from a defined and segregated physical and psychological space. These two experiential statements will now be explored.

#### Experiential Statement 1a: A protected space

The participants derived a sense of psychological safety from the intensive EMDR mainly from the sense of it being a protected space, separate to and different from their everyday lives. Participants described an experience that provided security and comfort, by excluding unhelpful distractions. Participants experienced a protected space as providing an opportunity to focus on the task at hand with greater commitment.

Harper explored how intensive EMDR was a protected space, separate to and different from the normal running of her life:

> It was something that I was doing to care for myself and that it was just sort of this time in this bubble of this place I've never been before. And, you know, I could have been in Ohio like it, it just…it felt like I was able to sort of step outside of my life for that time, um, that I was there each day. And (pause) and just be … with myself, and, um, take care of myself.

For Harper, psychological safety was derived from her experience of a protected space or 'bubble' of intensive EMDR, which felt far removed from her ordinary life as she likened it to being thousands of miles away from her home: "I could have been in Ohio". Due to this experience of separateness and the protection of the intensive EMDR, Harper became very inward looking, as it afforded her to "take care of [herself]". Earlier in the interview, Harper described herself as being "a sponge for other people". The pause in her final sentence above thus might have indicated that taking care of herself was unfamiliar to her. It is possible that the physical and psychological separation from the usual obligations in her life was necessary to find space for herself. The phrase "just be … with myself" conjures a timelessness of a vacuum, that excludes others and everything else. For Harper it seemed, a protected space and safety meant a distance from distractions, where she could focus exclusively on her own needs.

In this quotation, Noah also drew on the metaphor of a bubble, like Harper. However, for Noah, the protective space of intensive EMDR, was a shield so "nothing … can get in":

> And so I think, because I was prepared for it and because it was, and as I said, in the bubble, it was like I thought, kind of like a bit being in a laboratory, you know, which is like, very hygienic environment, you know. Nothing else can get

> in, you know, what I mean, sort of thing. So I think that was it, I think, really, it was, I had total permission to visit the traumatic situation.

Regarding the protective space, Noah's emphasis is on how intensive EMDR creates the right conditions to speak of his trauma. For him it seemed that screening out unwanted intrusions was important, and this gave him the necessary safety to "visit the traumatic situation". In contrast to Harper's bubble of self-care, Noah's laboratory metaphor hints at a need to control, as it invoked a strict, secure, and controlled environment, under quarantine, which emphasised the importance of this protected space for him.

Like Harper, Noah also needed to exclude distractions to focus, and therefore it was essential that "nothing else can get in". The importance of a protected space for Noah's sense of safety and control, appeared intrinsic to his ability to fully engage with the process and was reflected in the absolute nature of his comment "I had total (emphasis added) permission to visit the traumatic situation". For the participants, a protected space which intensive EMDR facilitated, seemed to provide psychological safety because it guarded against distractions and facilitated a focus on the self or therapy.

For Honoka, a protected space was the freedom to focus on one task, and the elimination of all other elements of her life:

> I mean at that point, you know, I was there, and then I blocked the whole two weeks. You know I just, you know... I was fully present and then ready to do whatever. Yeah. Yeah.

Here, it seemed in Honoka's mind, that a protected space that the intensive EMDR provided was absolute and reflected in the emphatic statement - "I blocked the whole two weeks". This may reflect how difficult or how important it was for her to do such a thing. Like Noah and Harper, there seemed to be a relationship between a protected space of intensive EMDR, and a confidence to fully commit to the task. This was reflected in Honoka's ability to be "fully present". It is possible that Honoka was unsure about what was going to be asked of her when she referred to being ready to do "whatever", and perhaps a protected space meant she could be 'present and then ready' for the therapy considering this uncertainty.

Emma's protected space was the structure and boundaries of a 'clinical environment':

> Um, and also, being in and off, like it…not at like home, uh, you know, being…
>
> Int: Uh-huh.
>
> Emma: in like a clinical kind of environment, but very comfortable while revisiting these uncomfortable memories and times in your head.

Like Noah's laboratory, Emma drew on the analogy of a clinical environment to describe her experience of a protected space during intensive EMDR. For Emma, the "clinical kind of environment" may have referred not just to the physical space but also to the hidden structures of the therapy, which she felt comfortable 'in'. While these parameters were comfortable for her, she appeared to recognise that it was different and separate from the comfort of home – "not like home … but very comfortable" - which suggested adequate comfort. Emma mirrored the common experience that a protected space meant being able to engage with the therapy to revisit "uncomfortable memories and times in your head". Just

like Harper, Noah, and Honoka's experiences, the safe experience of intensive EMDR was felt from the clear demarcation between ordinary life and the therapy.

Several participants including Lucas, referred specifically to the physical environment as a source of care and comfort:

> um, um, very comfortable waiting rooms and amenities you know, I brought my lunch every day, so they had little lounges, but they were- they were almost like living rooms in a home.

Similar to Emma, Lucas reflected on the experience of the environment being like home, but not home. Lucas seemed to recognise the environment as a public space with inherent rules for behaviour when he referred to "waiting rooms" and "amenities". However, his comparison between "little lounges", which implies privacy and discretion, with the more communal "living rooms in homes" was in recognition of the comfort and homeliness he experienced in the shared space. Beyond this, it was meaningful to Lucas that he was able to use the facilities and bring his lunch in every day. This is perhaps an indication of a sense of being cared for and held in mind, within the generic, communal space. It seems that for Lucas, a protected space of intensive EMDR was a socially structured environment where he could feel comfortable in his surroundings.

James also experienced a protected space during intensive EMDR; however, for him, a protected space meant protected time:

> just the…the benefit of doing a week's worth, you get to dive into it more 'cause you're dealing with such sensitive issues that……to really take that time and that

> space aside to do it in a week's worth of time rather than in, like, blocks of time over weeks.

In this quotation, James found safety in the expanse of ‘time and space’ he felt was available to him during intensive format of EMDR therapy. James seemed time conscious, which was reflected in the perpetual motion portrayed in his statement about weekly therapy as ”blocks of time over weeks”; therefore condensing sessions into intensive EMDR “doing a week’s worth” seemed advantageous. For James, he seemed to view a protected space that intensive EMDR provided, as submersion, where he could “dive into” the hidden depths of his “sensitive issues”. The term “dive into” also invoked a level of commitment and completeness seen across participants. Similar to Harper, Noah, Honoka, and Emma, it seemed that James was reflecting on the necessary conditions to fully engage with the therapy. In contrast to the others, it seemed that James experienced psychological safety and a protective space as expansive time and space, which was freeing, permitting a deeper focus.

For the participants, a protected space was vital to a sense of psychological safety. For them, a protected space was separate to and different from their regular lives. It acted as a shield, a distance from distraction, a structure with dedicated time that was a different experience than their regular lives. A protected space contributed to a sense of preparedness for what was to come, and a condition for full commitment to themselves and the therapy.

Experiential Statement 1b: The importance of a continued connection

Participants also described the importance of a continued connection for a sense of psychological safety which the intensive EMDR facilitated. For the participants, psychological safety was experienced as containment, which provided a sense of selfdetermination, autonomy, and control over their experience. The view of being the protagonist in their experience was complimented by a continued connection, a tether between themselves and some part of the process which intensive EMDR provided. They also described this connection as reassuring, a container for distress, and comforting.

The continued connection in intensive EMDR was derived from a variety of sources, including ongoing and repeated connection to the therapist, the therapy, or from contact with loved ones. For most of the participants, intensive EMDR facilitated a continued connection which provided a sense of autonomy during the therapy, while for others, the ongoing link was a means of obtaining answers and reassurance. The level of continued connection experienced ranged from a light, guiding touch to a continued reassurance: Harper sums this up below:

> Um, but that felt very doable and very safe, uh, and that someone was there. But although it was all me processing, I had somebody checking in with me every step of the way, um…

Harper was one participant who spoke explicitly about the experience of safety during intensive EMDR. For her it seemed safety, comfort and support were gleaned from the ongoing contact with her therapist that intensive EMDR provided. For Harper, it is likely that the continued connection with the therapist meant the experience felt more manageable, or

"doable". It may be that she felt safe because she was not alone; she had regular and frequent contact with the therapist to check in on her "every step of the way". Although Harper appeared to value the continued connection with the therapist, it seemed she also felt some agency, and possession of the process; this was revealed when she said in no uncertain terms "it was all me processing". For Harper, her experience of psychological safety during intensive EMDR was related to being continuously tethered to the therapist, while simultaneously experiencing some autonomy in the process.

For Emma, it is likely that the continued connection was an uninterrupted effort to complete the therapy. The continued connection was with the therapy, and the repeated and immediate return to the process, rather than with the therapist:

> But with the intensive, I was like I can go 100% today, you know. I can go 100%… …because I know that I'm going to come back tomorrow, and I can, and I can finish. This But if I was doing it weekly, I would go in and maybe give 30% because I knew that if I did 100%, I would have a really bad week until the next session.

For Emma, continued connection was returning the next day to finish the task – "I'm going to come back tomorrow, and I can, and I can finish" - and the continued connection was a full, and continuous investment of her efforts: "I can go 100%". The continued connection during intensive EMDR possibly meant avoiding unpleasant and unsupported periods between sessions: "[the] really bad week until the next session". Interestingly, she used different words to describe her efforts for intensive, verses weekly sessions; for intensive sessions, she was 'doing' 100%, while for weekly, she was 'giving' 30%. Like Harper, Emma appeared to

be viewing herself as somewhat self-governing in the way she carefully measured her investment, and she felt the continued connection during intensive EMDR permitted this. The continued connection seemed to be knowing the therapy was there to return to, to pick up again where she left off, and this provided a sense of comfort and control.

Like Harper, Jack also felt the value of a continued connection to the therapist. For him, safety was drawn from being able to speak to the therapist at any time, "morning, noon and night":

> I think that I had Lincoln [therapist] there to if I had a problem or if I had a question on A, B, or C, that I had that support, that I could call him morning, noon, or night, and just say listen I don't understand this, and he would sometimes stay on the phone for 10, 15 minutes just to elaborating exactly what I needed to do and what it meant, and why it mattered, so that support was there and it was fantastic.

Here, the free and constant access to the therapist during intensive EMDR seemed to provide a continued connection, which may have fostered reassurance for Jack. Jack appeared to find the continuous contact and easy access to the therapist which intensive EMDR provided, helpful in making sense of his material and finding answers. Jack's strong experience of connection and accompaniment may be reflected in his choice of the word "stay," when he described the contact with Lincoln between sessions: "he would sometimes stay on the phone with me" (rather than a more mutual 'we spoke on the phone'). This turn of phrase may have revealed a man in need, and being supported until he felt better, and which invoked a sense of endurance in their contact during intensive EMDR.

In Jack's account, he used "I" which showed a separateness from the therapist, echoing Harper and Emma's autonomy, and he positioned Lincoln as his guide who would tell him what "[he] needed" to do, rather than tell him 'what to do'. Although Jack needed continued connection for support, he had no doubt in the relevance of his material or his questions; this was reflected in his clarity in his use of "A, B or C" to define his queries in a list, and in how he referred to being told "exactly" what to do. Although Jack appeared to be viewing himself as somewhat independent from his therapist, he was gaining reassurance and did not appear to feel the sense of agency felt by Harper and Emma. Thus, safety seemed to be derived from the unrestricted access to the therapist that intensive EMDR provided, and Jack gleaned comfort and support from the continued connection available to him.

Grace's continued connection was perhaps found in access to an ongoing dialogue between her and her therapist. It also seemed that her thoughts in between sessions served as a connecting bridge between one day and the next:

> I needed, as I said, if something came up for you, in between sessions, you could go back and say, "I can't stop thinking about this now." And you know, sometimes that might be hugely relevant, but I maybe didn't see the relevance of, you know, something to whatever we had been dealing with or working with that kind of way.

In this quotation, the continued connection of which intensive EMDR provided, may be the uninterrupted process where Grace attended therapy, went away, and thought about it, then this was followed up by further discussion of her thoughts. It seems that safety was derived

from a loop of feedback that the intensive EMDR format facilitated, where she would 'see' what she was unable to see, and that nothing would be overlooked.

In comparison to Jack, Grace's experience of a continued connection reflects a more doubting and dependent stance, while still finding psychological safety in the form of reassurance. In this interview, Grace appeared to doubt her ability to understand if something was relevant; this was reflected in her use of "maybe" and "might". In a divergence from Harper and Emma, and Jack who felt independent, Grace relied on her therapist to make space for the relevance of new material to emerge. Like Emma, the return to therapy meant getting things resolved; for Grace, intensive EMDR meant addressing the things she "can't stop thinking about". In this statement, there was some angst and anxiety that she might be missing something important by jumping around so much. To her, it is possible that the continued connection provided by intensive EMDR meant remaining thoughtful about the therapy between sessions.

Interestingly, Grace's statement begins with "I needed", which may highlight the importance for Grace that she had someone to talk to; however, she quickly switched to a more distant "if something came up for you", which may have suggested a discomfort in talking about her emotional needs. This switch from first to second person contrasted with Jack's clarity of "A, B or C". If Grace felt unsure about her ability to identify relevant material, and uncomfortable with her needs, it appeared that she found solace in the ongoing dialogue with her therapist, and the continued connection which intensive EMDR provided.

For Lucas, continued connection meant repeated opportunities to master previously unresolved tasks:

> Uh, the comfort, the um, reassurance that let's try this and see if it works, it doesn't work for everybody but it may work for you, you know, specific methods or specific patterns of things, um, revisiting them a couple days later to say, "Oh, it didn't work the other day but maybe- maybe you'll be able to do it today".

Lucas seemed to be reassured that during his experience of intensive EMDR, there was a continued connection with "specific methods or … patterns"; meaning he could return to tasks that were not completed previously in the therapy. Lucas seemed to reveal a sense of psychological safety when he felt "the comfort" and "reassurance" of continuing with previous tasks, or perhaps a sense of relief from expectations. Therefore, for Lucas, the continuity of intensive EMDR means it felt more within his capabilities. The continued connection with these tasks meant he was reassured to know that nothing was entirely lost. Like the other participants, Lucas situated himself as the main agent in the therapy, but was coaxed by the therapist, when he spoke the therapist's words, "maybe you'll be able to do it today". Thus, it seems that psychological safety during intensive EMDR was gleaned from the unbroken connection with the tasks of the therapy, and repeated chances to revisit them over again.

In a divergence from the other participants, Mia found safety in a continued connection outside of the therapy process - the presence of her mum who stayed in her home while she accessed the therapy:

> And I'm like lucky enough that I got my mum to come stay with me while I was getting treatments so that made me feel safe.

Unlike the other participants, it was Mia's mum who was the consistent companion who provided a sense of psychological safety during intensive EMDR. To Mia, the continued connection was the backdrop of support that she had from her mother. The importance of this continued connection, even one that appears to be in the background, is reflected in Mia's sense of being "lucky" to have her mum there.

The continuous "stay" used by Mia, invoked a permanent presence during intensive EMDR, which is reminiscent of Jack's experience of his therapist. However, in contrast to the other participants, Mia's mum was positioned in the background waiting, while Mia left her, went out and was "getting" treatments. Again, like Harper and Emma, it seems that Mia put herself at the centre of the therapy, as the phrase "getting treatments" may have reflected an experience of self-efficacy, where she obtained something for herself. Still, a continued connection with her mum, even outside of the therapy, meant a sense of constancy which provided psychological safety.

For the participants, a continued connection of intensive EMDR was integral to a sense of psychological safety. For most participants, this appeared to translate to a sense of autonomy or reassurance. The nature of the continued connection varied across participants; for some, it was the continued guidance from the therapist, while for others, it was returning to finish the task, a second chance to revisit material or a companion waiting in the background. From the

participants experiences, it was clear that the continued connection which frequent and perpetual contact provided, meant a sense of psychological safety in intensive EMDR.

### Personal Experiential Theme 2: The changing self

The analysis revealed that the experience of a changing self was meaningful to participants. The participants experienced a changing self in terms of new insights, changes in perspective, an altered view of themselves, their lives, and a change in relationship towards others. For the participants, changes in their internal world manifesting in surprising new perspectives was most salient, alongside a new ability to live their lives in a way they had always wanted to. This theme encompasses two experiential statements, the first shows participants' experience a Wow! moment, a spontaneous moment of clarity or insight during the intensive EMDR, which impacted on their sense of self. The second shows how participants experienced living their lives differently after the intensive EMDR, in a way that they had always wished to but could not previously.

#### Experiential Statement 2a: Wow! moment

The participants shared a Wow! moment experience during the intensive EMDR. The Wow! moment appeared to be a sudden experience of a new perspective, or self-knowledge. The change seemed to represent a significant and fundamental shift in an internal and personal state 'within' or a change in perception.

It seemed that the most important Wow! moment for Honoka was one evening during the intensive EMDR, when her children were arguing with each other:

> wow, I'm just like, I hear them fighting and then like, oh wow, you know, I have this peaceful mind, what do I do with them now? Like how should I say, mm, like that kind of... yeah, that was strange, it's almost like I can be very, um, observant, um, I just didn't... Yeah.

In this quotation the probable change Honoka experienced in herself appeared to catch her by surprise, which is revealed in her repeated use of "wow!", and the bafflement by this completely new experience of space to reflect on her response to her arguing children "what do I do with them now?". Honoka seemed to experience a general change in perspective when she referred to a peaceful "mind" rather than the possible alternatives - 'a sense of peace,' or 'moment of peace' - and this meant she saw the argument from a more observant standpoint. It is possible that Honoka was describing a new way of experiencing herself and the world. It was also possible that during the interview, Honoka seemed to remain unsure about what the changes meant to her, and was indicated by the 'strangeness' she reflected on, and the lack of conviction in her speech "it's almost like I can be very, um, observant, um, I just didn't... Yeah".

