An Interpretative Phenomenological Analysis (IPA) of the link between EMDR and post-traumatic growth

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Dissertation submitted as part requirement for the

MSc degree in EMDR at the University of Worcester.

August 2019

Wordcount: 15,229

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Abstract

Up to this point, there have been few studies mentioning the link between EMDR and post-traumatic growth (PTG). One of the main discoveries of this study is that the concept of PTG is not well understood and that there is limited recognition of its quantitative measures. There was some understanding of the potential links between an EMDR process and the facilitation of PTG, yet this was little formulised or congruent in its delivery. Using Interpretative Phenomenological Analysis (IPA), this project attempted to investigate the connection in greater detail. Four EMDR Consultants were enlisted to participate. Five major themes materialised during the data analysis: EMDR is a powerful and efficacious intervention, PTG is more than just symptom relief, EMDR can have a part to play in promoting PTG, the re-evaluation phase is a key component in recognising and identifying PTG, and the need for more research is crucial for further understanding. In line with the IPA method, all of the themes are accentuated via the capture of, and analysis of, comprehensive accounts of the research participant's lived experiences. Results showed the need for a better understanding of PTG and the necessity of further research.

Introduction

Eye Movement Desensitisation and Reprocessing (EMDR) is an evidence-based, empirically supported psychotherapy used for the treatment of Post-traumatic Stress Disorder (PTSD) and other psychological disorders. Since its inception by Francine Shapiro in the late 1980s (Shapiro, 2017), it has been recommended as a trauma treatment of choice by organisations such as the World Health Organisation and the International Society for Traumatic Stress Studies (Foa et al., 2008; WHO, 2013). Post-traumatic Growth (PTG) is a term used to reference the positive psychological changes resulting from a previous traumatic or distressing event (Akhtar, 2017).

The Adaptive Information Processing (AIP) model, which underlies the workings of the three-stage, eight-phase EMDR protocol (Shapiro 2005), posits that fragmentation in the storage of distressing memories is the root cause of psychological distress (Shapiro 2012). EMDR and Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) are regarded as the primary treatment interventions in treating psychological trauma (Bisson & Andrew, 2007; National Institute of Health & Clinical Excellence [NICE] 2005). Further evidence suggests that EMDR can be applied in the treatment of other mental health disorders such as addiction (Soberman, Greenwald and Rue, 2002), phobias (Logie & de Jongh, 2014), depression (Capezzani et al., 2013) and Obsessive-Compulsive Disorder (Marr, 2012).

In order to flourish following an adverse experience, a consolidation of the experience and a derivation of a constructive and positive meaning is essential (Seligman, 2012). The profound and adaptive changes reported following trauma, as acknowledged by Tedeschi and Calhoun (1995), is known as PTG. Elements of PTG identified include an increase in personal strength, the revelation of new potentialities, enhancement of one's spirituality, the

reinforcement of interpersonal relationships and a greater reverence for life (Tedeschi & Calhoun, 1995). As well as being associated with optimism, religiosity and purpose (Tsai et al., 2015), PTG has been witnessed in the recovery from cancer, bereavement, HIV infection and serious transport accidents (Tedeschi & Calhoun, 2004).

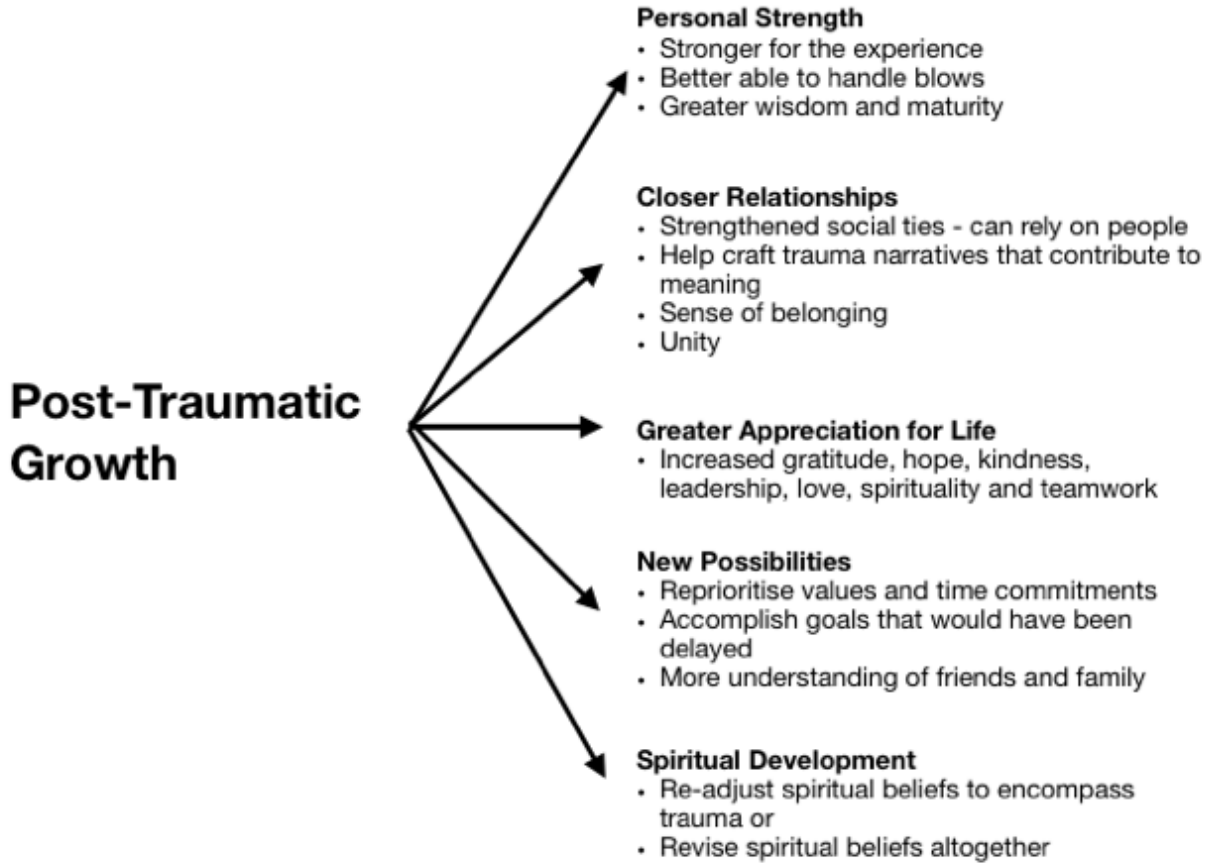

Figure 1. The Five Domains of Post-traumatic Growth (Tedeschi & Calhoun, 1995)

Literature Review

A systematic literature review of studies up to June 2019 was conducted on the link between EMDR and PTG using the following databases: The Francine Shapiro Library, Pubmed, Scopus, ScienceDirect and Google Scholar. Inclusion and Exclusion criteria included the necessitation of the following: the journals were published in peer-reviewed journals, were original studies and were published in English. The search terminology was informed by The American Psychological Association (Psychological Index Terms) and included “EMDR”, “Eye Movement Desensitisation and Reprocessing”, “PTG” and “Post-traumatic Growth”. Table 1 shows the connectors “And” and “Or” utilised along with the concomitant search terms administered.

Table 1.	And Post-traumatic Growth	Or Post-traumatic Growth	And/Or Post-traumatic Growth	And PTG	Or PTG	And/Or PTG
EMDR	√	√	√	√	√	√
Eye Movement Desensitisation and Reprocessing	√	√	√	√	√	√

Table 1. Search terminology utilised in the literature search

The search results were limited in range and neoteric in publication. The first paper on this link was produced in 2011 and the most up to date in November 2017. This research suggests that EMDR is both an efficacious psychological intervention in reducing traumatic symptoms and is also one way of helping to facilitate PTG. The content of literature is limited, and more research is required to explore this connection, including the addition of more qualitative research, cohort studies and random clinical trials (RCT).

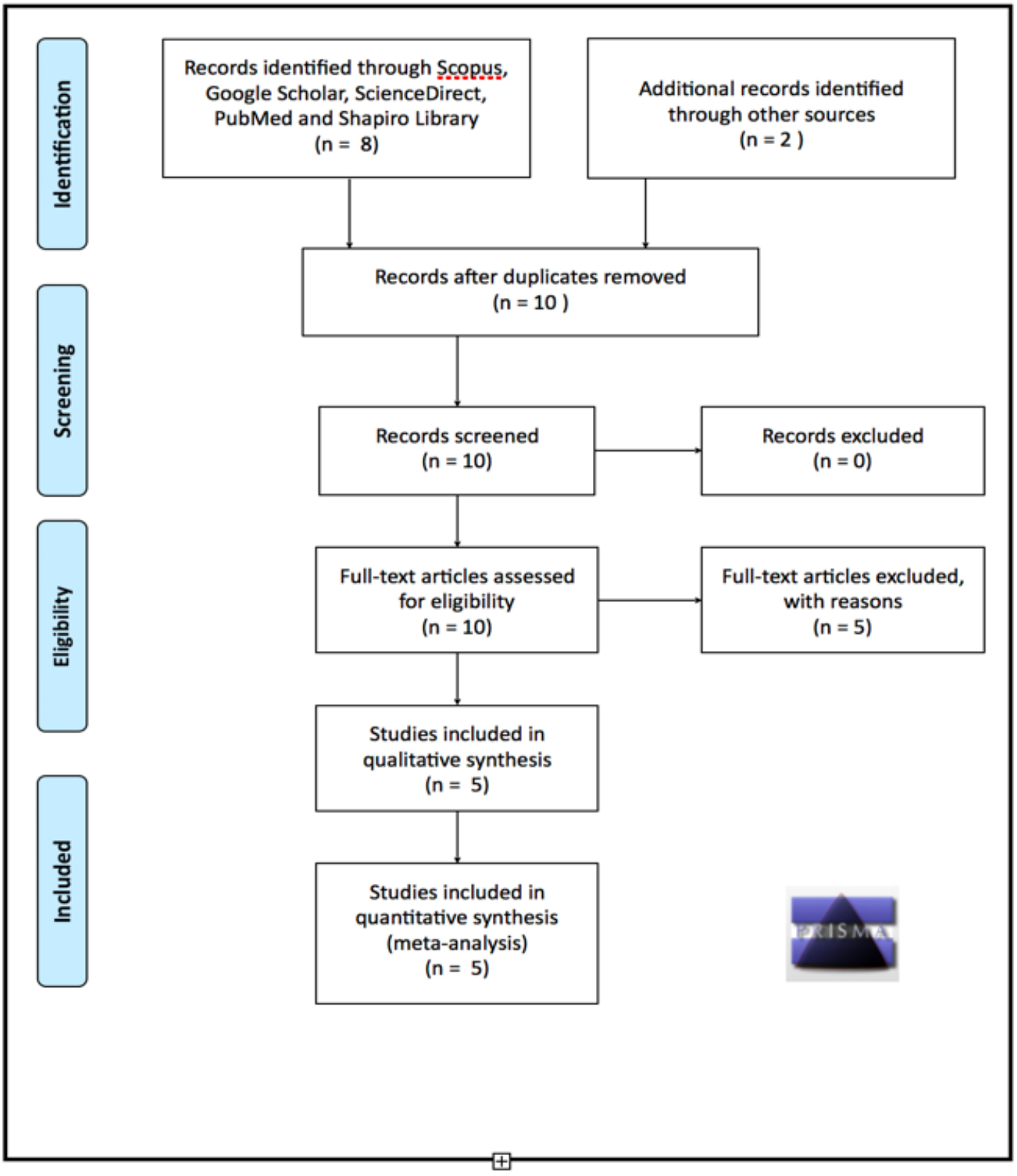

Figure 2. PRISMA 2009 Flow Diagram From Moher et al. (2009).

Results

Two published books (Blore, 2012; Akhtar, 2017), two unpublished theses (Blore, 2012; Pennington, 2016), a journal review (Timson, 2013) and five published studies (Pagani et al., 2011; Jeon & Han, 2015; Angel, 2016; Jeon et al., 2017; Nijdam et al., 2017) were discovered through the search. As identified in Figure 2, it was necessary to omit the journal review, the books and the unpublished theses.

In order of publication, the first study (Pagani et al., 2011) is a preliminary results and methodology paper describing the pre-treatment, intra-treatment and post-treatment Electroencephalography (EEG) imaging of an EMDR process. This study had two intentions: to pinpoint the neurological regions activated during phase 4 desensitisation when listening back to the client's autobiographical text, and to capture, online, the EMDR sessions using the EEG unit and its advanced data analysis potential. The study captured biometrics relevant to PTG using the Post-traumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1995, 1996), a twenty-one question self-report test of PTG, which was conducted pre and post-treatment. The PTGI scores dropped slightly (decreasing from 47 to 41), however, this was not statistically significant and cannot be used as evidence of facilitation of PTG as a result of EMDR.

An open trial carried out by Jeon and Han (2015) at the Department of Psychiatry, Ansan Hospital, College of Medicine, Korea University, investigating whether EMDR can be utilised in the promotion of PTG, constituted the second study. This trial was premised on the notion that due to EMDR's effectiveness in ameliorating trauma symptoms, a concurrent facilitation in PTG was expected. The trial sampled six survivors of a shipping accident from April 2014 in the West Sea. The intervention started five weeks following the tragedy, with a sole doctor performing, over five months, a total of eight EMDR sessions. PTSD, PTG and resilience biometrics were captured throughout the trial (before treatment, following

sessions 1, 3, 5 & 7 and after treatment). Of the six survivors, a significant decrease in PTSD was discovered in two of the participants, PTG was tracked in four of the subjects and in two PTG was identified with no significant change in PTSD symptoms. Of the five evaluations included in the PTGI sub-scale, the 'spiritual change' and 'gratitude for life' factors showed the greatest increase for the survivors who completed the therapeutic process. Jeon and Han concluded that EMDR does have a positive effect on the facilitation of PTG. Along with this, the authors also concluded that EMDR can have a positive impact on PTG even if there isn't a significant impact on the reduction of PTSD symptoms. The trial posits that the genesis of PTG is seen to benefit the treatment of PTSD, as well as identifying resilience as a key component in improving both the promotion of PTG and an improvement in PTSD symptoms.

The third study (Angel, 2016) is an expansion of the functioning of resilience and PTG in the treatment of PTSD. This report integrates, elaborates on and defines each of these terms within the context of support and referral services for both veterans and operational members of the US armed services suffering from PTSD. The author argues that educating those nurses working in the Joining Forces Initiative in the identification and assessment of PTG, Resilience and PTSD, will save lives. Close to three-quarters of those suffering PTSD, it is argued, will develop PTG (Pietrzak et al., 2010; Tsai et al., 2015). The report emphasises Bonnanno's 2004 definition of resilience as, following a catastrophic incident, a return to a prior-event functioning. It is argued that those participants who have higher levels of resilience will develop fewer PTSD and PTG symptoms (Levine et al., 2009). Angel argues that the concepts of PTSD and PTG are separate from the concept of resilience, as they are the outcome of a ruminative and reflective process and have their origin in severe trauma. This study identifies PTSD as an abnormal response by those military personnel or veterans who have left a war-zone (Bonanno et al., 2012), assaying that their PTSD is a result of fractured memory, an incomplete narrative and an inability to make sense of what happened

during the adverse occurrence (Van Der Kolk, 2014). Having defined and identified PTG, resilience and PTSD, Angel then proceeds to mention best-practice clinical guidelines for those wishing to treat PTSD as TF-CBT, EMDR and the medications Paxil and Zoloft (Bisson & Andrew, 2009; Castro 2014). This report concludes with a call for an increased discussion of PTG and resilience, concurrent with continued education on PTSD reduction, in the training of nurses.

The fourth identified study (Jeon et al., 2017) is an examination of the effectiveness of EMDR therapy on the facilitation of PTG. The study was conducted in conjunction with ten subjects who had survived a ferry accident in the Yellow Sea, off the South Korean Peninsula. Over five months, at fortnightly intervals, a psychiatrist administered eight EMDR sessions, with the treatment commencing around twelve weeks following the tragedy. The Stress-Related Growth Scale (SRGS), Connor-Davidson Resilience Scale (CD-RISC), PTGI and CAPS biometric data was collated. This data was collected before treatment, post the fourth and eight sessions, and three months after the intervention. The authors found a significant decrease in PTSD, as well as significant increases in PTG and resilience. There were no significant changes in the PTGI, CAPS or SRGS scores identified in the time between the finishing of the eighth session and the three-month follow-up. The authors concluded that the use of the EMDR Standard Protocol (Shapiro 2005) for the treatment of the survivor's trauma symptoms did indeed facilitate PTG. Jeon et al. then go on to recommend that further control studies would be welcome to generalize their findings, as well as a comparison of other psychological interventions for the treatment of PTSD.

The final study identified during the literature review (Nijdam et al., 2017) explores two psychological interventions and their relation to PTG: EMDR and Brief Eclectic Psychotherapy (BEP). As well as looking at both modalities and their effect on both the evolution and improvement of symptoms, the authors wished to determine if treatment responses advanced PTG. They also discuss the important factor that the majority of PTSD

studies have their focus on adverse psycho-social outcomes to the detriment of investigating the potentially favourable results following the development of PTSD. This Randomised-Controlled trial (RCT), comparing EMDR with BEP, has a large sample cohort of one hundred and sixteen outpatient clients, all who have been diagnosed with PTSD. The level of PTSD was measured weekly, and the PTGI was used to measure PTG before and after treatment. Following both interventions, Nijdam et al. found notable improvements in PTG, including increases in personal strength, new possibilities, appreciation of life and relating to others. A greater increase in PTG was reported in relation to a decrease in PTSD symptoms. The authors located no predictive results, with no observable changes between the treatment interventions, except that BEP showed an increase in relating to others on the PTGI, in comparison with EMDR. Although a robust RCT, the authors identified limitations in their study and room for improvement in future research, including the addition of a control group that received no psychological care. The study concludes that decreases in PTSD symptoms result in an increase of PTG with both psychological interventions, independent of whether there is a focus on PTG during the actual treatment. Another suggestion is that future studies could differentiate the various components of both BEP and EMDR and examine their specific contributions to PTG.