For Fiadh, a Wow! moment seemed to be a change within herself, combined with the speed in which it occurred:

> That's probably the best that is a difference that you can see within...like, you know, I'm not saying that there's no differences afterwards, but just even in like

> between two hours, like you can see a change in yourself or whatever. So I think that's good. Yeah.

In this quotation, Fiadh seemed to experience an intrinsic and deeply personal change illustrated by her statement “a difference you can see within”. Faidh did not elaborate on what that change was, this was a possible indication of how difficult it is to articulate such an experience or how private it was. The change seemed particularly important to Fiadh as she opened her statement with ”the best” and then reinforced this with “I think that’s good” at the end of the statement. The short time between the intensive EMDR and experiencing changes seemed to be a revelation to Fiadh when she said “but just even in like between two hours”. For Fiadh it seemed the Wow! moment was a change in self, experienced ‘within’ and faster than she expected.

Noah seemed to have a similar Wow! moment experience that involved a sudden change in his sense of self and his feeling towards his perpetrator. He elaborated more than Fiadh and described new feelings, and a transformation to being “free”:

> So I actually felt compassion [towards the perpetrator], you know, and I think that...and I think that was really significant, because suddenly I was free.

For Noah, it seemed the change in self was a sudden realisation when he believed he was free. This seemed to be a pivotal moment in the intensive EMDR, where he viewed the perpetrator of his trauma with compassion for the first time “because suddenly I was free”. There are several possibilities of what he may have felt liberated or “free” from, most likely ties to the perpetrator or feelings of hate/anger (the opposite of compassion). He stated this change was

"significant" possibly alluding to the impact this had throughout his life. Interestingly, the potential for some disbelief in the change, is revealed in the emphasis on the "actually" in "I actually felt compassion". For Noah, it seemed that his Wow! moment was that he experienced a change in orientation towards the perpetrator and himself in the world, to feeling compassionate and free.

Grace referred to several Wow! moments during the intensive EMDR:

> I can think of three specific occasions where, where suddenly my whole attitude, the way I thought about it, even that evening, and that next day was different. And not, you see, you know how you should think about it. And you know, how you should feel about something. But that's not the same as believing it, do you know what I mean?

Grace felt a sudden and surprising change which was implied by the "even" in "even that evening" she was different. For her, as for Honoka and Noah, the change seemed fundamental, and broad reaching, when she referred to her "whole attitude" as different. In this quotation, Grace likened this change in her "whole attitude" to believing something, and she recognised the difference when she contrasted the intrinsic 'belief', with a more superficial, "[knowing] how [she] should" feel about something. In terms of the changing self, here it seemed that Grace was describing the possibility of a more authentic existence where her feelings and behaviours reflect each other, and this was important to her.

Mia also described a Wow! moment of personal change, and new experience. However, for her, it seemed less sudden and more of a gradual falling into place:

> So I think that was the most powerful piece that kept me involved was I could see that the pieces were falling together with every event that we did. And, so I really believed in it.

For Mia, it seemed that the Wow! moment was seeing a coherent bigger picture, as the pieces were "falling together". Mia's statement drew on a metaphor of a jigsaw puzzle with several disparate pieces coming together to create a whole picture. She seemed clear that this experience was "powerful" for her, which magnified its importance. Her statement possibly implied a growing appetite for the process, as she could see "every event that we did" helped and meant that she "really believed in it". Similar to other participants, Mia referred to a deeply personal process of believing, as opposed to doing or thinking, this reflected a theme of a new, intrinsic knowledge of herself, and thus, a changing self.

For Emma, her experience of a changing self was to feel for the first time, emotions in different parts of her body:

> I hadn't ever experienced anxiety or, or emotions in my shoulders or, or in my knees, you know. Mm-hmm. Or, or moving up my back. And, and so, I thought that was just very cool.

For Emma it seemed that one of the most important experiences for her during the intensive EMDR was an encounter with her physical self. This was unlike the other participants who

described changes in perspective and beliefs. In this quotation, Emma's Wow! moment appeared to be experiencing emotions such as anxiety, in her shoulders and knees. She appeared to have discovered a link between her emotions and her body, and was quite excited by this new self-knowledge. This excitement was reflected in the momentum found in her speech "Mm-hmm. Or, or moving up my back". Emma also found this experience "very cool" possibly a reiteration of her excitement and the credibility of the insight into herself. For Emma, living the Wow! moment was the joining of her emotional experience and physical body.

During the intensive EMDR, the participants seemed to experience a changing self in the form of internal changes such as deeper insights and understandings and physical experiences, which impacted on the way they viewed themselves and the world. The changes seemed to be of great significance and meaning to the participants and the speed of the change seemed to counter expectations. Collectively the participants experienced the changes as new, positive, and fundamental.

### Experiential Statement 2b: A chance to live the way I want to

In this experiential statement, participants described a changing self in terms of living their lives the way they wanted to after the intensive EMDR. The participants described a change in how they experienced themselves, how they lived their lives, and how they experienced the world and other people. Participants seemed to value being more like themselves since the intensive EMDR, and how they had perhaps always wanted to live this way but were unable

to for various reasons. For some, this change was reflected in how they saw themselves relating to others, for other participants it appeared to be related to personal values, and a sense of control over their destiny.

For Harper the changes she experienced after the intensive EMDR meant she could achieve what was best for her:

> And I feel like I'm finally behaving a way that's true to myself and doing things that are good for myself. And it's something I always wanted to have but I never knew how to get there.

Harper's experience of her changing self-seemed to link with how easily she helped herself. For Harper, it seemed that making the right choices that were "good for myself" were particularly important to her. Since the intensive EMDR, Harper appeared to be living a life that was more in keeping with her view of herself, which she said was "something I always wanted" and could not achieve. A possible lengthy struggle to achieve being "'true to myself" prior to the therapy may be exposed by her use of emphatic vocabulary; "finally", "always", and "never" as she related her experience of change. In this statement Harper appeared to be reflecting on a change to a more congruent and authentic experience of herself, a person whose behaviours matched what she wanted for herself. Thus, the changes that occurred after intensive EMDR, provided an opportunity to live the life she wanted "and it's something I always wanted to have but never knew how to get there".

Similarly, Grace seemed to have enjoyed a more coherent sense of herself after the intensive EMDR:

> Yeah, the energy and I finally feel like that the little things that should have been making me feel okay, do actually now and I always said they did, but they didn't.

For Grace, the intensive EMDR meant a change in herself illustrated by how she felt and responded to wellbeing advice. It seemed that prior to the intensive EMDR, Grace tried what she could to feel better and yet nothing was bringing the expected results (to "feel okay"). In this statement, she also seemed to divulge an incongruence between what she said outwardly, and how she felt inside "I always said that they did, but they didn't". Therefore, it is possible that the change she saw felt more in keeping with the way she wanted to live, and this meant a more authentic, and congruent existence. Like Harper, Grace described a long journey prior to the change, and some relief in her words; "finally" and "always". For both Harper and Grace, it seemed that the experience of the intensive EMDR was a chance to live a life they had always wanted for themselves and to being a more authentic self.

Fiadh conveyed her experience of a changing self, and living the way she had always wanted to, using an example of choosing a dress to wear:

> It's...I've had this in the wardrobe maybe like six years and I've worn it, like, twice. But it's something...where am I going to wear it to? […] You know, or there there's no reason to get dressed up. Or I'd feel uncomfortable, I feel like I'm overdressed. Whereas now I'm like, I felt like wearing it, so I'll just wear it, you know. So yeah.

Here it seemed that Fiadh was describing a change in herself which constituted fewer barriers and inhibitions. Her statement revealed that prior to the intensive EMDR, she had numerous obstacles between her and wearing a particular the dress. This was followed by a new, and

simple justification for wearing the dress “I felt like wearing it, so I’ll just wear it”. It looks like Fiadh was experiencing herself with fewer inhibitions which has enabled her to fulfil her aspiration to wear the dress. As a simple metaphor for life, perhaps Fiadh is better able to live the life she desired (wear the dress) by reconnecting to the part of her which had been hidden for years (in the wardrobe). Here it seemed Fiadh is living the life she has always wanted to, one where she embodied her aspirations.

While it seemed that Fiadh began to experience herself as the embodiment of her aspirations, James seemed to inhabit a role of architect of his life:

> And all my life I've seen...my life in dreams I created like a house. So that's kind of what my brain process. And since then and the therapy I've been doing, I'm just...in my dreams I'm kind of like rebuilding it. In essence, I'm rebuilding my life.

In this quotation, James appeared to experience a change in himself to a builder and the architect of his life – “in essence, I’m rebuilding my life”. The re-assembly of the house might have represented a subjectivity with more agency than before, as a curator of his life. The notion of a rebuild may have implied having choices and oversight that he did not have before “in my dreams I’m kind of rebuilding it”. It seems clear that James is not referring to a new self, but a reconstitution of a ‘torn down’ self. Therefore, it seemed he was contemplating the use of original parts of him to contribute to his future life. For James, the chance to live the way he had always wanted to, seemed to be about consciously redesigning his life.

For Emma, the shift in her sense of self was experienced as developing patience for herself and other people:

> um, because I think it's true, how you treat yourself is how you treat others. Um, more, more patience. I have more patience for myself, and I think, you know, I have more patience for other people now. Um, and I can really understand myself and like my behaviours, you know.

After the intensive EMDR, it seemed that Emma was better able to live by her motto as she had newfound patience for herself and other people. In this statement it appeared that "how you treat yourself is how you treat others" is a closely held personal value. She also seemed to describe a depth of self-knowledge perhaps more than ever before, indicated by the emphasis in "I can really understand myself". Emma had applied her new selfknowledge and patience for herself to a new way of relating to others, reflecting both inter and introspective changes. Emma is perhaps saying that she felt better able to live her values of patience, since the intensive EMDR. For Emma, a chance to live the way she always wanted to meant living her values.

Lucas also drew on connection to others to illustrate changes in how he experienced himself after intensive EMDR:

> …and I couldn't articulate or I- and I wasn't mentally present to help them so it was a lot of confusion, it was a lot of worry, fear, you know, safety concerns, um, it was a relief to be able to you know, sit with someone again and have a conversation or um, go out to- well that took a long time, go out to lunch with my

> best friend um, or get me out of the house, um, you know, the- the change was dramatic.

Lucas reflected on a time when he was inarticulate and ”mentally” absent to then being able to “have a conversation” with his best friend. Perhaps for him, the change in self is gauged by how well he can make himself be understood by others. It seemed important to Lucas to connect with his best friend over lunch, and the connection seemed to have a sense of reparation and relief because he was no longer causing ”confusion … worry, fear, you know, safety concerns” for others when he was unable “to help them”. Throughout this statement there was a sense of Lucas’ sense of vulnerability via his punctuating remark “the change was dramatic”. His sense of himself and living the way he always wanted to meant returning to a connection with others.

For Jack changing self was being able to be the kind person he had always wanted to be:

> I didn’t have that inert kind of kindness that I would’ve liked to have because I just didn’t have it in myself, so I can make decisions now and do things that I wouldn’t have been able to do before, […] It’s just amazing day to day how these things, you know, it made me a better person.

For Jack, a sense of living the life he always wanted is related to being a better person – “it made me a better person”. However, in this statement he appeared to be considering whether he acquired kindness since the intensive EMDR, or if it was there all along. This quandary is revealed in his choice of the word ‘inert’ in “I didn’t have that inert kind of kindness”. This could be interpreted in two ways, firstly that this word was used

in error, and he intended to say ‘innate’ meaning that kindness was never inherent in him. Alternatively, the choice of word showed he was pondering the presence of a quality that lay dormant in him, that has since been awoken. Jack also framed the changes in terms of his ability to make decisions which suggested a new-found sense of agency, like James viewing himself as the architect of his life. For Jack, a chance to live the way he had always wanted to, meant possessing a kindness that he had always wanted, which made him a “better person”.

The participants experienced a change in self that seemed to bring forward qualities and behaviours that they were previously unable to execute. There seemed to be a new alignment between how they saw themselves (e.g., kind, patient) and the life they lived, and this was the chance to live the way they always wanted to. The participants also seemed to allude to an element of agency in their new sense of self.

## Discussion

The analysis generated two personal experiential themes and four experiential statements. The first personal experiential theme was the importance of psychological safety during

intensive EMDR. Participants defined this as a sense of support and comfort during the therapy. Psychological safety was derived from two personal experiential statements, (1) A protected space, and (2) The importance of a continued connection. Intensive EMDR provided a protected space, far removed from their usual lives which felt protective and facilitated self-care and a greater commitment to the therapy. The second experiential statement was the importance of a continued connection. The continued connection was defined as an ongoing tether between the participant and some part of the process of intensive EMDR. The continued connection derived from the perpetual motion and momentum of intensive EMDR was experienced as reassuring and comforting and facilitated a sense of autonomy during the therapy. The second experiential theme was the changing self, where participants experienced changes in their internal worlds, and new perspectives on their lives and relationships. Two personal experiential statements were developed from this theme, (1) Wow! moment and (2) Living the way I always wanted. The Wow! moment was as sudden experience of an insight and self-knowledge which felt exciting and pleasing. A chance to live the way I always wanted highlighted a change in the experience of self, where participants felt they were more like themselves because of the intensive EMDR. This pertained to how they related to others, making the right choices, how they saw themselves, and how they experienced more control over their future.

The following discussion will reflect on the findings of this study, make links with existing psychological theory and research, and explore the study's contribution to the field of counselling psychology. It will then discuss implications of this research for practice and make recommendations for future research. Limitations of the study will also be presented.

## Achieving psychological safety

During a traumatic experience, individuals can experience a sudden and extreme sense of unsafeness and lack of control, which then persists over time (American Psychiatric Association, 2013). This sense of unsafeness or threat can become pervasive, and significantly impede a person's ability to trust themselves, other people, and the world (Ehlers and Clark, 2000). Therefore, it is essential that a level of psychological safety is established in the therapeutic process for healing to take place. Traditionally, models of psychotherapy have deemed it necessary to allocate long periods of time to establish psychological safety prior to embarking on trauma focussed therapy, usually by means of building rapport between the therapist and client or through building psychological resources within the client (Parnell, 2007). However, it appears from this study that psychological safety can be established within the period of intensive EMDR by way of a protected space, which fosters a sense of preparedness and confidence, and a continued connection, promoting a sense of agency. The following discussion will link established theories to these findings.

It appears that intensive EMDR provided psychological safety in the form of a protected space, which was separate to and different from participants' usual lives. A protected space provided security and comfort for participants, as it excluded outside distractions, and guarded against intrusions. A protected space was also experienced as an expansive space, where emotions could be explored freely and in depth. A protected space is similar to the therapeutic frame referred to in psychotherapy literature, which is defined as governing parameters within which therapeutic material is contained and discussed, providing continuity and consistency (Gray, 2013). Various theories about what constitutes the frame have been proposed, including but not limited to: practical arrangements (allocated time, fees, and

cancellation policies), an attitude of mind of the therapist (providing containment, neutrality, interpretation) and relationship boundaries (confidentiality, defining the therapist's role and the expectation of the client;  Lemma, 2013). Similarly, in a phenomenological study by (Marich, 2010) 10 female participants were interviewed regarding their experiences of EMDR during an alcohol rehabilitation program. Their analysis highlighted the importance of the structure of the treatment programme, the sense of encouragement by staff, and the programme's commitment to quelling doubts all contributed to participants' sense of safety. Marich (2010) findings support the knowledge that diverse elements of EMDR treatment contribute to the experience of safety.

For the participants of this study, A protected space was defined and valued as a psychological and emotional venue that expanded time, which separated them from their lives, to which they directly attributed a confidence in their abilities to engage with the process. Furthermore, the participants valued the clear and prolonged demarcation between their ordinary lives, and the intensive EMDR. Thus, participants experienced intensive EMDR as stepping outside of their normal roles and lives for a period, rather than an activity that was integrated into their week, like weekly therapy sessions. Therefore, this suggests that an advantage of intensive EMDR is that it provides a sustained and much appreciated physical and psychological separation from the outside world. Furthermore, this complete separation was experienced as freeing, with enhanced focus and commitment for the participants. This study reveals the burden of external factors in therapy and their relationship with participants' perceived ability to engage with the process. These findings, which highlight a potential unhelpful influence of external factors during therapy, are similar to

Ramsey-Wade's (2006). Ramsey-Wade (2006) interviewed six students attending a university counselling service and found that students frequently experienced therapy as interfering with their studies and that committing to therapy during exam periods was problematic. Furthermore, attending counselling in the same venue as studying interfered with therapeutic change (Ramsey-Wade, 2006). In contrast, intensive EMDR was experienced as ringfenced time and space which appeared to circumvent such difficulties for participants, thus perhaps may offer a more coherent experience.

### An extended frame

This study participants perceived safety as essential to a good experience of intensive EMDR, and safety was determined by additional factors including comfort, the environment, and a sense of autonomy. Participants experienced the therapeutic frame as stretching beyond the therapeutic relationship, into parameters of time and space. Furthermore, for several participants procedural elements such as the bank of assessment and follow up questionnaires were experienced as continued care and concern, and therefore an extension of the frame beyond the treatment period. The overall sense of safety gave rise to feeling prepared for the task ahead.

### Feeling prepared for the task

Avoidance of reminders of traumatic memories is a key component in the maintenance of PTSD (American Psychiatric Association, 2013). Therapy that requires revisiting the traumatic memories can evoke fear and present an enormous challenge to clients. In contrast,

intensive EMDR provided a protected space that led to a sense of preparedness and confidence for participants, where they felt better equipped to approach (rather than avoid) difficult memories. This sense of preparedness and confidence because of feeling safe, is explained by developments in neuropsychology exploring safety and the therapeutic alliance. Allison and Rossouw (2013) has identified that a sense of safety derived from the therapeutic relationship triggers the opening of neural networks involved in effective emotional processing, and that safety enriched environments facilitate neuroplasticity, and enhance control and stress reduction. Thus, safety is essential for a sense of wellbeing and progress in therapy. This study proposes that participants of intensive EMDR experienced appropriate levels of psychological safety, which led to a sense of preparedness necessary for trauma-focused work to be undertaken.