Table 2.

Title author, year	Sample (n)	Main Findings	Conclusions
Pagani et al., 2011	1	PTG remained stable before and after treatment (46 and 41).	No causal link between EMDR and PTG can be determined from this study.
Jeon & Han, 2015	6	Promotion of PTG observed in all participants.	EMDR has a positive effect on promotion of PTG.
Angel, 2016	n/a	EMDR recommended in treatment of PTSD and implication that it can help PTG.	Greater education needed for nurses in the concepts of PTG, PTSD and Resilience.
Jeon et al., 2017	10	Significant increase in PTG reported post EMDR treatment.	EMDR helped facilitate PTG amongst the survivors
Nijdam et al., 2017	116	Both EMDR and BEP resulted in a significant increase of PTG.	Increases in PTG followed a decline in PTSD symptoms, providing strong evidence for EMDR's efficacy in promoting PTG..

Table 2. Main findings and conclusions of research papers identified in the literature review

In conclusion, three of the studies show that an EMDR intervention has a positive effect on the facilitation of PTG during targeted therapy for PTSD (Jeon & Han 2015; Jeon et al., 2017; Nijdam et al., 2017). One of the studies (Angel, 2016) reported the success of an EMDR process in treating PTSD, implying that this will, in turn, advance PTG (however this is only implied and never made explicit). And finally, one study shows no significant change in PTG during the treatment, even though EMDR was shown to reduce the client's Impact of Events Scale (IES).

The literature regarding the role of EMDR in facilitating PTG is scarce, even if there has been a recent increase in publications and interest over the last four years. These more current studies (Jeon & Han 2015; Angel, 2016; Jeon et al., 2017; Nijdam et al., 2017) are the most convincing in showing the positive link between an EMDR intervention and the genesis of PTG. Three of these studies (Jeon & Han 2015; Jeon et al., 2017; Nijdam et al., 2017) show an increase in PTG, with the fourth (Angel, 2016) recommending TF-CBT or EMDR to treat PTSD, with the modality then expected to enable PTG.

In terms of levels of evidence, the most robust study is the RCT (Nijdam et al., 2017). This study not only had a large sample size (n=116), it also has an integrity to its design that can't be dismissed, including both clinician and client self-reporting, and the fact that it is, at its core, a randomised control trial (RCT). This allowed for the following: high treatment fidelity, including a systematic implementation and standardised execution, random allocation of therapeutic intervention, and independent evaluation of the results. The study participants also had PTSD as a result of a wide range of trauma histories, which in turn allowed for a robust proto-typical sample.

The next study, in terms of rigorous psychological testing, is the pilot study (Jeon et al., 2017). It is not an RCT, yet with a sample size of ten participants, it makes for a thorough cohort study. It is limited by the inability to generalize the terms due to its sample size

nevertheless it has many favourable aspects. In line with this study, the primary goal is to measure how EMDR can facilitate PTG, with very positive results. Seven of the ten subjects showed significant increases in PTG, which the authors assert shows that EMDR is significant in promoting PTG. Further evidential significance can be found in the trials' set-up: all the subjects had experienced the same trauma (length of time, type and severity) and all were treated by the same clinician using the same EMDR protocol.

In a similar vein, the 2015 open trial (2015), resulted in similar findings with a similar set-up, concluding that EMDR facilitates PTG: it had a small sample size (n=6) and the therapy was administered by the same EMDR therapist over a comparable time-frame. However, it has less in its favour, in that this open trial was an abstract-only submission, therefore restricted in the number of details and data that can be analysed, resulting in a diminished explanatory power compared to both the RCT and the pilot study. Missing elements include any citation of follow-up methods and the duration of treatment (the authors were contacted in relation to additional data but they could not accord any further than what has been published).

Although the other two identified studies mention PTG within their respective processes, they were not designed, nor was the focus, on PTG and its relationship with EMDR. Hence their explanatory power is weak within the context of this study and the information has to be inferred from their conclusions. The Angel (2016) study has its focus on PTG and resilience, and as a result, the connection to EMDR, while useful and important, is only implied and no actual causal connection can be asserted. The Pagani et al. study (2011) reports no significant change in PTG pre and post-treatment, although this is only mentioned in passing and is not significant to the intentions of the study.

Limitations in the Current Literature

All of the identified studies had clear limitations. Definitive conclusions are hard to administer, and compatibility of the data is seriously compromised due to a lack of correlation in the intervention techniques, sample sizes, follow-up procedures, study designs, and outcome measures. The amount of peer-reviewed studies is scant and follows an ever-decreasing hierarchy of evidence in the following order: an RCT, a cohort study, a pilot, an analysis of interventions and a single case study (Daly et al., 2017). This implies the need for further study in identifying the links between EMDR and PTG, as well as expanding the types of research. Future researchers could expand the body of work to include more RCT (including larger sample sizes), case-studies, correlational-studies, further professional recommendations and the addition of qualitative studies. There are gaps in the research that include a need for thorough follow-up sampling and the potential collection of longitudinal material. It was observed that not one of the studies had a control group, which could help generalise the individual findings and help examine the effectiveness of a range of PTSD therapeutic interventions (for example, contrasting the effectiveness of TF-CBT vs. EMDR in contributing to PTG). In addition, it was noted that there was no long-term monitoring of PTG data in any of the studies, which would allow for a measure of stability in clients and their experiences.

Reflections on the Literature

Shapiro (2012) draws significant attention to the fact that EMDR is a safe and effective therapeutic intervention in the treatment of PTSD (Feske and Goldsteina, 1997; Shapiro, 2012; Hase et al., 2008; Novo et al., 2014; Gerhardt, 2016). EMDR, as well as improving a client's trauma symptoms, could well be seen as a significant instrument in both alleviating trauma and promoting PTG. This qualitative study is timely for two reasons:

EMDR is becoming increasingly used as an efficacious psychological intervention, and the recognition and research of PTG are increasing too. Concurrent with an emphasis on research concerning the links between EMDR and PTG, there needs to be an equal focus on the "why" EMDR would facilitate PTG. This study hopes to add valuable information in answering both these questions.

The positive consequences of an EMDR intervention match with some fundamental components that constitute the notion of PTG. EMDR processing moves the fragmented, episodic form of a disturbing memory to an integrated, narrative memory, which in turn allows a client to make meaning and sense out of their adverse experience. As fresh, novel adaptive information is engendered during the stage 4 processing, it can be argued that as well as reducing the traumatic symptoms, a client becomes a more integrated, complete person than before the commencement of the treatment intervention (Shapiro & Solomon, 2008). Clients not only shed light on the meaning of their experience during the free-association that occurs during an EMDR process, the installation of a positive cognition, the reduction of negative somatic symptoms, and the integration of new constructive thoughts and beliefs result in a promotion of psychological growth. During an EMDR process, it is often observed that a parallel process occurs where the client not only lets go of their traumatic symptoms, they start to experience a sense of self-transcendence, signifying the existence of positive post-traumatic change.

PTG is a process based on the reconstruction of the subject's inner reality, taking place after a preceding deconstructing process. The 'Shattered Assumptions Theory' of Janoff-Bulman (1992) hypothesises much of the 'how' of PTG synthesis, asserting that a traumatic incident destroys a client's presumption that we live in a benevolent world and that benign people live according to a righteous code and moral functioning. Adverse events lead to dismissing these beliefs, decimating the notion that 'we live in a fair and just world'. The PTG process starts with a client embracing their new reality, in conjunction with the building

of new cognitive structures which facilitate significant positive shifts in how they see themselves in their new reality.

PTG theory can also be found in Joseph and Linley's (2005) theory of 'a tendency to self-actualisation'. Their theory of 'organismic valuing' posits that a client has a predilection to flourish and thrive, reaching their potential. Adverse events result in a deterioration or disintegration in the client's core beliefs surrounding their identity with the advent of PTSD seen as a marker for the need for a new, cognitive restructuring to make sense of their new reality. According to this theory, PTSD behoves the propulsion into PTG, warranted by the idea that clients have an inherent drive to manage and amalgamate the disturbing data into novel ways that will elevate their mental health. Joseph and Linley postulate that it is the 'how' of rebuilding one's inner reality that will fundamentally decide whether someone will go on to develop PTG. This emphasis on 'how' opens a door for an EMDR process, as the reprocessing element in the trauma confrontation can be seen as a significant restructuring of one's internal world.

Research Question

The research relating to the connection between PTG and EMDR is not yet adequate in informing and promoting evidence-based, customised psychological protocols for utilisation with clients. As long as there is no further research, this will continue to be the case until a more robust understanding of the role of psychotherapy in the genesis of PTG is recognised. This research project aims to both reinforce the understanding of the connection between an EMDR process and the facilitation of PTG, and to augment the research evidence, critically enquiring and observing how mental health professionals construct and perceive their experience of the connections unifying EMDR and PTG.

The literature review shows that there has been no specific, qualitative, enquiry into this specific relationship between PTG and EMDR. The articles under review reveal only a

handful of studies that either mention or investigate such a relationship, thus illuminating a need to determine if EMDR, as well as being an efficient intervention in trauma reduction, promotes PTG at the same time. This lack of clear knowledge indicates merit in pursuing research into whether there is any causal connection between an EMDR process and the facilitation of PTG. Therefore, due to the lack of any qualitative studies on the subject, the following question will be investigated:

'Does EMDR facilitate post-traumatic growth?'

Methodology

Interpretive phenomenological analysis (IPA) seeks to examine, in detail, a subject's awareness of their own personal and social world, with social cognition as its leading systematic focus (Smith & Osborn, 2007). It allows for a research process that is structured and for an organised methodology for data analysis. It is phenomenological in its approach, seeking to investigate the subject's individual perception of an event or experience, as opposed to creating an objective report of the experience itself (Smith, 2007). As a methodology, IPA presupposes that there is a web of connections between a subject's emotional state, their cognitive reasoning and their use of language. Nevertheless, an IPA process acknowledges that gaining a complete or direct perspective of these elements is impossible. The researcher brings their own interpretations that complicate the 'accessing' process: because a subject will often struggle to express their feelings and thinking, the researcher will have to offer their own interpretations of the emotional and cognitive world being explored. These interpretations must be made explicit and open to being both modified and challenged. This means that IPA research is a dynamic process due to the researcher's active role in the interview and analysis activities. IPA entails two phases of analysis which is termed the double hermeneutic (Smith 2007). The subject involved in the process is

attempting to create meaning of their inner states while concurrently the researcher is attempting to make sense of the participant's attempt to create meaning of their inner states (Braun & Clarke, 2013).

Aspect	Issue	Objectivist Position	Subjectivist Position
Ontology	The nature of being.	Guided by concept of **Realism**. There is a real social world with real structures. Existence exists independent of consciousness.	Guided by the concept of **Nominalism**. There are no real structures in the world.
Epistemology	The theory of knowledge rooted in the theoretical perspective, with an emphasis on the distinction between validated belief and mere opinion.	Believes in **Positivism** and states that knowledge is based on natural phenomena and their causal connections. Information is interpreted through reason and logic, which forms the exclusive source of all certain knowledge.	Believes in **Anti-positivism**, stating that objective knowledge is impossible – therefore the investigative significance is based on understanding.
Methodology	The proposed plan of action in approaching the investigation/ research.	**Nomothetic** approach searching for universal theories/laws	**Idiographic** approach that analyses and investigates individual cases for detailed insight.
Method	The system, including the operating procedures used to bring together and analyse the data.	Use of systemised biometric measures e.g. surveys, questionnaires, experiments, observation.	The use of spoken or written word e.g. focus groups, text analysis and interviews,.

Table 3: A summary of contrasting objectivist and subjectivist qualitative research.

(Adapted from Crotty, 1998)

Design

This study is qualitative in nature (Dey, 2003) and took an idiographic perspective, defined as research that considers the subject in her or his own right (Howitt, 2013). The subject's opinions and experiences were captured via the use of semi-structured interviews, with an analysis of both the distinctive meanings and the data collection methods (Braun & Clarke, 2013). The data was collated through the use of relevant, mindful and open-ended

questions through a conversational style. Throughout the interview processes, an attempt was made at all times to try and build as strong a rapport as possible with all the interviewees, to give each subject the greatest opportunity to detail their experiences and allow the subject to enter their social and psychological sphere (Smith, 2007). These IPA techniques and its framework allowed for a positive collation of constructive data to be analysed (Howitt, 2013) and the semi-structured nature of the interviews allowed for questions to be asked in an auspicious method, permitting the process to reveal new perspectives should they arise (Pietkiewicz & Smith, 2014).

Justification for using IPA. IPA is becoming a more and more validated method for research, as evidenced by both the growing body of IPA research and the thorough guidelines on offer, encouraging a flexibility to those new to research (Smith et al., 1999; Smith & Osborn, 2007; Flowers et al., 2009). IPA is congruent with the researcher's epistemological point of view and expresses their psychotherapeutic philosophy. The method is based on the exploration of how a subject make sense of their life experiences within both a social and personal context. Aside from the initial interview and transcription analysis, the procedure does not take up too much of a participant's time, while allowing for both an investigation of the subject's opinions and deriving their over-riding themes and issues (Flowers et al., 2009).

The researcher had to consider the criticism of both IPA and qualitative research in general, particularly in relation to its focus, generalisability, and the query around a subject's ability to accurately articulate their thoughts and feelings (Biggerstaff & Thompson, 2008; Willig, 2013). This reasonable set of concerns was taken into account whilst simultaneously weighing it up against the positives on offer: the potential for gathering rich, descriptive data, the nature of the approach and the fact that those being interviewed were experts in the field, experienced in reflecting upon and articulating thoughts and emotions in their day-to-day work life, and likely to be able to articulate clearly in an interview setting.

Participants. The study purposively selected and evaluated four UK based EMDR Consultants in line with contemporary sampling recommendations (Brocki & Wearden, 2006). They were chosen due to their clinical expertise in the field, their experience of working with multiple clients over many years (the accreditation process to become a Consultant is a minimum of six years following the complete EMDR training) and would have had to have presented a minimum of one hundred clients within their own EMDR supervision process (Farrell, n.d.). The Consultants were recruited through the UK & Ireland EMDR Association and the interviews either took place in person or via Skype. The average interview time was forty-seven minutes, with the shortest being forty and the longest sixty minutes. The audio was recorded, encrypted and then transcribed (see Appendix A for an example of a transcript). The facilitation of the interview process was conducted at a phenomenological level, guided by the knowledge that the purpose was to capture both the complexity of the meanings contained in the data and the content itself (Pietkiewicz & Smith, 2014).

Sample size. Marshall (1996) states that for a qualitative study, the criteria for sample size is determined by its ability to answer the research question. IPA sample sizes are guided by suggestions in the literature that include considering the level of commitment required to analyse the data, recognising the extent and diversity of data capture, and acknowledging any organisational restrictions a researcher will be working under (Smith et al., 2009). In contrast to quantitative studies, whose aim is to identify generalisations obtained through standard, biometric measures, in general, qualitative research seeks to adopt an idiographic approach without making generalisations (Dallos & Vetere, 2005). While IPA does not reject generalisations in relation to larger samples, it does allow for the possibility of deriving generalisations off the back of analysing a small sample group (Smith, 2003). While this may limit IPA's power in substantiating theory, it does allow for a deeper scope of investigation (Smith, 2009).

As a result of this understanding, IPA was chosen in order to mine a depth of understanding that is rich in detail and personal understanding, guided by the sense that under IPA less is more, resulting in greater detail as against the option of a shallower analysis of a greater number of participants (Reid et al., 2005). Eatough & Smith (2006) suggest that researchers should choose a subject sample size that is sufficient in capturing differential elements in analysis, without becoming overloaded by too much data engendered by larger sample sizes. Analysis of the IPA literature reveals no conclusive answer to actual sample size, however, a range of one to fifteen or more is indicated (Smith et al., 1999; Brocki & Wearden, 2006; Smith, 2007). With these factors in mind, it was decided that four participants would provide sufficient data for this study.

Confidentiality and Ethical Considerations. The British Psychological Society (BPS) states that a participant's information and identity must be kept confidential and if research is published, all identities must be unidentifiable (King, 2010; BPS, 2014). Participant anonymity was safeguarded by assigning random initials for use within the study with no reference to gender (using 'they' instead of 'he or she' etc.), from transcription to analysis, protecting their identity throughout.

During the interviewing process, all participants were fully informed that the whole process was entirely voluntary and that they could withdraw their consent at any time. All matters regarding confidentiality, data storage, the utilisation of appropriate pseudonyms and anonymity were explained both in person and in the interview contracts that each participant signed (See Appendix B for an example of the interview contract). This open and transparent process ensured that each interviewee could make a fully informed decision to participate (Smythe & Murray, 2000) with all ethical methodology (Silverman, 2013) guided by reference to the EMDR UK & Ireland ethical guidelines (Piper, 2010).

Data Protection. The Data Protection Act (Parliament, 1998; Charlesworth, 1999) stipulates the following requirements when processing, using or holding information on private individuals: the data is used lawfully, for specifically stated purposes within a limited time-frame, is accurate in nature, kept for as long a time as is necessary, stored in a safe and secure manner and cannot be transferred outside the UK without sufficient safeguarding (Iversen et al., 2006). This is concurrent with the notion that individuals have the right to access their personal data at any time including asking for copies of the collated personal data (Pollock, 2012).