Given the level of safety that participants experienced during intensive EMDR, the notion that extensive preparation work to establish psychological safety is necessary prior to trauma focussed therapy ( Van Der Kolk, 2014; Cloitre et al., 2012; Janet, 1919) can be questioned. This study's author suggests that a protected space may be inherent in intensive EMDR; this space is more complete than other approached, due to the level of segregation it provides which in turn leads to a sense of preparedness for the task. When safety and a protected space was valued, it seemed that a continued connection to a part of the process was also important.

The importance of a continued connection

‘Psychological safety was found to also have derived from a continued connection. The continued connection represented an uninterrupted and unrestricted tether between the client and part of the therapy process. This connection can vary in nature but often provides continuity and reassurance. Furthermore, the continued connection was important to participants as it empowered them to engage with the process and gave a sense that the therapy was manageable. The concept of continued connection corresponds with the notion of continuity of care explored mainly in general practice studies. In a discussion by Freeman, Olesen and Hjortdahl (2003, p.624) several elements to continuity of care are described including experiential continuity, ‘’coordinated and smooth progression of care from the patient’s point of view’’ and longitudinal continuity, ‘‘care from as few professionals as possible’’. Freeman, Olesen and Hjortdahl (2003) asserted that these elements are essential for developing trust and respect between patient and doctor. Gulliford, Naithani and Morgan (2006) described two dimensions to continuity of care: providing a seamless service which means coordinated and consistent care, and continuous caring relationship which encompasses care for the ‘whole’ person tailored to the individual’s needs considering the context of their lives. Though empirical research into continuity of care mainly addresses primary care general practice and health care, intensive EMDR may provide both a seamless service and a continuous caring relationship, by eliminating the disruptions to service delivery and providing a single point of contact through the patient’s journey within one block of time, as indicated by the current findings.

In a phenomenological study which interviewed ten service users of a community mental health centre, Biringer et al. (2017) showed that perceived elements of continuity of care such

as ‘timeliness’ (getting help when it’s needed), ‘knowledge’ (being informed about what is going to happen) and ‘mutuality’ (where both patient and professional were working together to resolve the difficulties) were important to mental health service users. Professionals and service users value continuity of care, in a survey of 109 paediatric consultants, 83% ranked continuity of care in their top three priorities. In the same study 19 service users were surveyed and more than half of the respondents felt it was important to see the same consultant. Sudhakar-Krishnan and Rudolf (2007) also reported inherent benefits to continuity, which brings about increased patient satisfaction and a greater sense of being in control of their health . There is also evidence that shows that continuity of care promotes engagement in psychotherapy. In a data analysis study, 200 cases who attended a community mental health centre were analysed and it was found that those patients who were assessed and then continued therapy with the same assessor (continuity) were significantly more likely to remain in therapy beyond session 3 (Wise and Rinn, 1983). The impact of discontinuity is highlighted in a large study which reviewed data from 15,137 university students who attended the universities counselling service. The data showed that those who experienced discontinuity between assessing therapist and treatment therapist were twice as likely to terminate therapy, improvement lagged behind those who experienced continuity, and required more sessions than their counterparts (Nielsen et al., 2009). Therefore, it can be suggested that continuity of care is important to both service users and service providers and dropout rates may have cost implications bearing issue. Intensive EMDR has the potential to offer a continuity of care which other approaches do not provide, which in turn may have a positive impact on the clients’ experience, and on the high dropout rates associated with standard PTSD treatments (Najavits, 2015).

In the current study, continued connection was derived from the ability to return for the next session later the same day or the following day. The continued connection was valued by participants and appeared to be drawn from frequent and repeated contact with an element of the therapy process. The potential benefits of a continued connection are highlighted in a unique study by Gutner et al. (2016). The study involced 136 women with PTSD with participants randomised to prolonged exposure or cognitive processing therapy. They found that sessions delivered in quicker succession (high frequency) and high consistency significantly improved PTSD symptoms when compared to low frequency and low consistency sessions, these outcomes were maintained at 5 years follow up. Gutner et al. (2016) recommended more frequent scheduling of sessions for PTSD to maximise outcomes(Gutner et al., 2016) and highlighted the potential benefits of the intensive therapy approach.

The findings of the current study support the value of a continued connection during therapy and its role in psychological safety. This study challenges the notion that the therapist necessarily has a central role in providing a continued connection as it presents the possibility of utilising a variety of means to provide and enhance a sense of continued connection and continuity during intensive EMDR.

### Confidence and manageability (Agency)

It has been proposed that participants of intensive EMDR experience a sense of agency brought forth from the continued connection. Agency was reflected through the participants'

experiences of feeling capable to go through the process, being at the centre of the process, and being self-governing.

Traumatic events such as physical assaults, transport accidents and workplace accidents are often random, unexpected, and extreme (American Psychiatric Association, 2013). Such events can evoke an extreme sense of vulnerability and helplessness and shatter one's trust and sense of predictability in the world. Thus, it is appropriate that therapy for PTSD be experienced as a safe, predictable place where the clients can possess some degree of agency (Bandura, 1989). This study shows that a sense of agency can be achieved during intensive EMDR for PTSD and benefit the client's experience. In the current study, participants experienced a sense of motivation to engage with the therapy which corresponds with Bandura (1989) and with Safran's (2016) theory of development, which states that agency is a sense of self generated influence, which incorporates motivational and volitional processes, and beliefs about one's ability to exercise control. The description of agency in Huber et al. (2021) states that feelings of being capable of acting, and having influence on the process of psychological change, cultivates engagement, and a selfdetermined stance. The research which surveyed 386 patients of psychodynamic therapy, found that agency can predict symptom improvement in psychotherapy. Similarly, this study found that participants valued a sense of agency which they experienced related to a continued connection and experience of safety.

## An experience of a changing self

The second PET of this study was 'The changing self'. The changing self was experienced by participants via a change in perspectives, an altered view of themselves, their lives, and changes in relating to other people. Two emergent themes were applied to the data, (1) The 'Wow! Moment', described as a sudden and surprising moment of change and perspective, and (2) 'Living the way I always wanted', described a recognition of changes in outlook and behaviours post the intensive EMDR. The suddenness of the Wow! moment and the nature of the change experienced, will be explained by the AIP model, which underpins EMDR therapy. Participants' experiences of 'Living the way I always wanted', post-therapy was valued in that they reported a return to an original self rather than a new self and will be discussed in light of Maslow's (1954) concept of self-actualisation. The following is a discussion of the participants' experiences of the changing self, considering psychological theory.

### Wow! moments

Participants experienced the Wow! moment as a sudden, surprising, and fundamental change in an emotional, physical, or sensory state that offered new self-knowledge and perspective. This reported change was described by participants as a felt sense, within themselves, and was experienced as exciting and joyful. Wow! Moments or moments of insight are not specific to intensive EMDR, as they are experienced in weekly EMDR and across several therapeutic modalities (see Jennissen et al., 2018). Nonetheless, the participants in this study also seemed to experience sudden and profound emotional and physical changes during intensive EMDR. These changes included feeling more detached in previously stressful situations, feeling more authentic and freer, possessing a sense of belief in what they were

doing rather than merely 'knowing' what to do, and feeling changes in bodily sensations, as explored in Timulak and McElvaney (2013). The apparent multimodal nature of their experience could be partly explained by the notion that EMDR is more like other 'bottom-up' rather than 'top-down' psychotherapies, and as such posits the benefits of recruiting the limbic system during emotional processing (Taylor et al., 2010). Therefore, it could be suggested that the participants' experience of fundamental change could be explained by the recruitment and engagement of the limbic system (sensory, imaginal, and emotional material) during intensive EMDR, just as in EMDR. Earlier EMDR studies reported similar experiences, such as Marich (2010), who, in a phenomenological study, interviewed 10 female participants of an alcohol recovery program which included EMDR therapy. They reported a theme of deep, personal change as EMDR ''goes to the emotional core'' and was accessing emotional issues which had been suppressed for years (Marich, 2010, p.503). Edmond, Sloan and McCarty (2004) also interviewed women receiving EMDR for survivors of childhood sexual abuse and found that the participants described changes on a deep, profound level, and said EMDR makes "changes on a cellular level'' (Edmond et al., 2004, p.267). Participants of intensive EMDR in the current study may have had similar experiences, as they described an encounter with sudden and multifaceted changes to their self, which they expressed as positive, radical, and affirming.

## The experience of change

The experience of change in therapy is common across therapeutic approaches (Lane et al., 2015), however, the participants' experience of rapid change appears to be unique to EMDR and is supported by existing research. Lipke and Botkin (1992) conducted case studies of 5

veterans hospitalised with chronic post-traumatic stress who underwent EMDR therapy for PTSD. The case studies revealed that participants experienced surprising, rapid insights related to their traumas and marked decreases in distress (Lipke and Botkin, 1992).

Participants in the current study had a similar experience of sudden change; however, unlike Lipke and Botkin (1992), they described a new sense of freedom, excitement and an increased connection with emotions and body, rather than just a decrease in distress.

Rapid, and participant generated, changes are what sets EMDR therapy apart from many other approaches that rely on the therapist's skill to introduce adaptive information. Accordingly, the cognitive behavioural approach for PTSD schedules insight orientated interventions several sessions into the therapeutic process (Ehlers and Clark, 2000). However, valuable changes in experience and perspective may occur within a significantly reduced time frame, as highlighted in findings of this study, which is contrary to other therapeutic approaches; this was experienced as motivating, powerful, and significant.

Additionally, current participants experienced the moments of change during intensive EMDR as emotional and corporeal events 'within' the person. This is demonstrated by participants speaking of a new experience that shifted from merely 'knowing', to 'believing' something about the world with conviction. For example, Emma's experience of excitement when sensing emotions in her knees, and Noah's elation from his new sense of freedom, are expressions of visceral and intuitive experiences. In a meta-analysis of insight events in psychotherapy, Timulak and McElbaney (2013) examined 15 insight events across 15 clients

using interpersonal process recall methodology. They found multiple processes involved in insight events during therapy, including a collaborative therapeutic alliance, client intent, emotional experience and reflection, and therapist intent, intervention, and observation.

Furthermore, they found that insights can be experienced as either painful, poignant, or both, by clients. The meta-analysis highlights a myriad of processes and experiences involved in the moment of insight. Similarly, Greenberg, Rica and Elliott (1996) found momentary insights result in emotional experience such as sadness, and empowerment, and awareness of an emotion evokes a sense of empowerment. Similarly, it was found in the current study that emotional awareness and new perspectives were experienced as helpful, pleasing and exciting, and these findings appear consistent with the literature regarding the nature and importance of insights in therapy.

### Living the way I always wanted

The following section will discuss the second emergent theme under 'The changing self', which is ''Living the way I always wanted'. This theme is discussed considering theories of human development and growth, including the concept of 'congruence' (Rogers, 1957) and 'hierarchy of needs' (Maslow, 1954). In the period after intensive EMDR for PTSD, participants of this study experienced living in accordance with their wishes, values, and sense of themselves. Participants valued this experience and saw it as an opportunity to live a more authentic life.

### Return to the true self

This study indicates that participants experienced an emergence of a latent self when they view themselves as more compassionate, patient, carefree and self-reliant. This emergence can be further explained by the theory of child development proposed by (Winnicott, 1965). In this theory, Winnicott proposed the idea of a true and false self. He recognised that infants, who are all highly dependent on others for safety and care, begin a process of negotiation with the world and relationships to get their needs met. In this negotiation, a proportion of the self, which included needs and desires, is suppressed. Over time, the original self is increasingly hidden from sight and subsumed by a highly adaptive and sophisticated false self, which operates in the world. The advantage of the false self is a perceived level of protection. The disadvantage of a highly developed false self is that previously unmet needs are neglected and fester, which leads to dissatisfaction in life and relationships. The experiences reported in this study may reflect a reconnection with the true self, in terms of a growing awareness of emotional experiences and a sense of regained self-efficacy. Similarly, participants expressed an experience of transition from incongruence to congruence.

From incongruence to congruence

Two common symptoms associated with PTSD are emotional numbing and a negative selfperception (American Psychiatric Association, 2013). Emotional avoidance in PTSD is an inability to feel emotions, which can lead to a sense of dissociation from the world and other people. The experience of emotional dissociation means that people with PTSD lack emotional connection and feel strange in their own lives (American Psychiatric Association, 2013). A negative self-perception such as feeling worthless, ashamed of what happened to them, or stigmatised by society, can also leave an individual with PTSD feeling on the

periphery of life, and unhuman. Thus, a trauma intervention that succeeds in developing a sense of congruence (a feeling of a match between internal, emotional experiences and the external world) is of great value to clients and therapists.

This study presents a common experience between participants prior to intensive EMDR, where they demonstrate coping in their lives, which feels inconsistent with their internal world. Roger's (1957) person-centred theory explains a sense of incongruence as a tension between one's ideal self (who one would like to be) and one's experiences. This theory would conceptualise fear-based behaviours such as avoidance and inhibition in people with PTSD as being inconsistent with their self-image and innate desire to progress. According to Roger's theory, a sense of congruence, where self-image is consistent with the ideal self, is achieved by the experience of unconditional positive regard, by accepting one's flaws, and actively exploring one's potential. This study shows that participants of intensive EMDR experience an increase in congruence after the therapy. They experience a sense of embodied aspirations, where they are living the life, they always wanted for themselves, by for example being patient with others where they have not been previously or being the architect of their lives more. All the participants described this experience in terms of connecting with what they had always believed about themselves but were unable to actualise. This differs from the findings of a systematic review and thematic synthesis of traditional EMDR by Whitehouse (2019). In the review, Whitehouse (2019, p.6) found that participants of EMDR reported that EMDR ''changes a person'' resulting in new cognitive and behavioural patterns that did not exist previously and included being more rational. Their findings indicate the experience of a new person, changed from before. However, this study shows that post-intensive EMDR,

participants experienced a reconnection with the true self, reflected in a newfound congruence between their self-image and ideal self. Here they were able to live their lives and relate to others in the way they had always wanted to. The findings of this study are more aligned with the AIP model that underpins EMDR, which suggests that trauma processing facilitates communication between blocked networks, releasing the person's natural and innate ability to heal, rather than the creation of new networks. Maslow's (1954) concept of self-actualisation provides a framework for making sense of the participants' experiences.

## Achieving self-actualisation

According to Maslow's (1954) theory, self-actualisation is the final stage of human motivation and development. When self-actualised, a person functions to their full potential, feels fulfilled and can be creative, spontaneous, and appreciate new experiences. Maslow's (1954) self-actualisation is the pinnacle of human development, which can only be achieved if other, more basic, needs are met. Maslow's theory of a hierarchy of needs suggests that progression to self-actualisation begins with the most basic need for physiological sustenance like water, warmth, and rest. This is followed by the second stage, the need for physical and psychological safety. The third stage is the need for belonging and connection, and the fourth stage is esteem needs, a sense of accomplishment, before reaching the final stage of self-actualisation (Maslow, 1954). The participants of this study had a similar experience to self-actualisation when they described helping themselves in ways they have always wanted to. They described embodying their aspirations, wanting to build their lives from the ground up, and relating to others in a way that was meaningful to them.

Reflecting on the themes presented above and participants' experiences reported throughout this study, it can be strongly argued that in this instance, intensive EMDR was experienced as supporting the stages of human development required for self-actualisation outlined in Maslow's theory. For example, A protected space provided a symbolic refuge separate from the outside world, which is comparable to meeting Maslow's primary need for water, shelter, and rest. Furthermore, the experience of a continued connection with part of the therapy process or person, which was fundamental to participants' ability to engage with difficult tasks, mirrors the 'belonging and love needs' of connectedness and affiliation described in Maslow's hierarchy. Together, these early themes define a sense of psychological safety experienced by participants during intensive EMDR, similar to the second stage in Maslow's hierarchy, 'safety needs'. Moreover, participants attached a great deal of importance to a sense of agency, self-efficacy, and preparedness during intensive EMDR, which are not dissimilar to the concept of 'esteem needs' described by Maslow as feelings of accomplishment and prestige. Finally, participants of this study described meeting their aspirations, and living the way they always wanted, which felt congruent and authentic to them, and is akin to Maslow's self-actualisation. Thus, Maslow's hierarchy of needs provides an established and theoretical framework of human development that is sympathetic to participants' experiences of intensive EMDR, and which confirms the reported value of intensive EMDR. It also offers a bona fide reference for evaluation of experiences of intensive EMDR.

At the same time, intensive EMDR also appears to engender Maslow's (1954) hierarchy of needs for participants in a way that may differ from the linear progression in Maslow's

hierarchy. This study's author suggests that the nature of intensive EMDR may generate a non-linear and simultaneous process of development that does not adhere to Maslow's progressive hierarchy. This conceptual reorganisation may partially explain the speed and potency of change experienced by participants.

It must also be acknowledged, however, that Maslow's theory was devised in the context of human development. It is not clear if the intention was to derive psychological interventions from it, and it is unlikely he had intensive therapy in mind. However, this study shows that fundamental, human developmental needs can be met in as little as a few days of therapy, for people experiencing a severe mental health difficulty such as PTSD, and without an extended period of preparation work or aftercare.

## Implications for counselling psychology

The impact of this study on the field of counselling psychology will now be explored. This includes how the nature of intensive EMDR coheres strongly with counselling psychology values, particularly in its attempts to relieve the stigma attached to people with PSTD. Intensive EMDR also challenges long held assumptions about how psychotherapy is delivered.