To comply with the Data Protection Act certain procedures were put in place. All participants signed consent forms, explaining clearly the procedures, aims of the research, their rights to the data and all aspects of confidentiality. Their names were changed to pseudonyms, audio files were encrypted and destroyed once transcribed, consent forms were kept in a secure filing cabinet and all electronic data was password-protected.

Pseudonym	Method of interview	Experience within field of mental health	Level of EMDR Training	Location
NU	Face-to- face	20 yrs +	Consultant	South England
MH	Skype	20 yrs +	Consultant	Middle England
FT	Skype	20 yrs +	Consultant	South England
SE	Skype	20 yrs +	Consultant	Wales

Table 4. Summary of the four participants taking part in the study

Interview Implementation. At the beginning of each interview, the subject was taken through the purpose and aims of the study with a review of the procedure, including the recording process (either via Skype's encryption function or on a password-protected iPad). Each participant was encouraged to narrate their observation of the phenomenon of PTG in relation to a client's EMDR process, with the interview schedule a useful guide in encouraging the capture of a free-flowing interview. If further clarity or focus was required,

the use of prompts allowed the interview to proceed smoothly and freely. The purpose of using open-ended questions was to enable the interviewees to elaborate on their narrative experiences throughout the semi-structured interview. Questions included the following:

1. ***As an experienced clinician what has attracted you to EMDR?***

This question was designed to allow participants to talk in general about their experiences of working with EMDR and trauma. Its purpose, as well as to establish a context, was to help the participants settle before moving the process on to more detailed areas.

2. ***What is your understanding of PTG?***

Question 2 was included to gain clarification of the context of the particular interview. It aimed to allow participants the opportunity to discuss their understanding of PTG, what it means to them and its connection with the therapeutic process.

3. ***Is PTG something you witness in your EMDR practice?***

Question 3 expands the detail from question 2 and allowed for further detailed exploration of PTG within the participant's specific clinical work. Furthermore, it gave participants the option of discussing a more personal experience of PTG.

4. ***What is your perspective on the relationship between the AIP model and PTG?***

Question 4 seeks clarification around a theoretical detail linking EMDR and PTG, thus deepening the context and exploring the participant's experience linking theory to practice. Conditional upon the interviewee's reaction, this question worked towards providing more detailed data.

5. ***Are there any specific aspects of the EMDR protocol that promote PTG?***

Question 5 is a direct follow-on from the previous question, moving the inquiry onto a more experiential focus, dependent upon the participant's answer to the previous question.

6. In your opinion how could the EMDR community address the promotion of PTG?

The literature review revealed that there is very little data on the link between PTG and EMDR. Question 6 was aimed at exploring the participant's thoughts on this issue in a context that would be familiar to them. Furthermore, it was hoped that this question could lead to further research questions, opportunities and lines of inquiry.

7. What has been your experience of this interview?

The final question was chosen in order to investigate the interviewee's experience of participating, going through a subject in a discussion format, seeing if they have had any new insights and emotional connections, whilst offering them a chance to reflect or expand on any part of the interview (including any of the particular questions) and possibly identifying any themes they have noticed. It also allowed for a gentle close to the interview.

The semi-structured interviews gave the interview a shape and a schedule. However, it is important to note that IPA is not constrained by a particular schedule, letting the schedule guide the process instead of trying to dictate it. This use of semi-structured interviews has a tremendous advantage in that it allows for the following:

- The facilitation of good rapport with the participant, putting them at ease and allowing them to relax. This relaxation allowed for greater access and the ability to go deeper in the process, bringing forth richer data than would be expected should the participant have been nervous, on edge or feeling pressured.

- The creation of an empathic attunement, which again put the participants at ease, allowing for the mining of deeper and more rewarding data, as opposed to being

restricted to a rigid structure, which had the possibility of rupturing the attunement (Rowe & Isaac, 2000).

Three of the interviews were carried out via Skype, with the content recorded through Skype's encryption service. The audio was then extracted from the Skype content, with the Skype content then deleted. The other interview was conducted in person with the audio recorded to an iPad recording device. The audio of each interview was then transcribed before undertaking the IPA analysis through the following stages: identifying initial themes, clustering these themes, followed by a process of identifying emergent themes.

Principle	
1	Undertake to set up good rapport with each research interviewee
2	Remember that the question order is not that important
3	Feel free to enquire into any engaging areas that may come to light in the interview process
4	Track the interviewee's interests, distractions or concerns

Table 5. Four principles to adhere to during the interview process (Smith & Osbourne, 2007).

The seeking of participants, collection of data and the general undertaking was a smooth and fluid process. Due to the clinical experience of the researcher in conducting interview-based questioning and extracting important information during previous client assessments, the use of interviews within the IPA framework had a huge advantage in uncovering valuable participant data within the use of using already honed therapeutic skills.

However, it must be noted that the researcher was surprised at the difference between conducting Skype and face-to-face interviews. Restrictions in time-management, finances, mobility, long distances between participants and the researcher, and participant availability, meant that face-to-face interviews were difficult to arrange, with most of the interviews performed over Skype (Carter, 2011). While still offering the ability to see the

interviewee over Skype, the slight visual/audio drag that can occur and the diminishing of access to non-verbal cues, along with the slight distraction of wearing headphones, came at a small disadvantage in losing some visual information that could have been useful in the later data analysis (Sullivan, 2012).

An additional issue that occurred during the interview process resulted from becoming too drawn into the conversation. This is an acknowledged feature of IPA and evolved from asking the interviewee to expand at times in an area deemed interesting to the researcher yet was not that relevant to the study subject. Becoming aware of this, and allowing for the possibility of discovering other, useful data, allowed the participants to talk through what they thought was significant, a crucial feature of IPA (Flowers, Larkin & Smith, 2009).

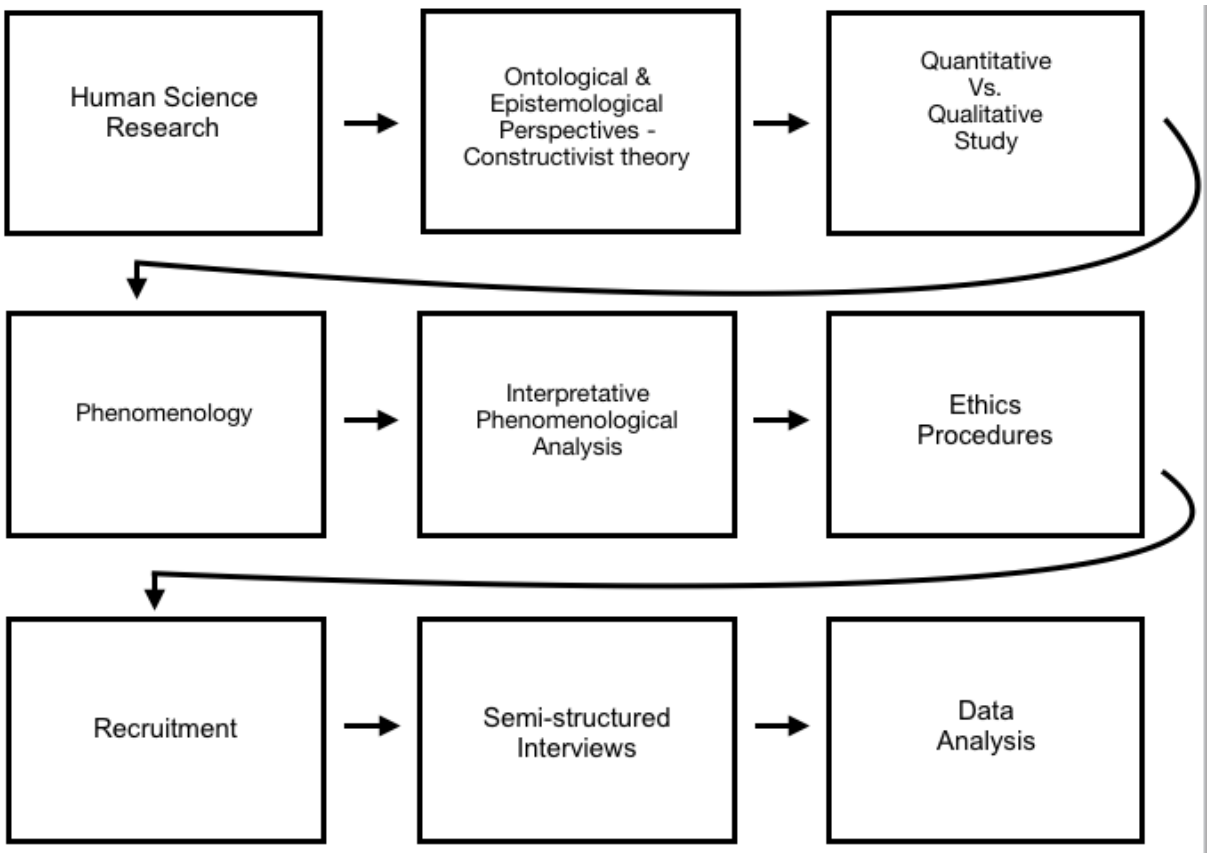

Figure 3. Study Design to Analysis

Data Analysis

IPA's purpose is to investigate, comprehend and convey the experiences and points of view put forward by its participants (Larkin et al., 2006). As well as basing studies on the evidence of the words spoken and using direct quotations in the substantiation of findings similar to other qualitative methods, IPA also involves a 'double hermeneutic' interpretation process (Smith, 2009). This double hermeneutic process has two intentions: to comprehend and accurately reflect the interviewee's inner-world and perspective, as well as recognising the role of the interviewer in their attempt to make sense of the complete social and theoretical context (Smith, 2004). IPA acknowledges that research is about trying to get close to the subject and that there is no exact path to grasping someone's experience. A comprehensive examination necessitates the use of critical questions such as 'am I aware of something that the participant is missing? What is the participant trying to establish? Is this going somewhere unexpected?' (Smith & Osborn, 2007). An essential aspect of IPA is that the analysis should evolve through the examination of substantial verbatim excerpts from the interview data.

In order to make the analysis easier and clearer to comprehend, participant utterances such as "um" and "err", repeated words and sounds (such as gasps etc.) were left out unless they were connected to the analysis. The same principle was applied to any similar intervention by the researcher, such as "right' or "mmm". Square brackets, with dots in the middle […….] were inserted to protect the anonymity of anyone involved. The researcher's questions are quoted in bold italic, with the participants' answers quoted in regular italic.

Step One. The interview transcripts were read, re-read and then re-read again in order to gain an overall sense of each of the interviewee's narratives. Throughout this phase, notes were made of possible themes with a concurrent observation of the interviewer's own

experience of participating in the interview. This process required an acknowledgement of both the outsider interpretative stance and the insider phenomenological position essential to IPA.

Step Two. Exploratory commenting of each participant started the coding process. The three-stage process, as suggested by Smith et al. (2009), was followed and the following text highlights were administered as shown in the following table (See Appendix C for examples of the coding):

Comment Type	Action
Descriptive - content that centred on what the interviewee was talking about.	These comments were underlined in grey pencil.
Linguistic - content that centred on specific use of language such as metaphor, tone, repetition and forms of animated affect (laughter, excitement etc.)	These comments were coloured in orange.
Conceptual - content that was more questioning, probing and more conceptual. The analysis involved more interpretation from the researcher and included any shift away from the main emphasis of the interview, new avenues explored and other leads discussed.	These comments were coloured in green.
Other - any other content that was deemed interesting or important that did not fit those suggested by Smith et al. (2009).	These comments were highlighted in pencil - often with a square around the text.

Table 6. Coding text highlights for the four transcripts

Step Three. This step involved analysing the coded data from step two and developing them into emerging themes (Table 7.), shifting the focus away from the original transcripts and onto the explorative comments.

Step Four. This next step required looking for any links across the newly identified themes. Comparable themes were banded together in order to create sub-ordinate themes. Themes that could not be linked were left on their own. Respecting the IPA process and its

commitment to investigating each transcript as equally valuable allowed for themes to emerge derived from both the participant and the researcher's experience.

Step Five. This final step looked for links, associations and patterns across all the transcripts. At times themes were reproduced in different sub-ordinate groups and as a result, were merged and renamed. The interrelationships between the themes were determined as well as a process of defining the themes themselves. This data was funnelled and condensed with a specific focus on the psychological components under examination during each interview (Osbourne & Smith, 1998). These were further organised and integrated in order to reach a deeper understanding of the interviewee's lived experience within the context of their narrative, as captured in the transcription. Examples of the coding process can be seen in Appendix C.

Expanding the Coding. During the process of qualitative research, data analysis organises the words and language used and deduces meaning. The coding process involved mining the four transcripts and delving under the surface in order to reveal any extra data (Huberman & Miles, 1994). This process is iterative, inductive and organises data in a reduced form, allowing the construction of themes and theories (Howitt, 2013). Data was dissected during the line-by-line coding process, with similarities and differences acknowledged and then categorised. The initial themes that emerged from the four interviewees were constantly cross-checked, reviewed, refined and clustered to create a new group. All of this data was repeatedly cross-checked, and further connections were identified, whilst continually checking back with the original interviews to ensure fidelity and precision in the analysis (Yardley, 2000; Goodwin & Horrowitz 2002). The differential refinement and re-integration of the data resulted in the identification of the following emergent themes within the four interviews, as shown below in table 7.

Participant	NU	FT	MH	SE
	EMDR Powerful and Interesting	Historically no alternatives to EMDR	Interest in unconscious processes	EMDR results in extraordinary changes
	Lack of alternate interventions	EMDR intriguing as a practitioner	Interest in personal development	There can be amazing results
	EMDR really helps	Historically no way of working with trauma	EMDR was an interesting modality	EMDR Creates new responses
	EMDR very positive results	Query of universality of EMDR	PTG goes beyond survivability	EMDR created a new journey
	EMDR Powerful	Growth comes after the cure	You can witness the change	Shifts in perspective as a result of therapeutic process
	Old treatments not helpful	Lack of follow-up a hindrance	Witness PTG in therapy	EMDR increases resilience
	Client underdeveloped	Cure results in behavioural change	Potential for growth always there	EMDR negates avoidance
	Symptom relieved (EMDR)	Cure results in psychic change and life direction	A client's strength as a resource	PTG goes beyond pre-trauma
	Greater than symptom relief - growth	PTG more than a cure	You are tapping into their resources	Trauma's importance/significance diminishes
	Change of character (growth)	Sensitivity required in discussing it	Sense of resilience at play	PTG witnesses in both complex and straight forward processes
	Life changing process	PTG talk should be retrospective	EMDR very powerful	The therapy opens you up
	EMDR facilitated the change (due to inertia of other modalities?)	PTG witnessed in practice	More causal factors at play	There is a reconfiguration of everything
	Witnessed change	PTG initiated by more than just EMDR intervention	A need to do the work to change	Beyond the individual - Growth in family dynamics
	Move towards independence (self-esteem)	More causal factors at play	Witnessing PTG a retrospective process	Not fond of AIP model
	Growth above just symptom relief	The cure give the potential for growth	Stabilisation a key factor in growth	EMDR is a reconsolidating process
	EMDR reaches a deeper place	An indirect protocol effect	Witnessing growth in therapy	EMDR creates a new personal freedom in the client
	Stabilisation - Protocol active in the process	Return to healthy brain functioning key	More research needed	A client needs disconfirming information to change
	FT and re-evaluation critical	PC's effect contextual on the nature of the PTSD	Questions about future lacking answers	Re-scripting a useful tool in acknowledging growth and change
	Reconnection to disjointed self	FT has potential for growth	No clear definition of PTG	Disconfirming information can be buried in sub-conscious
	Revelation of self to client	Need for more research	More than one factor at play	All of the EMDR protocol is important

Participant	NU	FT	MH	SE
	Re-evaluation key	Disappointment at lack of reference in literature	Community would benefit from more evidence	Unearthig of resources crucial
	Growth in esteem	Caution required in discussing with clients	PTG could happen anyway	Future Template can create a new personal freedom
	Positive Cognition plays a role	Understanding of PTG unreliable at present	EMDR is a vehicle for change	PTG not a significant subject within EMDR community
	Growth in stability	PTG very interesting subject	EMDR goes deeper than the other modalities	More research needed on the link
	Growth in safety	EMDR as potential for growth	Stabilisation a key component	Re-evaluation so important - 'how did you survive?'
	EMDR speeds up process	Possibilities for growth and research	More research needed	
	Growth in identity and purpose	Better alternatives than EMDR for peak performance		
	Space for PTG biometrics in process	Caution using EMDR for everything		
	PTG a retrospective process			
	Retrospective reflection			
	EMDR Vital in process of PTG in these cases			
	More research needed			
	never occurred to make biometrics of PTG'			

Table 7. List of emergent themes derived from the four interviews

The initial themes were analysed for connections and patterns covering the data set that embodied the most important and thought-provoking elements of the interviewee's narrative (Flowers, Larkin & Smith, 2009). It was found that many of the themes naturally grouped themselves, and connections were clustered together, like-with-like. From this process, a group of master themes was distilled and identified (summarised in Figure 4.).