This study has important implications for the field of counselling psychology research and practice, with counselling psychologists being ideally placed in services that may consider

further research into intensive EMDR. Counselling psychology is grounded in humanistic philosophy, which values the subjective experience and acknowledges that this occurs within a world constructed by meaning (Ponterotto, 2005). Counselling psychology also values deep change over superficial change achieved by methods of being 'done to'; in this, it honours the individual's inner resources and innate ability to self-actualise. This study indicates that intensive EMDR as an intervention for PTSD is experienced as supportive, empowering, and person-centred by participants. Thus, counselling psychology can use these findings as enlightening for future research.

People living with PTSD suffer from a double disadvantage of social stigma, and the reticence of some practitioners, who fear destabilising traumatised clients (Zoellner et al., 2011). This study challenges the social stigma and practitioners' fears by providing a platform for this client groups' voice to be heard. By doing so, it raises the profile of the individual's lived experience of therapy and humanises this client group. The hope is that counselling psychologists will be encouraged by the findings and understand that intensive EMDR is in keeping with their values of working relationally with clients (The British Psychological Society, 2013).

Furthermore, counselling psychology aims to challenge accepted norms and assumptions in a variety of fields, including research studies in psychology, and the conceptualisation of illness and wellbeing. In keeping with this aim, this study challenges several assumptions and traditions closely held by parts of the psychotherapeutic community. For example, the notion

that a period between sessions is required to consolidate learning and insight, and that it is necessary to have a long period of preparation work prior to trauma-focused therapy (Cloitre et al., 2012). This study does not propose that consolidation or stabilisation be omitted; rather, that they are achieved in intensive EMDR in an unconventional fashion. This study also challenges the notion that manualised approaches achieve superficial change or 'sticking plaster' and do not adapt to the individual (Martin and Helmore, 2006). Indeed, this study finds the contrary, that intensive EMDR is experienced as personalised, and as facilitating deep and fundamental change. Going forward, this study represents a possible bridge between evidenced-based, manualised therapy, and the core values of counselling psychology.

## Implications for practice

The desired outcome of this study of participants' experiences of intensive EMDR for PTSD is to improve patients' experiences by building knowledge for services and practitioners. This study indicates that intensive EMDR may offer a continual and discrete sense of safety, connection, and change for people with PTSD. The level of continuity and quality described by participants seems beyond what can be replicated in weekly therapy. The traditional delivery of psychotherapy involves weekly sessions of between 50 to 90 minutes, potentially interrupted by sickness, holidays, childcare issues, and work commitments which can lead to a protracted and lengthy healing process and may explain high dropout rates reported in Najavits (2015). Furthermore, in the weekly scenario, what is achieved in a single therapy session does not have an opportunity to develop and consolidate when in competition with the other 167 hours of distraction in the week. Consequently, a large proportion of a

therapy session is allocated to re-establishing safety and a meaningful connection, and to addressing difficulties that arose in the week. In these circumstances, the time for a therapeutic intervention is significantly reduced to approximately 20 minutes, '20 minutes hello, 20 minutes intervention, 20 minutes goodbye' (Greenwald et al., 2020). The nature of intensive EMDR, as described by participants in this study, provides the possibility to not only eliminate several of these difficulties, but may also offer an enhanced experience to participants. However, it must be noted that the commitment required for intensive EMDR is substantial and may pose a barrier to individuals who are disadvantaged. For example, some people with PTSD may not be able to afford to take time off work as sick leave or annual leave, and other people with caring responsibilities or young children may not be able to meet the commitments required for intensive EMDR. Without consideration, this could lead to intensive EMDR only being accessible to the privileged few.

This study recommends that existing services such as UK NHS secondary care services, armed forces community mental health teams, and third sector providers introduce an intensive EMDR stream alongside regular treatments for PTSD. This would meet the remit of patient's choice, and speed of access (NHS England and NHS Improvement, 2016), and has the potential to swiftly help people back to the normal functioning in their lives, while reducing waiting times. To deliver this, extra training and supervision can be provided to existing EMDR practitioners, so they become more conversant in the delivery of intensive EMDR and its unique features. Facilities need to reallocate adequate space and resources and to adapt existing safety protocols to this format.

On a practical level, implementing intensive EMDR does not present much deviation from existing procedures and protocols. Practitioners may need to consider their ability and wish to dedicate the time and space for an intensive EMDR client, and perhaps obtain a level of 'protected space' for themselves. Maintaining resilience may also be a consideration if working consecutive days, and this would include regular access to supervision. Participants in this study highlighted the importance of a holding environment for this work. On behalf of the clients, adequate arrangements need to be made for break-out facilities and access to refreshments. Furthermore, an adapted risk management plan and between-session contact arrangements may be necessary for the intensive format. Arrangements for pre- and after care was also cited as important to clients; therefore, efforts should be made to enhance and incorporate these into the process. These adaptations are easily assimilated over time.

A further consideration is the change in the therapeutic process, and what this may present. This study identified that intensive EMDR may occupy a therapeutic frame that reaches beyond the arrangements of typical weekly therapy. For future practice of intensive EMDR, consideration of the extended frame may consider the client's ability to clear a period from other commitments, responsibilities and distractions, their access to family support systems, their personal circumstances, and their personal resources. In addition, consideration must also be given to pre- and post-therapy contact such as during data collection points and follow-up calls to provide a robust framework for the therapist and client. An extended frame was important to participants' experience of intensive EMDR in this study; however, the minimal or optimal arrangements necessary are not yet established. Currently, the extent to which the extended frame is achieved before embarking on intensive therapy falls to the

judgement between the practitioner and their client. The definition, criteria, and assessment of optimal arrangements need be a topic of future research to ensure quality and consistency is achieved. Services need to consider how and if they can best meet these criteria.

In addition to the change in frame, the level of commitment required of participants in intensive EMDR cannot be overlooked; however, this arrangement seemed to be beneficial to participants in this study. It must be acknowledged that clearing responsibilities and commitments for several days or weeks is difficult for most people and could possibly put people in full time work, carers, people with lower resilience due to health conditions, and parents requiring childcare, at a disadvantage. Among the participants of this study, the ability to commit to intensive EMDR may indicate a level of privilege among this group of participants, in that they had the means to take time off work, had access to support, and access to childcare. The participants were mainly White and from a population which is mainly educated and employed. However, intensive EMDR could be particularly favourable in settings that can easily accommodate an extended frame without much adjustment, such the armed forces setting, rehabilitation centres, secondary care services, and private practice and the level of commitment required seemed to add value for participants and provided an enhanced level of safety and focus, which contributed to the speed of change.

For future practice of intensive EMDR to flourish, practitioners' reservations about intensive EMDR need to be addressed. As with any profession, there are long standing assumptions regarding procedures that do not necessarily have a theoretical grounding, such as the

frequency of therapy sessions in psychotherapy (Gutner et al., 2016; Gray, 2013). Other assumptions from within the EMDR community are that an extensive period of stabilisation (Ter Heide et al., 2016) and building of the therapeutic relationship, and/or a period of consolidation between sessions, are necessary before embarking on trauma-focused work (De Jongh et al., 2016b). This study begins a conversation around these assumptions, as it shows that adequate conditions for safety and connection where participants feel safe and supported, can be achieved during several sessions per day over consecutive days. This study shows that participants derive safety from sources not previously identified in research, such as the opportunity to return to therapy the next day, observing speedy change, and the complete segregation from their lives.

It is hoped that the findings of this study, which show intensive EMDR is experienced as safe, relational, and empowering for the participant group, will be of interest to counselling psychologists working with PTSD, and who might consider intensive EMDR is a humanistic approach. In light of this knowledge, counselling psychologists may also reconsider employment in the NHS where the use of EMDR is increasing alongside its more established cognitive and behavioural cousins.

A further consideration for practice is that it was clear that participants had previously experienced several attempts at psychotherapy prior to intensive EMDR, which they found disappointing and demoralising, and that safety and change were of high importance to them. Therefore, services should be mindful of the sometimes long and protracted journey some

participants have endured, and the courage and conviction required to ask for help for another time. It must also be recognised that there are numerous competing forces involved in service delivery of this kind, including the significant impact of PTSD, the additional requirements of an extended frame, funding pressures, the allure of reduced waiting times, and the potential benefits of intensive EMDR. These competing forces may lead services to offer intensive EMDR in less-than-ideal circumstances and with minimal safety and alliance features in place. Based on the current findings it is recommended that measures of safety such as adapted risk management strategies and assessment for suitability, are a priority when implementing intensive EMDR. In this study, all participants reported benefitting from the therapy, however, accommodations must be made for people who may not benefit from this approach. Furthermore, regardless of the money saving potential of intensive EMDR, relieving suffering, and improving patient experiences of therapy remain the primary objectives when implementing intensive EMDR. These objectives could be achieved through community outreach and service users' participation in the set-up and design of such services and the use of patients' feedback and further qualitative research.

## Reflection on IPA, counselling psychology and intensive EMDR

The following section will reflect on the choice of IPA as a methodology for this study and the use of interviews as a method of data collection. It will then reflect on the potential symbiosis between IPA, counselling psychology, and intensive EMDR.

The IPA methodology provides insight into the depth and complexity of the human experience (Morrow, 2007; Gelso and Carter, 1994). This study has put the individual's

experience centre stage of the research in the hope to de-pathologise and destigmatise people with PTSD whose voices are frequently underrepresented in research (Morrow, 2007). As a phenomenological approach, IPA can penetrate and help to deconstruct the social context and meaning of an experience which is rich and nuanced. This emphasis on often overlooked groups is in keeping with the counselling psychology agenda of fairness and equity in research.

Furthermore, IPA facilitates the scientist-practitioner role of the counselling psychologist as it supports the evaluation of practice and acquisition of knowledge (Woolfe, Dryden and Strawbridge, 2003). The scientist-practitioner recognises that they have a valid role in generating new knowledge, as well as consuming it (Woolfe, Dryden and Strawbridge, 2003). The scientist-practitioner position brings insights and knowledge gained from practice into the public sphere and in doings so, challenges the current domination of a positivist agenda. This challenge is essential to advancing knowledge in the field, and IPA alongside other qualitative methods, provides counselling psychologists with a suitable mechanism to do this.

The intention of this study was not to be generalisable in the traditional sense, as IPA seeks to gain rich knowledge from small, purposefully chosen samples. Bearing in mind the epistemological assumption that knowledge in constructed and subjective, it hopes to possess a naturalistic generalisability (Smith, 2018) in that it resonates with the readers' life, interests, and experiences. In its analysis, it may also achieve a level of analytical generalisability in

that the findings link to an already established theory, that of Maslow's (1954) hierarchy of needs.

## Limitations and future research

This research has foregrounded the voices of service users and shown valuable insight into the experiences of participants who attended intensive EMDR for PTSD. However, as with all research, this study has limitations.

The participant group for this study comprised of 9 White adults, and 1 person of Asian origin. Furthermore, the participants were predominantly middle class, educated people. Although this study does not intend to draw conclusion about a broader population, this ethnic and social imbalance underrepresents the breadth of people who experience PTSD and who could benefit from innovative delivery of interventions. However, the participants better represented males and females (4 males to 6 females) and sexual diversity, with a mixture of participants identifying as gay, lesbian, bisexual, and heterosexual. Future research should endeavour to incorporate voices from more diverse ethnic and socioeconomic backgrounds, in keeping with the counselling psychology ethos of inclusion and diversity (Woolfe, Dryden and Strawbridge, 2003). The aim would be to reflect the true composition and variety in this clients' group and explore how various social, gender and ethnic identities intersect with people's experiences of intensive EMDR, this could perhaps be achieved through broader sources of recruitment.

A further limitation of this study was that the participants were drawn from two sources - 6 participants from a free victim support service in the US, and 4 participants from a private provider in Ireland - which means that although participants shared the experience of intensive EMDR for PTSD, they lacked homogeneity in domains such as culture, context, and structure and delivery of the programme. The victims of crime setting may have been experienced as more absorbing, as people were there from 9am until 5pm every day. In my analysis, both groups experienced intensive EMDR as potent, powerful, and segregated from other parts of their lives. The Irish cohort of participants experienced preliminary sessions with the same therapist before the intensive format was agreed. This approach highlights consideration of what constitutes intensive EMDR, its advantages or disadvantages, and how much or how little preliminary or preparatory processes are required. It also raises questions about the function of these sessions for the client prior to embarking on intensive EMDR, and whether this influences the client's experience of the therapy overall. It is possible that the participants who had a pre-existing relationship with their therapist may have experienced the therapeutic relationship differently or that it influenced the speed of engagement or level of acclimatisation required. This group praised their therapist more than the victims of crime group and appeared to have more of an emotional attachment to the therapist. All participants shared a gratitude for the intensive EMDR; however, the notion of participating in the study as 'paying it forward', or a desire to reciprocate in some way, was apparent for some of the victims of crime participants, who had received their treatment for free and so felt that participating in the study was reciprocating. This study did not aim to compare individuals or groups' experiences; however, there is an argument for future research to have a more homogenous group, for more specific data and findings. While IPA requires a homogenous sample (Smith, Flowers and Larking, 2022), flexibility is permitted if the researched group is small and specific. Future studies should aim to research participants from the same intensive EMDR facility to reduce the variability within the group's experience. This would also provide a shared participants'

context for further interpretation and would allow for further focus on other forms of variability, divergences and convergences within the group.

The Wow! moment.

A further limitation of the study is the theme of a Wow! moment. Although significant and impactful in the participants experiences, it cannot be said that the Wow! moment is specific to intensive EMDR. The Wow! moment has been reported in weekly EMDR and in various other psychotherapeutic modalities as a proposed mechanism of change and thus is a feature of therapeutic change outside of the intensive EMDR paradigm (Castonguay & Hill, 2007). However, it is possible that future research could shed light on the qualities and nature of change moments specifically in intensive EMDR and try to understand if these differ or vary from change moments in other therapeutic modalities.

Another consideration is that all the participants said they benefitted and continued to benefit from their experience, and it was important to them to participate in the research.
This means that people who had alternative experiences were not represented in this study. Therefore, it is essential that future research brings forward alternative views, to develop a more rounded and comprehensive understanding of the experience. This could be achieved by contacting people who did not complete the therapy or identifying participants prior to the therapy.

Going forward, this study provides access to the lived experiences of participants who have engaged with intensive EMDR for PTSD. Existing qualitative research is limited in this area. Therefore, there is plenty of scope for rich and enlightening research going forward. Future research that further explores the meaning participants attach to the processes and procedures

in intensive EMDR, alongside the development of a robust definition, assessment criteria and protocol, may help to improve the clients' experiences, quality of the intervention, and consistency of the approach. New research could be conducted by means of qualitative and quantitative designed studies, which verify the value of the approach from the participants' perspective. This process would also facilitate service users' involvement in service design and delivery. This approach could also be of value in service design because research shows that co-produced services and interventions are often more effective (Staniszewska et al., 2022). EMDR has historically lacked lived experience or expert by experience involvement in its development. Future research should consider how to redress this imbalance.

For service providers to adopt intensive EMDR as a potential treatment pathway, service developers must be convinced of the potential added value this approach can bring. A cost benefit analysis that compares the expenditure of funds and resources required for intensive EMDR to existing treatments would be beneficial. It could include the commitment of one therapist for several consecutive days, compared to the current arrangement of one session per week, for between 12 and 20 weeks (incorporating holidays, sickness, and other interruptions). For the analysis to be of value, it should compare patients' satisfaction, the number and cost of missed sessions, relapse rates, recovery rates, dropout rates, supervision requirements, number of subsequent treatment episodes, and the impact on waitlists. Intensive EMDR may offer an improvement in several of these areas, but more research is needed to confirm or refute this.

This study appears to show an inherent link between participants' experiences of intensive EMDR and Maslow's (1954) hierarchy of needs which was unpredicted. A qualitative study similar to this one, could offer further detail and texture to this initial point of exploration, or alternatively offer interesting divergences. This would be of interest to the EMDR fraternity, counselling psychologists, and humanistic practitioners by way of advancing our theoretical understanding of intensive EMDR as a psychotherapy. Other research offering some insight into the ways in which intensive EMDR quickly creates and sustains a sense of psychological safety, a functional therapeutic alliance, and facilitates sudden therapeutic changes, would be of value. A qualitative design which examines possible linguistic adaptations, metaphors and other techniques that abbreviate or accelerate these processes would add to the knowledge generated from the current study.

The growing interest in intensive EMDR is also indicated by the spring 2023 issue of EMDR Therapy Quarterly (EMDR Association UK), which is a special edition dedicated to intensive EMDR. Furthermore, the EMDR association UK has offered to recognise an intensive EMDR special interest group for practitioners.

Intensive EMDR requires further investigation from the client's perspective, which could be juxtaposed with the experiences of practitioners delivering intensive EMDR. Furthermore, future research would be necessary to develop a better understanding of how intensive EMDR may be utilised and implemented in services. Though this study is the first step towards understanding participants' experiences, there is broad scope for more qualitative research in this area, and quantitative research which compares outcomes of intensive EMDR

to weekly EMDR. Future research could also explore how stabilisation and rapport is enhanced and maintained during intensive EMDR. This research could test the hypothesis that these fundamentals of trauma therapy occur in a non-sequential manner during intensive EMDR. This research could reveal a potentially new way of viewing the therapeutic process within EMDR and inform practitioners of the most effective ways to achieve the optimum conditions for therapy.

## Conclusion

This study is the first to explore and represent participants' experiences of intensive EMDR using an IPA methodology, thus providing an opportunity to reflect on the intervention from the participants' perspective and complementing existing research. This study situates intensive EMDR within the humanistic approach that values clients' subjective experience and the individual's ability to heal and reach their potential. Therefore, intensive EMDR is conducive to the values of counselling psychology, which also emphasises humanistic values and practice, including a facilitative therapeutic relationship and equity in care. Thus, this study presents intensive EMDR as an interesting proposal to counselling psychologists who work with or wish to work with clients with PTSD.