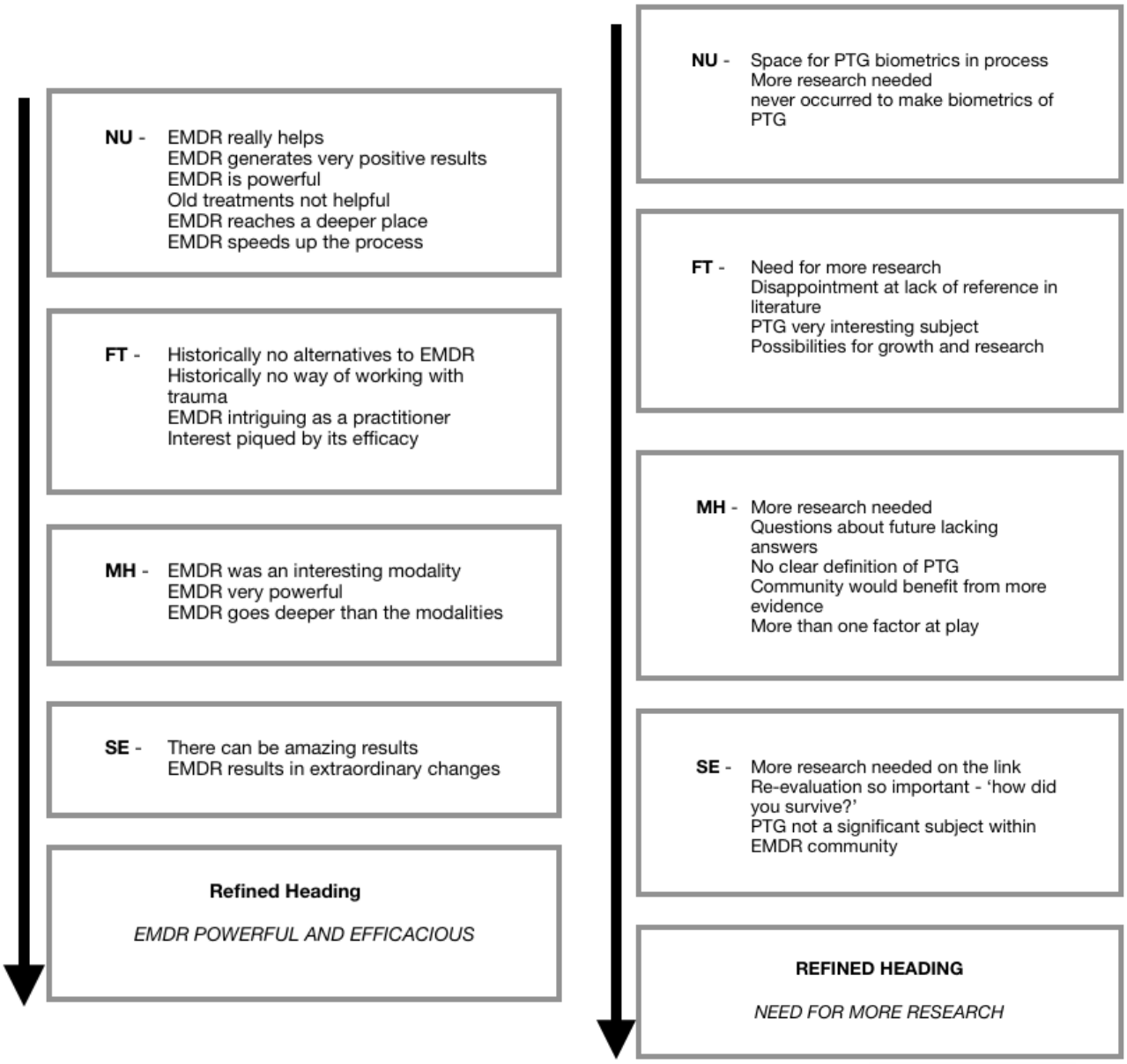

Figure 4. Examples of the refinement process of emergent themes

The individual themes were printed out and spread out on the table in order to help the mapping process. As there was a large amount of data to integrate it was crucial not to become too overwhelmed. Stepping back, looking at the data in large text, allowing the text to land, then taking breaks, allowed a sense of refinement and restructuring of the data into a more organised and user-friendly form in mind. To keep encouraging a sense of rigour and fidelity to the source material, transparency and consistency were necessary throughout

the process, with new connections explored until a coherent set of final master themes was identified that could answer the research question (Patton, 2005).

The next stage, by re-examining the line-by-line coding, involved analysing the interview text to discern quotations that best represented the master-themes. This gave each participant a voice whilst providing evidence for and validating each of the master-themes. These are discussed in the results section.

Findings

All the participants were uniform in their praise for the efficacy of EMDR and the positive impact of their therapeutic work. It was clear that they found the work stimulating, rewarding and deeply satisfying. The descriptions of their work and the results they were getting from using EMDR as an intervention in reducing traumatic symptoms in clients was infused with passion and integrity.

Answering the Question

Five master themes were identified that explored and represented the participant's experiences and could provide an answer to the research question:

1. EMDR is a powerful and efficacious intervention
2. PTG is more than just symptom relief
3. EMDR can have a part to play in promoting PTG
4. The re-evaluation phase is a key component in recognising and identifying PTG
5. The need for more research is crucial for further understanding

Theme 1 - EMDR is a powerful and efficacious intervention

One of the most powerful themes infused in all the interviews related to the tremendous respect and admiration for the power of EMDR as a therapeutic intervention. All the interviewees spoke of the enormous, positive changes they had witnessed in clients during an EMDR process, not only in its curative effects but in how it has impacted their clients' future lives too. This was first noticed in each of the participant's explanation of what drew them to EMDR in the first place. There was a sub-theme of a deficit in effective interventions available to each participant in their early careers that arose at the start of the interviews. This ranged from being dissatisfied with what tools they already had, to finding EMDR as the only solution that worked.

Examples of this include FT stating:

"Originally it was because there wasn't, there really didn't seem to be anything that was addressing trauma in anything like an effective way…….that what interested me about it was the fact that conventional talking methods just didn't seem to be all that useful, basically."

While NU expressed frustration with alternate therapeutic interventions:

"the various different therapeutic approaches that we were using within that context could take people so far, but actually dealing with the really crippling flashbacks that people were having, and the general reliving, just felt like something that we weren't breaking through that. And so, when I heard about EMDR as a therapeutic intervention, that potentially could really help that sort of symptoms, that's why I became interested."

For SE disclosed what they saw as remarkable changes:

“I worked with him for several months and didn’t really get anywhere and my wife […] had been on an EMDR course and so I said to her one day ‘why don’t you go and have a look at this boy’ which she did and she had about 4 sessions with him and then we saw the family and said ‘well what's going on now?’ Well, absolute extraordinary change. “

Once the context of where the participants started with their EMDR journey was established, each of them enthused on how powerful an intervention EMDR is for working with trauma. This was established not just in the stated facts but also in the strength and passion of the language used.

For example, NU using the word ‘shocked’:

“*we all worked on an issue and experienced first-hand how incredibly powerful it was…….they were just really shocked by actually the experience*”

And in response to the question posed by the researcher:

“So it was an exciting new modality?

Definitely, definitely,……..I’ll never forget.”

SE expressed his wonderment with the whole EMDR process:

“‘*well what's going on now?’ Well absolute extraordinary change…….his whole behaviour had changed in an amazing way……..I also had quite an amazing experience which convinced me that it was great……..So, she did EMDR on me and so the result was amazing….So, it made a big difference and I never looked back after that…..So, she just opened up like a flower, it was just amazing…..it opens up*

the world…..I mean I think it is wonderful EMDR. I think it is an extraordinary development….the wonder of the whole process."

FT's passion for EMDR is visible in the following statement:

"*I, it was, obviously it was totally unheard of, it had only just been invented and I was intrigued because it sounded so nuts…...that really did tell you just how marvellous the EMDR was…..it was terrific. So anyway, that was enough to pique my interest so that's how I got into that……Yes, completely and utterly. It's been transformational….in my experience it is tremendous…..this was a tremendously useful tool"*

And MH's language of being 'blown away' is striking and powerful:

"*I find it fascinating. I'm very, very, very interested in the unconscious really….I clocked it really. It was a light bulb that went on……I'm still blown away, even now when it does work.*"

As can be seen from these examples, these are not just passionate statements, they shine with bold and dramatic language. FT's repeated use of the word 'tremendous', NU being 'shocked' and 'never forgetting', SE repeatedly using the words 'amazing', 'wonder' and 'extraordinary' and MH being 'blown away' all add to a rich and deep connection to EMDR and its potential for positive change. It was also noted that three of the interviewees believed that EMDR is a process that went deeper in its impact than other available therapeutic modalities at the time, giving credence to the belief that EMDR can potentially impact growth in a more meaningful way.

NU acknowledges an improvement in symptom relief with alternate interventions but with EMDR taking the process into a deeper place:

"*But at some point she probably would have bounced back because that earlier trauma, which actually happened in her mid-adolescence, wouldn't have been processed and so although the issues, you know, there probably would have been improvements because of the issues or as I say the imprisonment issues, but I don't think it would of got to the core of the problems and I think that's where EMDR reached something that I don't think we would of got to without using that.*"

This sentiment can also be seen by MH, who stated:

"*Well I sometimes think of EMDR as sort of like, you know, the advert Heineken, reaching the parts that are just sort of…..when we've done the EMDR, that's the bit that shifted it and then they've grown."*

And this was also highlighted by SE:

"it goes beyond what was pre-trauma"

This belief that EMDR results in a deeper psychological healing warrants attention as it could mean, if shown to be true, that EMDR could have the best chance in facilitating PTG. This is discussed later in the recommendations section of the analysis.