This study has primarily provided a platform for a group of underrepresented and stigmatised people who often struggle to access and remain in mental health services to make their voices heard. By exploring the experiences of participants of intensive EMDR, the analysis has pointed to several phenomena such as agency, sudden profound change, and returning to

congruence, which can inform theory and the future development and implementation of the intensive EMDR approach. This study has achieved its aim of adding to our understanding of intensive EMDR using participants' experiences, the role of the therapeutic relationship in its practice, and how intensive EMDR could benefit participants considering the wider context of their lives, their diagnosis, and their sense of themselves.

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## Summary of thesis

# How do clients experience intensive EMDR for PTSD? A phenomenological analysis

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There is a dearth of qualitative research exploring the benefits and challenges of intensive Eye Movement Desensitisation and Reprocessing (EMDR) from the clients' perspective. However, existing studies indicate that intensive treatment for PTSD may offer an improved client experience, faster reduction in symptoms, greater symptom reduction, and reduced dropout rates (Najavits, 2015). The aim of this study is to understand what might be lost and gained from intensive delivery of EMDR from the clients' perspective. Interpretative phenomenological analysis (IPA) was applied to interview data from 10 participants who had experienced intensive EMDR treatment for PTSD. The Personal Experiential Theme (PET) 'The importance of psychological safety' generated two emergent themes of 'A protected space' 'The importance of a continued connection'. The PET 'The changing self' generated two emergent themes of a 'Wow! moment', and 'Living the way I always wanted'. Findings suggest that intensive EMDR can be experienced as safe, facilitating agency and engagement, and affecting a meaningful change, which was valued by participants. These findings concur with Shapiro's (2001) assertion that EMDR is a humanistic and integrative psychotherapy, and correspond with established humanistic theories such as Maslow's (1954) hierarchy of needs.

Keywords EMDR, intensive, PTSD, phenomenological,

Post-Traumatic Stress Disorder (PTSD) is described as a psychiatric disorder resulting from direct exposure to or witnessing a traumatic event such as natural disaster, sexual violence or serious accident, or learning about a loved-one's violent death (American Psychiatric Association [APA], 2013). For a diagnosis to be made, symptoms must fall under four categories; (1) intrusions of memories, thoughts, images, emotions, and sensations of the traumatic event, (2) avoidance of reminders of the traumatic event, (3) alterations in cognition and mood, including changes in beliefs about the self, other people, and the world, and (4)

alterations in arousal and reactivity, including hypervigilance and being easily startled (APA, 2013).

Prevalence of PTSD is high, with over 70% of the global population having been exposed to more than three traumatic events in their lifetime (Kessler et al., 2017). In the United Kingdom (UK), approximately one third of adults have been exposed to a traumatic event, and many go on to develop symptoms of post-traumatic stress (McManus, Bebbington and Brugha, 2014).

Recommended treatments for PTSD commonly involve a phased-based protocol which can include psycho-education, managing distressing memories, processing trauma memories, overcoming avoidance, and re-establishing adaptive functioning (NICE, 2018). These phases are each completed in sequence, before progressing onto the next phase (De Jongh et al., 2016a).

Evidence based treatments for PTSD are limited, and show variability in efficacy (NICE, 2018), with dropout rates ranging between 0% and 30% (Lewis et al., 2020), and lower recovery rates when compared to other mental health conditions (Baker, 2018). Existing guidance for single event trauma recommends between 8-12 sessions of either CBT or EMDR (NICE, 2018) however, there is a lack of consensus in the number of sessions required for multiple traumas, with estimates ranging from 4 months to several years for the most severely impaired clients (Cloitre et al., 2012). Therefore, when we apply the existing guidance to multiple traumas, delivered at a pace of once per week, this equates to a commitment of several months of therapy. Whilst previous PTSD research has mainly focused on quantitative studies to measure treatment efficacy, few studies used qualitative methods to explore the individuals' experiences of treatment for PTSD.

Eye Movement Desensitisation and Reprocessing (EMDR) is a model of psychotherapy used for the relief of psychological distress caused by traumatic experiences. EMDR comprises of an 8-phase treatment protocol which includes (1) History taking, (2) Emotional regulation skills, (3-6) Target identification and memory processing, (7) Closure, and (8) Re-evaluation of target memory. Phases 3-6 involve the use of Bilateral Stimulation (BLS) in the form of saccadic eye movements, alternate hand-tapping, or alternative audio beats to facilitate access to, and processing of traumatic memories in a way that is tolerable to clients. The understanding of how EMDR works is based on the Adaptive Information Processing (AIP) model which posits that simultaneously accessing the trauma memory and more adaptive memories or information available to the client, will lead to a spontaneous reconsolidation of memories and a reduction in distress (Solomon and Shapiro, 2008). EMDR is considered one psychotherapy that has a 'bottom up' approach which accesses the limbic system, responsible for affect and autonomic regulation (Taylor et al., 2010). EMDR is currently one of two psychotherapeutic approaches recommended by the National Institute of Care Excellence (NICE) for the treatment of PTSD (NICE, 2018), therefore it is worth exploring how it may be applied in different circumstances and contexts.

Intensive EMDR is defined in this study as the delivery of the standard protocol (Shapiro, 2001), at a higher frequency than the common practice of once per week sessions. However, currently there is no definition or criteria for what intensive EMDR is or how it should be delivered. Thus, it has been previously described as 'massed' 'condensed' and 'intensive' interchangeably (Ragsdale et al., 2020). If the efficacy of EMDR is unchanged by the increase in session frequency, intensive EMDR may provide a timelier relief to people who are experiencing PTSD symptoms.

# Literature review

## Intensive EMDR

The rationale for intensive treatment of PTSD is that it is equal in efficacy when compared to once weekly sessions (Hurley, 2018; Ehlers et al., 2014; Ehlers et al., 2010), and therefore provides a quicker recovery and potentially less disruption to clinicians and clients. It is hypothesised that intensive therapy builds on momentum, provides additional safety and mitigates avoidance of reminders of the trauma which is a maintaining feature of PTSD (Foa et al., 2018). There is currently no consensus regarding the definition of intensive EMDR. This omission may explain the variety and disparity of procedures between studies. For example, there is a huge variation in dosage across studies, which range from a single session (D'Antoni et al., 2022; Jarero, Artigas and Luber, 2011) up to several sessions over several days for 4 weeks (Wibbelink et al., 2021), with most studies reporting an average length of treatment between five and ten days (Bongaerts et al., 2021; Blount, Ford and Peterson, 2014;). In the same vein, a rationale for the use of a condensed version of the original protocol (Shapiro, 2001) versus an abridged version of the treatment in some studies is not provided. There is also great variability and experimentation in procedures, some advocating lengthy assessments, periods of stabilisation, several follow up treatment sessions or intensive therapy as an adjunct to regular weekly sessions. Gutner et al. (2016) have attempted to examine the impact of session frequency and consistency on outcomes and found that frequency and consistency have a significant correlation with a reduction in PTSD symptoms. Furthermore, they found that a longer period between sessions 4 and 5 correlated with a smaller reduction in symptoms. Thus, the treatment of PTSD is sensitive to session timing and consistency. There is evidence to suggest that treatment chronicity has a positive

correlation with outcomes in studies of survivors of natural disasters, with the more recent the trauma, the greater likelihood of recovery (Zepeda Méndez et al., 2018; Murray, El-Leithy and Billings, 2017; Jarero, Artigas and Luber, 2011; Chemtob, Nakashima and Carlson, 2002). A limitation in terms of establishing the treatment efficacy of intensive EMDR is that it is common for treatment programmes to combine other activities such as yoga (Haugland Thoresen et al., 2022; Wachen et al., 2019; Zepeda Méndez et al., 2018), exercise, psychoeducation (Wagenmans et al., 2018; Bongaerts, Van Minnen and de Jongh, 2017a; Blount, Ford and Peterson, 2014), equine assisted therapy (Steele et al., 2018), and mindfulness (Roque-Lopez et al., 2021) with EMDR. The potential additive effects of these components are acknowledged in the literature; however, they present a problem in treatment and research validity and thus questions the value of these additional activities. Overall, studies of intensive EMDR indicate chronicity and frequency have a role in outcomes, however they give very little consideration of confounding variables, the therapeutic relationship, the optimum timing of treatment, adequate dosage and who might benefit the most from this format of delivery. This leaves opportunity for further research to explore the experience of intensive EMDR from the clients' perspective.

In a rare qualitative study of intensive EMDR, Haugland Thoresen et al. (2022) interviewed eight participants of an intensive therapy programme for PTSD. The programme combined EMDR, prolonged exposure (PE), physical activity, and psychoeducation, over eight days and used therapist rotation. The authors identified five major themes: (1) terrible but worth it, (2) continuous pressure through therapist rotation, (3) physical activity as a necessary break from mental marathon, (4) sense of unity in an intensive treatment program, and (5) the whole is greater than the sum of its parts. Haugland Thoresen et al. (2022) showed that participants experienced intensive therapy as easier to stay tuned into, and easier to get back

into, when they compared it to their previous experiences of weekly therapy. They also said that the format reduced avoidance as it was more difficult to cancel the sessions. The participants experienced the therapist rotation as enabling different perspectives and new relational experiences which they felt contributed to change. They also reported a sense of being cared for by the therapists as a collective, rather than each therapist one by one. Participants revealed that after the therapy they felt the two-week gap before a follow up call was too long, and they wished to reach out to their therapists in that time.

### Intensive EMDR Efficacy

Most of the current efficacy research is from one institution in the Netherlands (Psytrek) that reports outcome data for a residential intensive treatment program consisting of regular EMDR, a prolonged exposure (PE) sessions with exercise and therapist rotation. The outcomes show that intensive EMDR is effective among various clinical populations such as older and younger people (Gielkens et al., 2021), patients with dissociative symptoms (Zoet, de Jongh and van Minnen, 2021), adolescents (van Pelt et al., 2021), and people with complex PTSD (Voorendonk et al., 2020; Bongaerts, Van Minnen and de Jongh, 2017b).

However, these studies like many others, lack treatment control groups and do not account for the additive effects of wellbeing activities during the programme.

### Randomised Controlled Trials for intensive EMDR

There are few randomised controlled trials of intensive EMDR, most of which are for EMDR group protocols. First, Molero, Jarero and Givaudan (2019) delivered the Integrated Group Treatment Protocol (IGTP) designed for administration to groups of trauma survivors, three times per day over three days to young refugees and found the programme was well tolerated and was culturally sensitive. Second, Pérez et al. (2020) successfully delivered online, intensive, group EMDR to health workers exposed to multiple patients' deaths during the

COVID-19 pandemic and showed a significant positive effect on PTSD, anxiety, and depression measures. The limitation of both these studies is that participants were not formally diagnosed with PTSD, therefore results cannot be generalised to the PTSD population. Finally, Jiménez et al.'s (2020) study population met the criteria for PTSD. Jiménez et al. (2020) delivered the EMDR-PRECI protocol to 32 survivors of sexual and/or physical violence aged between 12 and 17 years old and compared outcomes to a treatment as usual (TAU) group. The treatment was delivered three times per week according to participants' availability. The outcomes showed significant reduction in PTSD, anxiety, and depression in the treatment group. The strength of this study is that the outcomes may be generalised to people with PTSD of a similar age, however the authors recognised that the sample size was small. The few RCTs regarding EMDR highlight a need for more studies investigating Shapiro's (2001) original protocol used for intensive EMDR, delivered on a one to one or group basis.

### Treatment dosage

NICE recommends twelve sessions of EMDR for a single incident trauma, however the frequency of the sessions or the number of sessions required for multiple traumas in not stated. Not surprisingly, the research shows a huge variation and little consideration of the dosage and frequency of sessions during the intensive treatment of PTSD. A study by Hurley (2018) found that weekly EMDR sessions compared to twice daily sessions for 10 days were equally beneficial to participants. However, they suggested that the intensive approach offers the following additional benefits: any reactivity may be immediately addressed, reduced dropout rates, increased engagement, and circumventing interruptions such as holidays and sickness. In other studies of intensive PTSD treatments (CBT and prolonged exposure), the

higher frequency and greater consistency of treatment sessions correlated with greater symptom reduction (Gutner et al., 2016). Furthermore, Van Minnen et al. (2020) explored the sequencing of EMDR and exposure sessions during intensive treatment for PTSD. They found that participants who received an exposure session in the morning followed by an EMDR session in the afternoon, showed significantly more progress than when the delivery sequence was reversed. This suggests that the benefits of treatment are sensitive to session frequency, consistency, and sequencing and therefore, should be considered more carefully in the treatment guidelines and research. A further limitation to these studies is that it remains unclear if stabilisation measures such as symptom management techniques were necessary or implemented prior to, or during the intervention. These studies show that research into intensive EMDR is in its infancy. Given that intensive EMDR may offer a short term, high dosage treatment for PTSD, there remains is great opportunity for research in many directions including RCTs, qualitative studies which access clients' and therapists' perspectives, and for theoretical debate exploring the definition and guidelines for intensive EMDR.

This study is the first to explore intensive delivery EMDR for the treatment of post-traumatic stress disorder (PTSD) symptoms using interpretive phenomenological analysis (IPA) for data from ten interviews. The qualitative methodology was selected because it reflects upon the intersubjective nature of a phenomenon between the researcher and research participant during the narrative, and it positions the individual's account at the heart of the project. Furthermore, given the rarity of intensive EMDR, an idiographic approach can offer knowledge which is unique and individual.

# Method

## Reflexivity

Reflexivity understands that knowledge is generated not discovered and is concerned with the interpersonal and co-constructed nature of experience between researcher and participant (Dodgson, 2019; Etherington, 2007; Ponterotto, 2005). I am a trainee Counselling Psychologist who has worked with Post Traumatic Stress Disorder PTSD since 2014, in the NHS and Ministry of Defence (MOD) settings. In 2016 I embarked on EMDR training where I learnt EMDR was reputed for gaining rapid results and being appropriate for more complex clients. I completed my EMDR training in 2017. My practice of EMDR left me with a curiosity regarding how, why, and with whom EMDR worked. In particular, I wanted to see how clients experienced intensive EMDR, and if they experienced a variability in effectiveness and outcomes.

During my practice, I have observed services under pressure to see clients with increasing complexity when more appropriate services do not exist, and services have waiting lists of more than 12 months. The length of PTSD treatment, which can be up to 20 sessions in some services, is also easily derailed by life events, deployment, and sickness. I came to this research topic because I am passionate that service users receive the best care in a timely fashion. For this reason, intensive EMDR appeared to offer a solution.

## Recruitment

Participants for the study were sourced through two organisations. The organisations were selected because of their extensive experience in delivering intensive EMDR for PTSD, and their access to previous clients. The first was The Trauma Institute, Massachusetts (MA), a state funded organisation which provides intensive trauma therapy to victims of crime. The second source of recruitment was Access Wellness, an independent practice in Ireland, which provides intensive EMDR to private clients.

Therapists within each organisation were requested to contact previous clients who they deemed appropriate for the study according to the criteria outlined below. The identified participants were contacted by email informing them of the scope of the study and invited to contact the researcher via email should they wish to participate in an interview. An initial online video call was scheduled to discuss the study, to help the participant to feel more relaxed in advance of the interview, to test the technology, and to answer any questions the potential participant had.

### ‘Sampling‘ considerations

A purposive sampling method (Etikan, Musa and Alkassim, 2016) was utilised as participants were identified and selected because of their participation in an intensive EMDR for PTSD. A diagnosis of PTSD was not required for acceptance into treatment. Inclusion criteria included having completed the trauma treatment program 3 months prior to participation in the research, conversant in English, deemed to be low risk by the treating practitioner, and agreeable to the use of online conferencing software. Exclusion criteria were participants considered to be at risk of their recovery being destabilised by participation in the interview and participants undergoing treatment for the same difficulty at the time of interview (within or outside of the organisation).

### Participants’ wellbeing

Participants were invited to share their experiences of the intensive treatment and informed that there was no requirement to disclose the trauma at any time. If the participant became distressed during the interview, it was planned that the interview would end, and an extended time for the debriefing would be allowed. I am an experienced EMDR and trauma therapist and could call on these skills should the participant become upset. An information sheet was also provided with relevant signposting to avenues of support. Participants were interviewed

in their own homes; therefore, they did not face any out of the ordinary risks other than those encountered in everyday life.

A three-month exclusion period between completing therapy and participation in the study allowed participants the time to reintegrate into their lives following their psychological therapy, while preventing interference with any residual processing and memory reconsolidation. The gap also supported a clear demarcation between the treatment process and the research.

## Analysis

In the following analysis I will present an overview and interpretation of the meaning and significance attached to the experience of undergoing intensive EMDR. The intention of the analysis is to represent and interpret the participants' experiences of intensive EMDR from their own perspective. Two PETs were identified: The importance of psychological safety and The changing self. Each PET encompasses two experiential statements. Table 1 below outlines the thematic structure.

Analysis

The process of data analysis in IPA is intended to be a reflexive one, with the focus of the analysis on making sense of the individual's experience (Smith, Flowers and Larkin, 2022). The analysis was guided by the steps outlined in Smith, Flowers and Larkin (2022), as they provide a clear outline of execution which can be applied flexibly. The analytic process is iterative and inductive (Smith, Flowers and Larkin, 2022).

First, each transcript was analysed in turn. Analysis began with making initial notations of my first impressions on the transcript, oscillating from broad to detailed observations. This was

followed by noting semantic, linguistic, and conceptual elements of the text, including hesitations and repetitions. Chunks of text were then isolated and reviewed for convergence, divergence, and relationships across the transcript. Mapping statements that fit together followed with clustering related statements, through a process of abstraction, creating personal experiential themes and through subsumption, when a statement within the text is promoted to a Personal Experiential Theme (PET). Moving to the next participant transcript and bracketing what has been learned before allowed new experiential themes to present themselves from each case. Finally, patterns were looked for across all cases by looking for connections and relationships between experiential statements and PETs, while noticing individual cases which could represent those themes.

Table 1: An overview of the thematic structure

| Personal Experiential Theme | | Experiential Statement |
|---|---|---|
| The importance of psychological safety | 1a | A protected space |
| | 1b | The importance of a continued connection |
| equateThe changing self | 2a | Wow! moment |
| | 2b | Living the way I always wanted |

Personal Experiential Theme 1: The importance of psychological safety

The importance of psychological safety during intensive EMDR was apparent as a key theme across the interviews. For the participants, psychological safety was defined as a sense of

support and comfort during the process of intensive EMDR. This theme encompasses two experiential statements. First, the participants derived safety from a continued connection, and a sense of an ongoing link with the process. The nature and meaning of the link varied between participants. Second, the participants derived safety from a defined and segregated physical and psychological space. These two experiential statements will now be explored.

### Experiential Statement 1a: A protected space

The participants derived a sense of psychological safety from the intensive EMDR mainly from the sense of it being a protected space, separate to and different from their everyday lives. Participants described an experience that provided security and comfort, by excluding unhelpful distractions. Participants experienced a protected space as providing an opportunity to focus on the task at hand with greater commitment.

Harper explored how intensive EMDR was a protected space, separate to and different from the normal running of her life:

> It was something that I was doing to care for myself and that it was just sort of this time in this bubble of this place I've never been before. And, you know, I could have been in Ohio like it, it just…it felt like I was able to sort of step outside of my life for that time, um, that I was there each day. And (pause) and just be … with myself, and, um, take care of myself.

For Harper, psychological safety was derived from her experience of a protected space or 'bubble' of intensive EMDR, which felt far removed from her ordinary life as she likened it to being thousands of miles away from her home: "I could have been in Ohio". Due to this experience of separateness and the protection of the intensive EMDR, Harper became very inward looking, as it afforded her to "take care of [herself]". Earlier in the interview, Harper

described herself as being ”a sponge for other people”. The pause in her final sentence above thus might have indicated that taking care of herself was unfamiliar to her. It is possible that the physical and psychological separation from the usual obligations in her life was necessary to find space for herself. The phrase “just be … with myself” conjures a timelessness of a vacuum, that excludes others and everything else. For Harper it seemed, a protected space and safety meant a distance from distractions, where she could focus exclusively on her own needs.

### Experiential Statement 1b: The importance of a continued connection

Participants also described the importance of a continued connection for a sense of psychological safety which the intensive EMDR facilitated. For the participants, psychological safety was experienced as containment, which provided a sense of selfdetermination, autonomy, and control over their experience. The view of being the protagonist in their experience was complimented by a continued connection, a tether between themselves and some part of the process which intensive EMDR provided. They also described this connection as reassuring, a container for distress, and comforting.

The continued connection in intensive EMDR was derived from a variety of sources, including ongoing and repeated connection to the therapist, the therapy, or from contact with loved ones. For most of the participants, intensive EMDR facilitated a continued connection which provided a sense of autonomy during the therapy, while for others, the ongoing link was a means of obtaining answers and reassurance. The level of continued connection experienced ranged from a light, guiding touch to a continued reassurance:

For Lucas, continued connection meant repeated opportunities to master previously unresolved tasks:

> Uh, the comfort, the um, reassurance that let's try this and see if it works, it doesn't work for everybody but it may work for you, you know, specific methods or specific patterns of things, um, revisiting them a couple days later to say, "Oh, it didn't work the other day but maybe- maybe you'll be able to do it today".

Lucas seemed to be reassured that during his experience of intensive EMDR, there was a continued connection with "specific methods or … patterns"; meaning he could return to tasks that were not completed previously in the therapy. Lucas seemed to reveal a sense of psychological safety when he felt "the comfort" and "reassurance" of continuing with previous tasks, or perhaps a sense of relief from expectations. Therefore, for Lucas, the continuity of intensive EMDR means it felt more within his capabilities. The continued connection with these tasks meant he was reassured to know that nothing was entirely lost. Like the other participants, Lucas situated himself as the main agent in the therapy, but was coaxed by the therapist, when he spoke the therapist's words, "maybe you'll be able to do it today". Thus, it seems that psychological safety during intensive EMDR was gleaned from the unbroken connection with the tasks of the therapy, and repeated chances to revisit them over again.

### Personal Experiential Theme 2: The changing self

The analysis revealed that the experience of a changing self was meaningful to participants. The participants experienced a changing self in terms of new insights, changes in perspective, an altered view of themselves, their lives, and a change in relationship towards others. For the participants, changes in their internal world manifesting in surprising new perspectives was most salient, alongside a new ability to live their lives in a way they had always wanted to. This theme encompasses two experiential statements, the first shows participants' experience a Wow! moment, a spontaneous moment of clarity or insight during the intensive EMDR,

which impacted on their sense of self. The second shows how participants experienced living their lives differently after the intensive EMDR, in a way that they had always wished to but could not previously.

### Experiential Statement 2a: Wow! moment

The participants shared a Wow! moment experience during the intensive EMDR. The Wow! moment appeared to be a sudden experience of a new perspective, or self-knowledge. The change seemed to represent a significant and fundamental shift in an internal and personal state 'within' or a change in perception.

It seemed that the most important Wow! moment for Honoka was one evening during the intensive EMDR, when her children were arguing with each other:

> wow, I'm just like, I hear them fighting and then like, oh wow, you know, I have this peaceful mind, what do I do with them now? Like how should I say, mm, like that kind of... yeah, that was strange, it's almost like I can be very, um, observant, um, I just didn't... Yeah.

In this quotation the probable change Honoka experienced in herself appeared to catch her by surprise, which is revealed in her repeated use of "wow!", and the bafflement by this completely new experience of space to reflect on her response to her arguing children "what do I do with them now?". Honoka seemed to experience a general change in perspective when she referred to a peaceful "mind" rather than the possible alternatives - 'a sense of peace,' or 'moment of peace' - and this meant she saw the argument from a more observant standpoint. It is possible that Honoka was describing a new way of experiencing herself and the world. It was also possible that during the interview, Honoka seemed to remain unsure about what the changes meant to her, and was indicated by the

‘strangeness’ she reflected on, and the lack of conviction in her speech ”it’s almost like I can be very, um, observant, um, I just didn’t... Yeah”.

### Experiential Statement 2b: A chance to live the way I want to

In this experiential statement, participants described a changing self in terms of living their lives the way they wanted to after the intensive EMDR. The participants described a change in how they experienced themselves, how they lived their lives, and how they experienced the world and other people. Participants seemed to value being more like themselves since the intensive EMDR, and how they had perhaps always wanted to live this way but were unable to for various reasons. For some, this change was reflected in how they saw themselves relating to others, for other participants it appeared to be related to personal values, and a sense of control over their destiny.

Similarly, Grace seemed to have enjoyed a more coherent sense of herself after the intensive EMDR:

> Yeah, the energy and I finally feel like that the little things that should have been making me feel okay, do actually now and I always said they did, but they didn't.

For Grace, the intensive EMDR meant a change in herself illustrated by how she felt and responded to wellbeing advice. It seemed that prior to the intensive EMDR, Grace tried what she could to feel better and yet nothing was bringing the expected results (to “feel okay”). In this statement, she also seemed to divulge an incongruence between what she said outwardly, and how she felt inside “I always said that they did, but they didn’t”. Therefore, it is possible that the change she saw felt more in keeping with the way she wanted to live, and this meant a more authentic, and congruent existence. Like Harper, Grace described a long journey prior to the change, and some relief in her words; ”finally” and “always”. For both Harper and

Grace, it seemed that the experience of the intensive EMDR was a chance to live a life they had always wanted for themselves and to being a more authentic self.

## Discussion

This study has highlighted that participants of intensive EMDR for PTSD experience the intervention as safe, relational, impactful, and meaningful to their lives.

For the participants, a protected space was vital to a sense of psychological safety. For them, a protected space was separate to and different from their regular lives. It acted as a shield, a distance from distraction, a structure with dedicated time that was a different experience than their regular lives. A protected space contributed to a sense of preparedness for what was to come, and a condition for full commitment to themselves and the therapy.

For the participants, a continued connection during intensive EMDR was integral to a sense of psychological safety. For most participants, this appeared to translate to a sense of autonomy or reassurance. The nature of the continued connection varied across participants; for some, it was the continued guidance from the therapist, while for others, it was returning to finish the task, a second chance to revisit material or a companion waiting in the background. From the participants experiences, it was clear that the continued connection which frequent and perpetual contact provided, meant a sense of psychological safety in intensive EMDR.

During the intensive EMDR, the participants seemed to experience a changing self in the form of internal changes such as deeper insights and understandings and physical

experiences, which impacted on the way they viewed themselves and the world. The changes seemed to be of great significance and meaning to the participants and the speed of the change seemed to counter expectations. Collectively the participants experienced the changes as new, positive, and fundamental.

The change in self that seemed to bring forward qualities and behaviours that they were previously unable to execute. There seemed to be a new alignment between how they saw themselves (e.g., kind, patient) and the life they lived, and this was the chance to live the way they always wanted to.

The participants' experiences appear to reflect elements of (Maslow's, 1954) hierarchy of needs and self-actualisation. For example, A protected space and The importance of continued connection mirror Maslow's basic, and belonging and love needs. Together, these themes signify a sense of psychological safety experienced by participants during intensive EMDR. Moreover, participants attached much importance to a sense of agency, self-efficacy, and preparedness during intensive EMDR, which is similar to the concept of 'esteem needs' described in Maslow's (1954) hierarchy as feelings of accomplishment and prestige. Finally, participants of this study described meeting their aspirations, and living the way they always wanted, which felt congruent and authentic to them, which is akin to Maslow's selfactualisation. Thus, Maslow's hierarchy of needs provides an established and theoretical framework of human development that is sympathetic to participants' experiences of intensive EMDR, and which confirms the reported value of intensive EMDR. It also offers a bona fide reference for evaluation of experiences of intensive EMDR.

Implications for practice

The traditional delivery of psychotherapy involves weekly sessions of between 50 to 90 minutes, which can lead to a protracted and lengthy healing process and may explain high dropout rates reported in Najavits (2015). However, intensive EMDR does not present much deviation from existing procedures and protocols and therefore, has the potential to swiftly help people back to the normal functioning in their lives, while reducing waiting times and may be easily implemented.

This study highlights that participants of intensive EMDR derive safety from sources not previously identified in research, such as the opportunity to return to therapy the next day, observing speedy change, and the complete segregation from their lives. This study also challenges the assumption that an extensive period of stabilisation (Ter Heide et al., 2016), and building of the therapeutic relationship, and/or a period of consolidation between sessions, are necessary before embarking on trauma-focused work (De Jongh et al., 2016b). This study suggests that these elements still occur but in a non-linear fashion.

### Limitations and future research

This research has foregrounded the voices of people attending intensive EMDR for PTSD. However, the primary limitation is the participant group predominantly identified as white, middle class, educated people. Although this study does not intend to draw conclusion about a broader population, this ethnic and social imbalance underrepresents the breadth of people who experience PTSD, who could benefit from innovative delivery of interventions.

This study appears to show an inherent link between participants' experiences of intensive EMDR and Maslow's (1954) hierarchy of needs and was unpredicted. A future qualitative study similar to this one, could offer further detail and texture to this initial point of

exploration, or alternatively offer interesting divergences. Other research offering some insight into the ways in which intensive EMDR quickly creates and sustains a sense of psychological safety, a functional therapeutic alliance, and facilitates sudden therapeutic changes, would be of value.

Future research would benefit from the development of a robust definition of intensive EMDR, suitability criteria, and protocol. Furthermore, qualitative, and quantitative designed studies which verify the value of the approach from the participants' perspective would facilitate service users' involvement in service design and delivery.

Intensive EMDR requires further investigation from the client's perspective, which could be juxtaposed with the experiences of practitioners delivering intensive EMDR and quantitative research which compares outcomes of intensive EMDR to weekly EMDR. This research could reveal a potentially new way of viewing the therapeutic process within EMDR and inform practitioners of the most effective ways to achieve the optimum conditions for therapy.

## Conclusion

This study is the first to explore and represent participants' experiences of intensive EMDR using an IPA methodology, thus providing an opportunity to reflect on the intervention from the participants' perspective which is complementary to existing research. This study situates intensive EMDR within the humanistic approach and counselling psychology that values clients' subjective experience and the individual's ability to heal and reach their potential. Thus, this study presents intensive EMDR as an interesting proposal to counselling psychologists who work with or wish to work with clients with PTSD.

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# Appendices

Appendix A Ethical approval

Faculty of Health & Applied Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

Tel: 0117 328 1170

UWE REC REF No: HAS.19.11.065

13th December 2019

Sarah-Jane Butler
Sarah5.Butler@live.uwe.ac.uk

Dear Sarah-Jane

**Application title: How do clients experience intensive EMDR for PTSD? An interpretative phenomenological analysis**

I am writing to confirm that the Faculty Research Ethics Committee are satisfied that you have addressed all the conditions relating to our previous letter sent on 3rd December 2019 and the study has been given ethical approval to proceed.

The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee. Amendments should be requested using the form at http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx

2. You must notify the University Research Ethics Committee if you terminate your research before completion;

3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

The Faculty and University Research Ethics Committees (FRECs and UREC) are here to advise researchers on the ethical conduct of research projects and to approve projects that meet UWE's ethical standards. Please note that we are unable to give advice in relation to legal issues, including health and safety, privacy or data protection (including GDPR) compliance. Whilst we will use our best endeavours to identify and notify you of any obvious legal issues that arise in an application, the lead researcher

This page has been removed due to containing personal and private information.

# Participant Information Sheet

How do clients experience intensive EMDR for PTSD? A phenomenological analysis

## An invitation

You are invited to take part in research taking place at the University of the West of England, United Kingdom because of your experience of an intensive treatment for PTSD using EMDR. Before you decide whether to take part, it is important for you to understand why the study is being done and what it will involve. Please read the following information carefully and if you have any queries or would like more information please contact Sarah Butler, Faculty of Health and Applied Sciences (HAS), University of the West of England, Bristol BS16 1QY. Email: sarah5.butler@live.uwe.ac.uk.

## Who is organising the research?

The project forms part of a Professional Doctorate in Counselling Psychology award. The project lead is Sarah Butler who is supervised by Christine Ramsey-Wade (Director of Studies).

## What is the aim of the research?

The research is looking at how people experience an intensive treatment for PTSD using Eye Movement Desensitisation and Reprocessing (EMDR). Our research questions are looking at your experience of the treatment and how it fits in with or affected your life. To help us answer these questions, we will be conducting interviews via online video conferencing (e.g. Skype/Zoom). The aim of the interviews will be to collect information that will be made anonymous.

The results of our study will be analysed and used in a doctoral thesis made available on the University of the West of England's open-access repository. The anonymised results may also be used in conference papers and peer-reviewed academic papers.

## Why have I been invited to take part?

As a researcher, I am interested in understanding your experience of the treatment, how it fitted into your life and how you feel about it now so the interview will ask you about these things. The purpose of the questions will be to gain a deeper understanding of your treatment experience and the impact it had on you (good or bad). Please note that you will not be required to talk about the trauma that brought you into treatment; the focus of the interview is on your treatment experience.

## Do I have to take part?

You do not have to take part in this research. It is up to you to decide whether or not you want to be involved. If you do decide to take part, you will be given a copy of this information sheet to keep and will be asked to sign a consent form. If you do decide to take part, you are able to withdraw from the research without giving a reason until the point at which your data is anonymised and can therefore no longer be traced back to you. This point will take place 3 to 6 months from the date you signed your consent form. If you want to withdraw from the study within this period, please write to Sarah Butler at sarah5.butler@live.uwe.ac.uk. Deciding not to take part or to withdraw from the study does not have any penalty or effect any future relationship or treatment with your therapist or from participating in any other research with University of the West of England. Withdrawal from the study does not affect the researcher's assessment marks or career progression.

## What will happen to me if I take part and what do I have to do?

If you agree to take part you will be asked to participate in a one to one interview via video conference, with the researcher Sarah Butler, at a pre-arranged time convenient for you. The interview will last approximately 60 minutes. The researcher is experienced in the subject matter and is sensitive to the issues it may raise.

The subject and focus of the discussion will be on your experience of the treatment and the meaning it holds for you. Your answers will be fully anonymised.

Your interview will be recorded via online conferencing facility and transcribed, but the recording will not contain your name. At the stage of transcription, a unique reference number will be allocated to each participant in order to anonymise the data. This number will be used to re-identify you if you choose to withdraw from the study within the period. At the point of transcription, your video recording will be deleted. Your data will be anonymised at this point and will be analysed with interview data from other anonymised participants.

## What are the benefits of taking part?

This work hopes to highlight the personal experience of people who undertake intensive therapy for PTSD and in doing so, will improve practitioners' understandings of the impact the treatment has on

the person. If you take part, you will be helping us to consider what is required for 'best practice' from the clients' perspective, which could ultimately influence the design of services in the future.

## What are the possible risks of taking part?

We do not foresee or anticipate any significant risk to you in taking part in this study. If, however, you feel uncomfortable at any time you can ask for the interview to stop. If you need any support during or after the interview, then the researchers will be able to put you in touch with suitable support agencies. The research team are experienced in conducting interviews and are sensitive to the subject area. The interviews have been designed with these considerations in mind.

## What will happen to your information?

All the information that you give will be kept confidential and anonymised when the interview is transcribed. The only circumstance where we may not be able to keep your information confidential is if during the interview you were at risk of harm, harming someone else or a child was vulnerable in some way. In these circumstances the relevant care authorities would be notified. Research material will be stored on the University secure Cloud facilities, to which only the researcher and Director of Studies will have access in accordance, with the
University's guidelines and the Data Protection Act 2018 and General Data Protection Regulation requirements. Video recordings will be destroyed securely immediately after anonymised transcription. Your anonymised data will be analysed together with other interview and file data, and we will ensure that there is no possibility of identification or reidentification from this point.

## Where will the results of the research study be published?

A report will be written containing our research findings. This report will be available on the University of the West of England's open-access Research Repository, and a published article will be available in online journal databases. A hard copy of the Report will be made available to all research participants if you would like to see it. Key findings will also be shared both within and outside the University of the West of England via presentations and conferences. Anonymous and non-identifying direct quotes may be used for publication and presentation purposes.

## Who has ethically approved this research?

The project has been reviewed and approved by the Faculty of Health and Applied Sciences and the University of the West of England University Research Ethics Committee. Any comments, questions or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at:

Researchethics@uwe.ac.uk

## What if something goes wrong?

Any concerns, queries or complaints will be dealt with in accordance with the University of the West of England procedures. Please contact the Director of Studies in the first instance Christine.Ramsey-Wade@live.uwe.ac.uk.

## What if I have more questions or do not understand something?

If you would like any further information about the research, please contact in the first instance: Sarah Butler, Faculty of Health and Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol. BS16 1QY.
Sarah5.butler@live.uwe.ac.uk.

| |
|---|
| Thank you for agreeing to take part in this study.<br><br>You will be given a copy of this Participant Information Sheet and your signed Consent Form to keep. |

# Privacy notice for research participants

## Purpose of the Privacy Notice

This privacy notice explains how the University of the West of England, Bristol (UWE) collects, manages and uses your personal data before, during and after your participation in the research project: How do clients experience intensive EMDR for PTSD? An interpretative phenomenological analysis. 'Personal data' means any information relating to an identified or identifiable natural person (the data subject). An 'identifiable natural person' is one who can be identified, directly or indirectly, including by reference to an identifier such as a name, an identification number, location data, an online identifier, or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.

This privacy notice adheres to the General Data Protection Regulation (GDPR) principle of transparency. This means it gives information about:

- How and why your data will be used for the research;
- What your rights are under GDPR; and
- How to contact UWE Bristol and the project lead in relation to questions, concerns or exercising your rights regarding the use of your personal data.

This Privacy Notice should be read in conjunction with the Participant Information Sheet and Consent Form provided to you before you agree to take part in the research.

## Why are we processing your personal data?

UWE Bristol undertakes research under its public function to provide research for the benefit of society. As a data controller we are committed to protecting the privacy and security of your personal data in accordance with the (EU) 2016/679 the General Data Protection Regulation (GDPR), the Data Protection Act 2018 (or any successor legislation) and any other legislation directly relating to privacy laws that apply (together "the Data Protection Legislation"). General information on Data Protection law is available from the Information Commissioner's Office (https://ico.org.uk/).

## How do we use your personal data?

We use your personal data for research with appropriate safeguards in place on the lawful bases of fulfilling tasks in the public interest, and for archiving purposes in the public interest, for scientific or historical research purposes.

We will always tell you about the information we wish to collect from you and how we will use it.

We will not use your personal data for automated decision making about you or for profiling purposes.

Our research is governed by robust policies and procedures and, where human participants are involved, is subject to ethical approval from either UWE Bristol's Faculty or University Research Ethics Committees. This research has been approved by the Faculty Research Ethics Committee (FREC) who can be contacted for queries, comments or complaints at Research Information and Governance, Research Administration, North Avon House, Frenchay Campus, Coldharbour Lane, Bristol. BS16 1QY or researchethics@use.ac.uk. The research team adhere to the Ethical guidelines of the British Educational Research Association (and/or the principles of the Declaration of Helsinki, 2013) and the principles of the General Data Protection Regulation (GDPR).

For more information about UWE Bristol's research ethics approval process please see our Research Ethics webpages at:

www1.uwe.ac.uk/research/researchethics

## What data do we collect?

The data we collect will vary from project to project. Researchers will only collect data that is essential for their project. The specific categories of personal data processed are described in the Participant Information Sheet provided to you with this Privacy Notice. Data obtained for the project is personal and confidential. Interview recordings will be destroyed once the interview transcription and participant numbers are allocated. For more details about data storage and disposal please see the Participant Information Sheet.

## Who do we share your data with?

We will only share your personal data in accordance with the attached Participant Information Sheet and your Consent.

## How do we keep your data secure?

We take a robust approach to protecting your information with secure electronic and physical storage areas for research data with controlled access. If you are participating in a particularly sensitive project UWE Bristol puts into place additional layers of security. UWE Bristol has Cyber Essentials information security certification.

Alongside these technical measures there are comprehensive and effective policies and processes in place to ensure that users and administrators of information are aware of their obligations and

responsibilities for the data they have access to. By default, people are only granted access to the information they require to perform their duties. Mandatory data protection and information security training is provided to staff and expert advice available if needed.

## How long do we keep your data for?

Your personal data will only be retained for as long as is necessary to fulfil the cited purpose of the research. The length of time we keep your personal data will depend on several factors including the significance of the data, funder requirements, and the nature of the study. Specific details are provided in the attached Participant Information Sheet and in accordance with the University's and the Data Protection Act 2018 and General Data Protection Regulation requirements including storing data on the University's secure Cloud. Anonymised data that falls outside the scope of data protection legislation as it contains no identifying or identifiable information may be stored in UWE Bristol's research data archive or another carefully selected appropriate data archive.

## Your Rights and how to exercise them

Under the Data Protection legislation, you have the following qualified rights:

(1) The right to access your personal data held by or on behalf of the University;
(2) The right to rectification if the information is inaccurate or incomplete;
(3) The right to restrict processing and/or erasure of your personal data;
(4) The right to data portability;
(5) The right to object to processing;
(6) The right to object to automated decision making and profiling;
(7) The right to complain to the Information Commissioner's Office (ICO).

Please note, however, that some of these rights do not apply when the data is being used for research purposes if appropriate safeguards have been put in place.

We will always respond to concerns or queries you may have. If you wish to exercise your rights or have any other general data protection queries, please contact UWE Bristol's Data Protection Officer (dataprotection@uwe.ac.uk).

If you have any complaints or queries relating to the research in which you are taking part please contact either the research project lead, whose details are in the attached Participant Information Sheet, UWE Bristol's Research Ethics Committees (research.ethics@uwe.ac.uk) or UWE Bristol's research governance manager (Ros.Rouse@uwe.ac.uk)

v.1: This Privacy Notice was issued in April 2019 and will be subject to regular review/update.

Appendix D Participant consent form

Consent Form

How do clients experience intensive EMDR for PTSD? A phenomenological analysis.

This consent form will have been given to you with the Participant Information Sheet. Please ensure that you have read and understood the information contained in the Participant Information Sheet and asked any questions before you sign this form. If you have any questions please contact a member of the research team, whose details are set out on the Participant Information Sheet.

If you are happy to take part in an interview via video conference/Skype to discuss your experience of treatment for PTSD, please sign and date the form. You will be given a copy to keep for your records.

- I have read and understood the information in the Participant Information Sheet which I have been given to read before asked to sign this form;
- I have been given the opportunity to ask questions about the study;
- I have had my questions answered satisfactorily by the research team;
- I agree that anonymised quotes may be used in the final Report and in any presentations associated with this study;
- I understand that my participation is voluntary and that I am free to withdraw at any time until the data has been anonymised, without giving a reason;
- I agree to take part in the research

Name (Printed)…….

Signature……. Date…….

Appendix E Interview schedule

# Final interview schedule

At the start of the interview discuss the following with the participant;

Remind of time required today,

Confidentiality

Data storage and right to withdraw

Procedure for disclosure of risk

Give help and support numbers or direct back to RG.

Give my contact details for any queries

Gain informed consent before proceeding.

Interview questions and prompts

Thank you for participating in the study. Begin with some introductory questions and building rapport (Have you ever participated in research before? Do you use Skype a lot? What is the weather like there?)
Introduce myself as a researcher
Give a short brief around the intention of the study. I am
interested in your story.

## PREPARING FOR TREATMENT

Q1 How did you find out about the programme?

- How did you feel / mean to you when you realised you could attend the programme?

Q2 When you found out that it was condensed/intensive over a week or two rather than once per week, what ran through your mind?

- How did you manage the time commitments?
  How did it fit in with your life and existing commitments?
  Prompt: How did you feel?
  Away from work?
  Away from family?

- Were you anticipating any advantages or disadvantages to the intensive therapy vs once weekly sessions?

Q3 What role did your support network have? /How did they respond?

## THE TREATMENT

Q4. So, pretend I don't know anything about the programme, how would you describe it to me?

Q5 What was the treatment like for you?

Set up, process and procedures
And the several sessions per day, per week?

Q6 During that time, what was most important/meaningful to you? (Relationship with therapist/facilities/access/choices).

Prompt: What was the best bit?

What was the worst bit?

What sticks in your mind about that time?

Q7 What was it that you think was the biggest contributor to you feeling better? The therapist, the eye movements, the environment, the format?

Prompt: How did this contribute?

## LOOKING BACK

Q8 Looking back what do you think the intensive format 'did' for you that perhaps weekly did not?

- What sticks in your mind?

Q9 Looking back is there anything that you would have liked done differently? Prompt:

are you glad you went for an intensive treatment vs weekly session?

Why is that?

Q10 Looking back, what impact has the experience had on you as a person?

Prompt: and your family/situation

How do you make sense of that?

Would you do it again or recommend it to anyone?

Q11 Anything you would like to add?

Draw the interview to a close:

Thankyou for participating

What has participating today been like for you?

Repeat right to withdraw

Any questions?

Give contact info for any questions

Appendix F Confidentiality contract with transcription service

# Data Processing Agreement

Date:

PARTIES

(1) University of the West of England, Bristol whose address is Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY (the "Data Controller") and

Party B dictate2us

Business Development Executive

UK Office: 0800 288 9013
USA Office: +1 866 302 1699
AUS Office: +61 180 057 2044

Rest of World office: +44 161 762 1100

Maple House
Haymarket Street
Bury, BL9 0AR

BACKGROUND

1. The Data Controller wishes the Data Processor to carry out the work detailed in Appendix 1 (the "Services"); Written transcription of audio file
2. Both parties agree that they have obligations under the DP Legislation (as defined in clause 25.1 );
3. This Agreement records the obligations of both parties.

AGREED TERMS

In providing the Services, the Data Processor shall process Personal Data (as defined below) on behalf of the Data Controller. The type of Personal Data to be processed, and the categories of Data Subjects are as follows:

| | |
|---|---|
| Subject matter of processing (description of service/goods provided by supplier e.g. cloud based learning support tool) | Transcription document posted via secure cloud |
| Duration of processing (how long will data be processed for e.g. duration of contract) | No more than 10 hours of audio |
| Purpose of processing (brief description of how and why personal data is processed e.g. e-mail addresses processed to verify users of software solution) | The personal data will be interviewees' first name. The audio file will be anonymised. |
| | |
| Type of Personal Data (types of personal data being processed e.g. names, email addresses) | Interviewees' first name |
| Categories of Data Subjects (whose personal data is being processed e.g. students or staff) | Research participant with consent (general public) |

Specifically, the Data Processor shall:

1. Not act in any way so as to cause the Data Controller to breach of any of its obligations under the DP Legislation;

2. Process Personal Data only in accordance with the written instructions of the Data Controller;

3. Process the Personal Data only to the extent, and in such manner, as is necessary for the provision of the Services or as is required by the DP Legislation, or any other applicable law (and immediately inform the Data Controller if it believes any instruction or processing is likely to breach such law) or any regulatory body ;

4. Implement appropriate technological and organisational measures to protect against accidental loss, destruction, damage, alteration or disclosure of any Personal Data. Such measures shall be appropriate to the loss which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and having regard to the nature of the Personal Data which is to be protected;

5. Take reasonable steps to ensure the reliability of any employees, workers, agents or sub-processors or contractors who have access to the Personal Data;

6. Ensure that any employees, workers or contractors authorised to process the Personal Data are informed of the confidential nature of the Personal Data and comply with the obligations set out in this Agreement;

7. Ensure that the Personal Data is not made available by default to all employees, workers or contractors of the Data Processor or any sub-contractor and only to such individuals as are strictly required in order to meet the obligations under this Agreement have access to the Personal Data;

8. Ensure that all Personal Data is treated as confidential information and is not published, disclosed or divulged to any third party by the Data Processor or any of its employees, workers or contractors, unless directed in writing to do so by the Data Controller;

9. Notify the Data Controller in writing and by email (as soon as possible and always within five working days) if the Data Processor or any of its employees, workers or contractors receives or becomes aware of:

    9.1. a request from a Data Subject to have access to that person's Personal Data;

    9.2. a complaint or request relating to the Data Controller's obligations under the DP Legislation;

10. Co-operate fully with the Data Controller in relation to any complaint or request made by any Data Subject, regulatory body, supervisory authority and/or court of competent jurisdiction, including by promptly (and in any event within the timescales required by the Data Controller):

    10.1. providing the Data Controller with full details of any complaint or request that it receives directly;

    10.2. providing reasonable assistance to the Data Controller in dealing with or responding to any request or any complaint;

    10.3. providing the Data Controller with any Personal Data it holds in relation to a Data Subject (within the timescales required by the Data Controller under the DP Legislation); and

    10.4. providing the Data Controller with any information (including any information required to demonstrate compliance with the DP Legislation) required by the Data Controller to respond properly to the request or complaint.

11. Permit the Data Controller's representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit its data processing activities (and/or those of its permitted agents, subsidiaries and sub-processors) and comply with all reasonable requests or directions by the Data Controller to enable the Data Controller to verify and/or procure that the Data Processor is in full compliance with its obligations under this Agreement;

12. Not process Personal Data outside the European Economic Area (which for the avoidance of doubt includes storage in any cloud or other such facility which is controlled, regulated and/or hosted outside the EEA) without the prior written consent of the Data Controller and, where the Data Controller consents to such transfer, to comply with:

12.1. the obligations of the Data Controller under the DP Legislation by providing an adequate level of protection to any Personal Data that is transferred; and

12.2. any reasonable instructions notified to it by the Data Controller;

13. At the Data Controller's option, return or securely delete all Personal Data (including any copies) from all systems of the Data Processor (i) after the use of the Personal Data for the Services (ii) following termination of this Agreement or (iii) in any circumstance where the Data Controller is required to do so by DP Legislation and provide written confirmation of this to the Data Controller. Where instructed, the Data Processor must return all Personal Data to the Data Controller;

14. Co-operate fully if the Data Controller serves an information notice on the Data Processor requiring the Data Processor within such time and as required by the information notice, to provide the Data Controller with such information as the Data Controller may reasonably require relating to compliance by the Data Processor with the

Data Processor's obligations under this Agreement in connection with the processing of Personal Data;

15. Notify the Data Controller immediately if the Data Processor or any of its employees, workers agents, sub-processors are requested to do any act which would infringe the DP Legislation or other data protection law of the EU or any member state;

16. Where the Data Processor wishes to appoint a sub-processor to assist it in providing the Services and such assistance includes the processing of Personal Data on behalf of the Data Controller, then the Data Processor must obtain the Data Controller's prior written consent (which may be withheld in the Data Controller's absolute discretion) to such appointment. It is a condition of the Data Controller's consent that the Data Processor ensures the subprocessor enters into written terms which are substantially the same and no less protective of the Personal Data as contained in this Agreement. The Data Processor shall remain fully liable to the Data Controller for the performance of the sub-processor's obligations;

17. Promptly (and in any case within 48 hours) notify the Data Controller in writing (providing full details) if any of the Personal Data has been lost, destroyed, damaged, corrupted or accessed by or disclosed to unauthorised third parties or if it suspects or has reason to believe any the Personal Data may have been lost, destroyed, damaged, corrupted or accessed by or disclosed to unauthorised third parties;

18. Not use any new technologies in the provision of the Services which could, when taking into account the nature, scope, context and purpose of the processing to be carried out as part of the relevant Services, result in a high risk for the rights and freedoms of individuals under the DP Legislation or to the security of the Personal Data, save where:

18.1. the Data Processor has notified the Data Controller in advance and the Data Controller, with the assistance of the Data Processor, has had a reasonable opportunity to carry out an assessment of the impact of the envisaged processing operations on the protection of Personal Data; and

18.2. following such assessment, the Data Controller has provided its written approval to the Data Processor of the envisaged processing;

19. Be liable for and shall fully indemnify the Data Controller (and keep the Data Controller indemnified) against each and every action, proceeding, liability, cost, claim, loss, fine, penalty,

expense (including reasonable legal fees and disbursements) and demands incurred by the Data Controller which arise directly or in connection with the Data Processor's processing activities under this Agreement, including without limitation those arising out of any third party demand, claim or action, or any breach of contract, negligence, fraud, wilful misconduct, breach of statutory duty or non-compliance with any part of the DP Legislation by the Data Processor or its employees, workers, agents, or sub-processors.

20. In addition to the indemnity to the Data Controller above, the Data Processor is hereby notified and acknowledges that under the General Data Protection Regulation, from 25 May 2018, Data Processors may be held directly liable by the Information Commissioner's Office ("ICO") for any breaches of the DP Legislation by the Data Processor. This may lead to fines being brought directly against the Data Processor by the ICO for breaches of the DP Legislation. In addition, Data Subjects who have been harmed by the improper transfer, storage or disclosure of their Personal Data will be entitled to make direct claims against Data Processors for any breach of their rights under the DP Legislation.

The parties agree:

21. No term of this Agreement shall be enforceable under the Contracts (Rights of Third Parties) Act 1999 by any third party, but this does not affect any right or remedy of a third party which exists or is available apart from under that Act;

22. Notices, including any notification to the University of the West of England, Bristol under Clause 9 above shall be made in writing and delivered by recorded mail to Pro-Vice Chancellor; Commercial Director and Corporation Secretary, University of the West of England Bristol, Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY with an email copy to VCOExecSupport@UWE.ac.uk and the University's Data Protection Officer dataprotection@uwe.ac.uk;

23. This Agreement constitutes the entire agreement and understanding between the parties in respect of the matters dealt with in it and supersedes, cancels or nullifies any previous agreement between the parties in relation to such matters;

24. This Agreement shall be governed by and construed in accordance with the law of England and Wales. Each of the parties irrevocably submits for all purposes in connection with this Agreement to the exclusive jurisdiction of the courts of England and Wales;

25. In this Agreement:

    25.1. "DP Legislation" means the European Directives 95/46/EC and 2002/58/EC (as amended by Directive 2009/139/EC) and any legislation and/or regulation implementing or made pursuant to them including but not limited to the Data Protection Act 1998, or which amends, replaces, re-enacts or consolidates any of them (including but not limited to the General Data Protection Regulation, EU 2016/679), and including, where applicable, the guidance and codes of practice issued by the supervisory authorities (including the ICO); and

    25.2. the terms "Data Processor", "Data Controller", "sub-processor" "process" and "Data Subject" shall have any meaning given to them in the Data Protection Legislation; and

    25.3. "Personal Data" means personal data (as defined in the DP Legislation) provided by or collected on behalf of the Data Controller.

This signature page has been redacted due to containing personal and private information.

Appendix 1 – The Services to be performed by the Data Processor

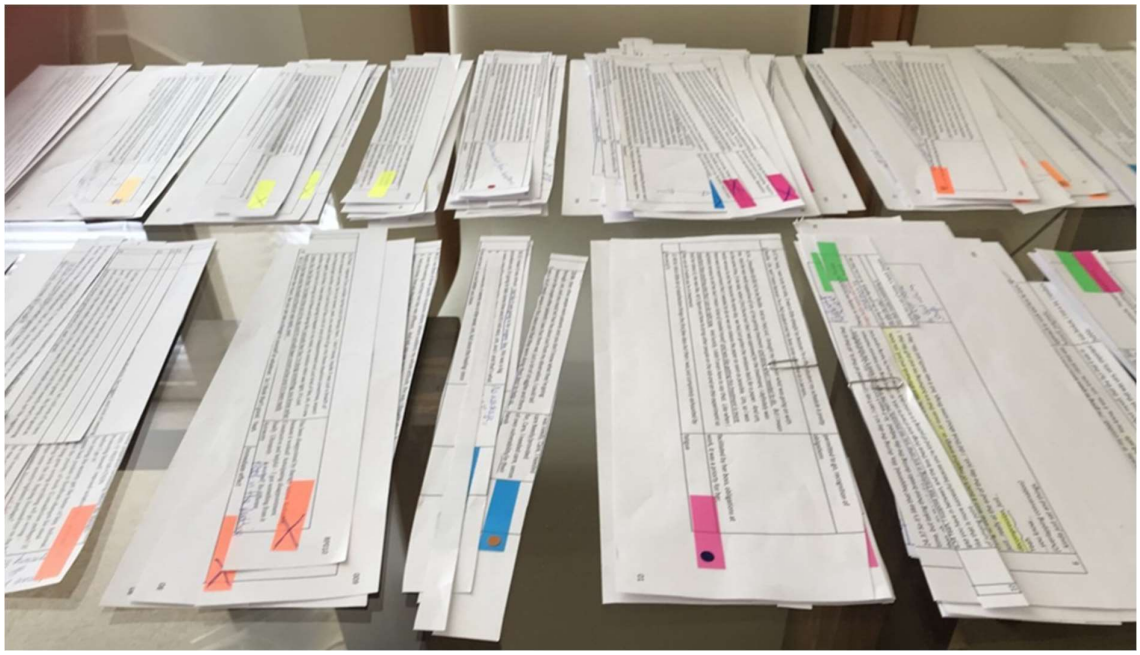
The goods/services to be provided are:

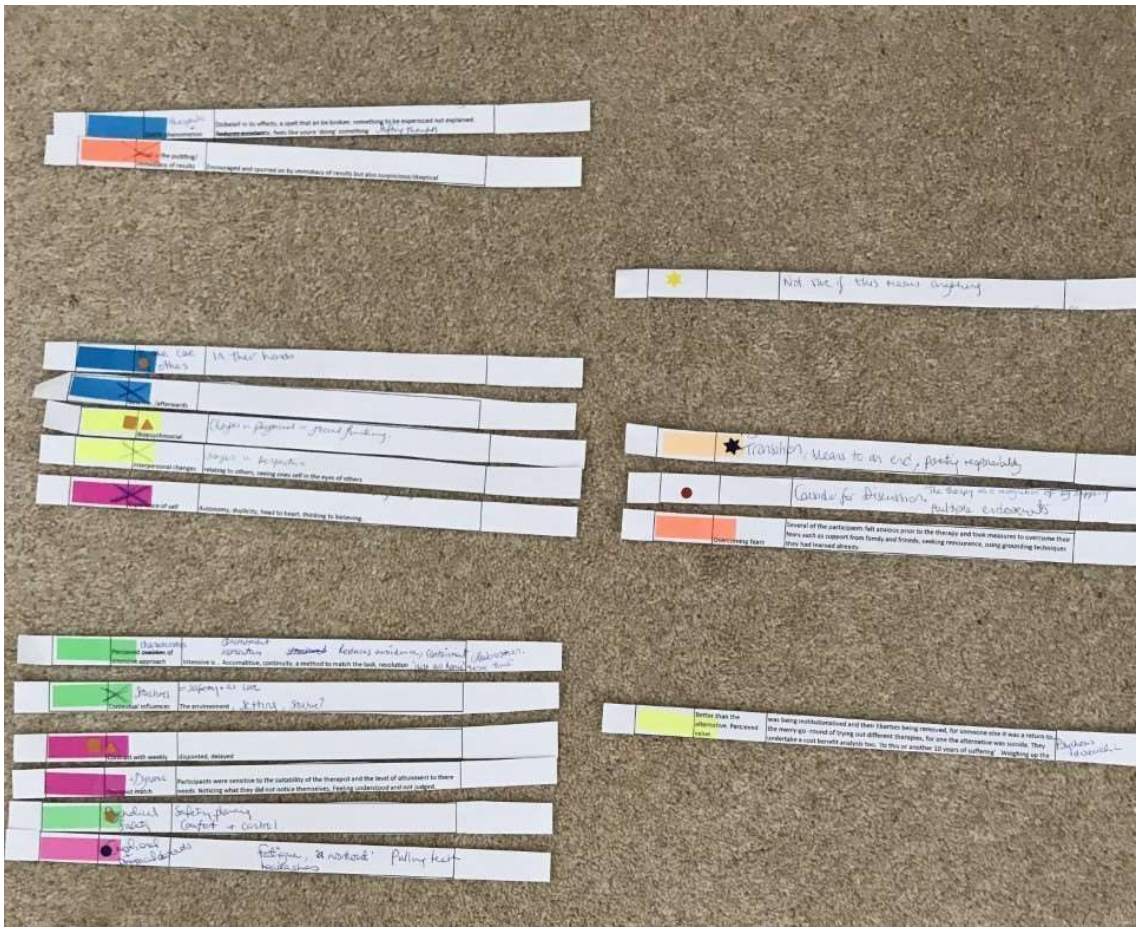
## Appendix G Key to transcription symbols and abbreviations

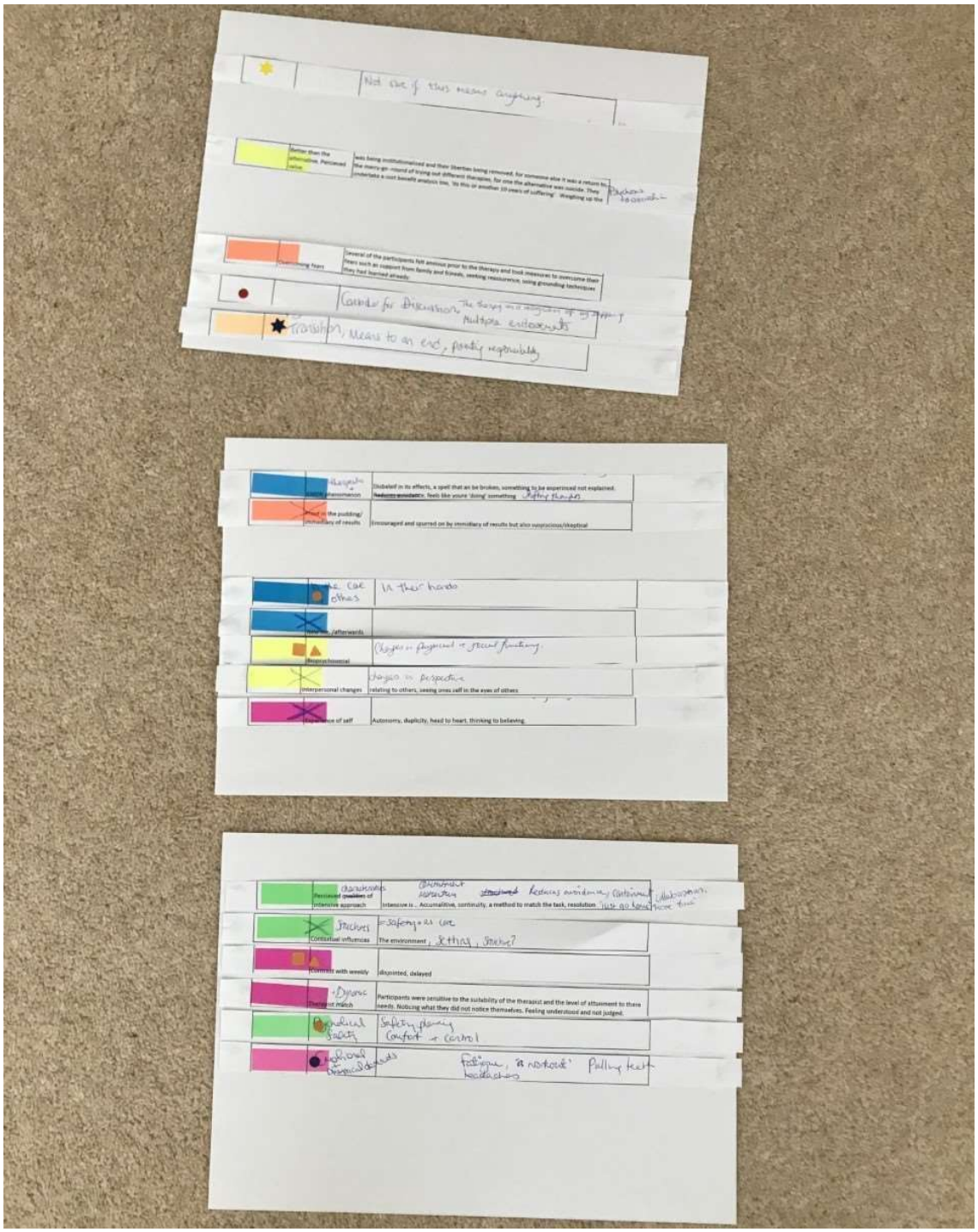
… data removed for brevity

…pause

Appendix H Illustration of process of analysis




Not sure if this means anything
Transition, Means to an end, partly responsible
Consider for discussion
Several of the participants felt anxious prior to the therapy and took measures to overcome their fears such as support from family and friends, seeking reassurance, using grounding techniques


Not sure if this means anything.
Transition, Means to an end, possibly responsibly
Unbelief in its effects, a spell that an be broken, something to be experienced not explained.
Encouraged and spurred on by immediacy of results but also suspicious/skeptical
In their hands
Interpersonal changes
relating to others, seeing ones self in the eyes of others
Autonomy, duplicity, head to heart, thinking to believing
Intensive is .. Accumulative, continuity, a method to match the task, resolution
Contextual influences
The environment , Setting , Stakes?
Participants were sensitive to the suitability of the therapist and the level of attunement to there needs. Noticing what they did not notice themselves. Feeling understood and not judged.
Safety planning
Comfort + Control
Fatigue, "a hangover" Pulling teeth
headaches

Appendix I Original table of quotations

Table 2. The importance of psychological safety Table 2. Cont.

| | Pseudonym | Quotation |
|---|---|---|
| a.Aprotectedspace | Harper | It was something that I was doing to care for myself and that it was just sort of this time in this bubble of this place I've never been before. And, you know, I could have been in Ohio like it, it just…it felt like I was able to sort of step outside of my life for that time, um, that I was there each day.<br>And (pause) and just be…[]…be with myself, and, um, take care of myself. |
| | Noah | And so I think, because I was prepared for it and because it was, and as I said, in the bubble, it was like I thought, kind of like a bit being in a laboratory, you know, which is like, very hygienic environment, you know. Nothing else can get in, you know, what I mean, sort of thing. So I think that was it, I think, really, it was, I had total permission to visit the traumatic situation. |
| | Honoka | I mean at that point, you know, I was there, and then I blocked the whole two weeks. You know I just, you know... I was fully present and then ready to do whatever. Yeah. Yeah. |
| | Emma | Um, and also, being in and off, like it…not at like home, uh, you know, being… Uh-huh.<br>…in like a clinical kind of environment, but very comfortable while revisiting these uncomfortable memories and times in your head. |
| | Lucas | um, um, very comfortable waiting rooms and amenities you know, I brought my lunch every day, so they had little lounges, but they were- they were almost like living rooms in a home. |
| | James | just the…the benefit of doing a week's worth, you get to dive into it more 'cause you're dealing with such sensitive issues that……to really take that time and that space aside to do it in a week's worth of time rather than in, like, blocks of time over weeks. |
| | Pseudonym | Quotation |
| | Harper | Um, but that felt very doable and very safe , uh, and that someone was there. But although it was all me processing, I had somebody checking in with me every step of the way, um… |

| | | |
|---|---|---|
| b.Theimportanceofcontinuedconnection | Emma | But with the intensive, I was like I can go 100% today, you know. I can go 100%… …because I know that I'm going to come back tomorrow, and I can, and I can finish. But if I was doing it weekly, I would go in and maybe give 30% because I knew that if I did 100%, I would have a really bad week until the next session. |
| | Jack | I think that I had Lincoln there to if I had a problem or if I had a question on A, B, or C, that I had that support, that I could call him morning, noon, or night, and just say listen I don't understand this, and he would sometimes stay on the phone for 10, 15 minutes just to elaborating exactly what I needed to do and what it meant, and why it mattered, so that support was there and it was fantastic. |
| | Grace | I needed, as I said, if something came up for you, in between sessions, you could go back and say, "I can't stop thinking about this now." And you know, sometimes that might be hugely relevant, but I maybe didn't see the relevance of, you know, something to whatever we had been dealing with or working with that kind of way. |
| | Lucas | Uh, the comfort, the um, reassurance that let's try this and see if it works , it doesn't work for everybody but it may work for you , you know, specific methods or specific patterns of things, um, revisiting them a couple days later to say, "Oh, it didn't work the other day but maybe- maybe you'll be able to do it today |
| | Mia | And I'm like lucky enough that I got my mum to come stay with me while I was getting treatments so that made me feel safe. |

Table 3. The changing self

| | Pseudonym | Quotation |
|---|---|---|
| a.Wow!moment | Honoka | wow, I'm just like, I hear them fighting and then like, oh wow, you know, I have this peaceful mind, what do I do with them now? Like how should I say, mm, like that kind of... yeah, that was strange, it's almost like I can be very, um, observant, um, I just didn't... Yeah. |
| | Fiadh | That's probably the best that is a difference that you can see within...like, you know, I'm not saying that there's no differences afterwards, but just even in like between two hours, like you can see a change in yourself or whatever. So I think that's good. Yeah. |
| | Noah | So I actually felt compassion, you know, and I think that...and I think that was really significant, because suddenly I was free. |

| | | |
|---|---|---|
| | Grace | I can think of three specific occasions where, where suddenly my whole attitude, the way I thought about it, even that evening, and that next day was different. And not, you see, you know how you should think about it. And you know, how you should feel about something. But that's not the same as believing it, do you know what I mean? |
| | Mia | So I think that was the most powerful piece that kept me involved was I could see that the pieces were falling together with every event that we did. And, so I really believed in it. |
| | Emma | I hadn't ever experienced anxiety or, or emotions in my shoulders or, or in my knees, you know. Mm-hmm. Or, or moving up my back. And, and so, I thought that was just very cool. |

Table3. Cont.

| | Pseudonym | Quotation |
|---|---|---|
| bLivingthewayIalwayswanted | Harper | And I feel like I'm finally behaving a way that's true to myself and doing things that are good for myself. And it's something I always wanted to have but I never knew how to get there. |
| | Grace | Yeah, the energy and I finally feel like that the little things that should have been making me feel okay, do actually now and I always said they did but they didn't. |
| | Fiadh | It's...I've had this in the wardrobe maybe like six years and I've worn it, like, twice. But it's something...where am I going to wear it to? [] You know, or there there's no reason to get dressed up. Or I'd feel uncomfortable, I feel like I'm overdressed. Whereas now I'm like, I felt like wearing it, so I'll just wear it, you know. So yeah. |
| | James | And all my life I've seen...my life in dreams I created like a house. So that's kind of what my brain process. And since then and the therapy I've been doing, I'm just...in my dreams I'm kind of like rebuilding it. In essence, I'm rebuilding my life. |
| | Emma | um, because I think it's true, how you treat yourself is how you treat others. Um, more, more patience. I have more patience for myself, and I think, you know, I have more patience for other people now. Um, and I can really understand myself and like my behaviours, you know. |
| | Lucas | …and I couldn't articulate or I- and I wasn't mentally present to help them so it was a lot of confusion, it was a lot of worry, fear, you know, safety concerns, um, it was a relief to be able to you know, sit with someone again and have a conversation or um, go out to- well that took a long time, go out to lunch with my best friend um, or get me out of the house, um, you know, the- the change was dramatic. |

| | | |
|---|---|---|
| | Jack | I didn't have that inert kind of kindness that I would've liked to have because I just didn't have it in myself, so I can make decisions now and do things that I wouldn't have been able to do before, […] It's just amazing day to day how these things, you know, it made me a better person. |