Theme 2 - PTG is more than just symptom relief

When reading the interviews it became clear that, when discussing the question 'What is your understanding of PTG?', a running thread emerged: PTG is much more than just the resulting state following the removal of traumatic symptoms, it is a significant evolution of individual consciousness and capacity to deal with life. This can be seen when MH states:

"My first thought when you said that was surviving, survivability, but it's actually more than that. It's beyond that……..I suppose making the most of life, making the most of what's offered to you really, sort of the survivability is kind of coming through the trauma really and it was traumatic grief that kind of led me to train really as a therapist in the first place. So it is beyond that…"

This evolution of consciousness and life beginning once the PTSD is cured is recognised by FT:

"Post-traumatic growth arises from, well post-traumatic growth sort of begins, it begins its sort of take off a bit like an aircraft going down the runway as a person's PTSD is cured..., I can see that you're going to make some fundamental changes to your life and you're not going to get on the 7:45 to East Croydon every morning after all…I often hear great things about how their lives have changed and how they are going, that they have changed their focus and so on and so forth…..well post-traumatic growth is more than being cured because it's sort of taking someone from -6 to 0 and then from 0 to +6."

The use of a strong metaphor of an aircraft ready to take off is striking, revealing a sense that a newfound freedom lies ahead once the therapeutic remedy has been administered, implying a significant change in a client following an EMDR process. This sense of 'taking off' is reflected in NU's narration, both in the statement that PTG is witnessed in a client making changes in their lives, reflected in their relationships, and the holistic awareness of 'real growth', implying change across the board of lived experience.

"But in terms of post-traumatic growth, I think it's when you really see people make changes in their life, whether that be forming relationships that they were too terrified to go on and have relationships, or improving current relationships, or actually taking,

doing things out there in the world that they never thought they would be able to do because they were so hindered by their symptoms. So it is not just a symptoms relief, it's a real growth……..yeah I've heard people say things like I'm a better person because of what happened to me, or you know, I've got examples of people who've changed the course of maybe their career based on the kind of compassion for self and for others that they experienced as a result of something really, really terrible……..But anyway when she came out the other end of it, it was life-changing for her in that she really felt, you know, I didn't die, that child did die, they haven't been given the joy of living to the age that I've lived to and I really need to do something important with my life, and that's what she went on to do, really think about how could she use some of the resources she had both financial and, you know, she wasn't just a vacuous young woman, is how she sort of self-referring…..This wasn't just about, you know, she was now symptom-free, how she really, really grew from that experience."

SE illustrates this concept of 'real growth' and 'going beyond' in the domain of resilience, evidenced by a behavioural change in relation to a decrease in avoidance activities:

"So, it made a big difference and I never looked back after that.

Never looked back?

That's a good example of post-traumatic growth……Well I suppose it tends, I think there are several things. I suppose it increases one's resilience in the face of adversity and that's one thing. I think that it helps with avoidance……..And I think it also means for me to that in some way, life is different, it goes beyond what it was pre trauma…. "

Theme 3 - EMDR can have a part to play in promoting PTG

All of the participants agreed that there is a role for a psycho-therapeutic intervention such as EMDR in facilitating PTG. However, the four views expressed were not uniform, with some believing that there are other causal factors at play, or that the mechanisms at play are not that well understood. This may be due to a lack of a solid definition of PTG in each case, meaning that they were all talking about slightly different concepts, with different constituent elements making up their understanding of PTG. Nevertheless, there was enough commonality of experience and identification in each interview to justify the analysis and explore what it meant for each of the participants.

SE's statement reflects seeing PTG in an array of different clients, using a strong metaphor ('opening up like a flower') to describe PTG in one particular client:

"***Is post-traumatic growth something that you witness in your EMDR practice with your clients?***

Yes. Yes. Definitely. Yeah. Various clients, I suppose and some fairly straight forward and some very complex…….she just opened up like a flower, it was just amazing…..almost a reconfiguration of her whole life….it changes more than just getting rid of the horror"

In answering the same question NU responds:

"Yeah, definitely…definitely…..So actually all of that reframing, psycho-education, interpersonal relationship stuff as well as then the next phase, the EMDR phase, was really, really important… was critical really."

The use of ‘critical’ is important here, as it shows just how important EMDR was in the generation of PTG. Later in the same interview, NU responds to the following question:

*“**So, do you think things like the positive cognition aspect of the installation of a positive cognition, do you think that that’s part of the facilitation of post-traumatic growth?***

Absolutely, and the very fact that the positive cognition is one of the elements is that it has to be generalizable.”

And when discussing the potential for EMDR to speed up the process of PTG, NU replies to the researcher:

*“**But talking with you I’m realising that as we were saying, I’m seeing this kind of post-traumatic growth in the context of within weeks as opposed to years.***

Yeah, we’re not talking about, you know X number of years….But a couple of men I was just talking about, that (PTG) was really very early on in our therapeutic relationship “

This points to an efficacy in EMDR to speed up the generation of PTG from taking years to weeks. And in response to the researcher’s questioning around EMDR and the generation of PTG, NU answers:

“***And just from listening to you it sounds like the intervention of EMDR was a necessary component in generating that growth.***

Vital.

Vital, yeah.

Definitely vital."

The repetition of the word 'vital' emphasises NU's belief that EMDR was essential in the promotion of PTG. FT takes a more cautious approach but still implies and relates links between EMDR and PTG:

"***so, one of my questions that is on my list but you've kind of already answered you know is post-traumatic growth something you witness in your EMDR practice and you've kind of already said that.***

Yes.

But do you think there is any connection say, the inability to, you know, I often refer to adaptive capacity in the context of the AIP model, that when the links are being made then it allows the person to make some connections.

It would do in theory. I mean I can see how in theory it could do. I mean, you might just say so when the kind of neural networks are restored or the blocks are removed or that kind of thing, you would expect the brain to just kind of flow more easily towards self-actualisation or whatever. Which you know is plausible but if I decide that from now on I'm gonna not wear shoes and socks at all over a weekend, which someone has done before, I very much doubt that's got much to do with the AIP model.

Right. So, what I'm hearing that you're saying which I think is true is that it can be part of the post-traumatic growth but there are many other factors that -

yeah, to me it would make sense to say that it would be a kind of a restored healthy brain function would be a contingent part of moving on to flourishing because you couldn't do it otherwise."

MH takes a more esoteric and holistic approach, using metaphor ('moving towards the light') to beautifully illustrate the conscious change at play during an EMDR process. The belief in the protocol and its impact on the client is easy to see:

*"**So, what would you, what's your perspective on the relationship between AIP model and post-traumatic growth?***

Its almost symbiotic…..about AIP and also about post-traumatic growth which is about sort of heading towards the light really, a natural innate tendency within us really….

OK. Is there anything about the actual mechanism that you see?

Well I think there is something in that dual attention, actually yes, it's not just the relationship and the contextual healing….I think that is a factor. I don't think there is any one factor

I was just wondering like when you look at it maybe from above or something, whether there's certain aspects to the protocol that really do promote post-traumatic growth or is it just the whole thing?

I would say the whole thing. I would say the whole thing……"

Later in the same interview, MH makes her thoughts more concrete when reporting feedback from a client in relation to EMDR's effect on PTG:

"Anyway, somebody, I bumped into her GP some years after and this client had had a very, very difficult time, something had happened and the GP said she coped

tremendously well. In fact, they had grown and had gone on to do other things and the GP and the client had both said they felt it was the stabilisation effect of the EMDR."

These examples lend themselves to the belief that EMDR can make a real difference and infer a need for further research, particularly of a quantitative kind, in order to establish 'what' it is about EMDR that led to the growth. At one point, MH states that it was the whole protocol that was critical, stating 'I don't think there is any one factor', at another point she refers to the phase 2, stabilisation effects as crucial. FT points to some ideas that could lead to causal understanding when discussing the restoration of neural networks and a return to healthy brain function but does not expand. NU and SE give accounts of EMDR's effect on PTG with little detail on the 'how'. While useful and rich in content, the narratives cannot be seen as any more than pointers to answering the question, due to the lack of detail and vagueness in operation.

Theme 4 - The re-evaluation phase is a key component in recognising and identifying PTG

An important aspect that appeared in each of the narratives was the importance of phase 8 of the EMDR protocol, known as the re-evaluation phase. Through gently questioning a client on both a micro and macro-level, this phase helps clients in therapy to raise their awareness of any psychological changes and their positive or negative impact. SE speaks of the importance of re-evaluation and the recognition of PTG that can come from this form of questioning:

SE: "One of the last questions is what happened to you, what effect did it have on you? what was your response? And then the last question is, how did you survive? How did you get over this? "

FT is concerned that PTG should only be mentioned or explored with clients within the context of re-evaluation:

"So the snag about it is that you have to be careful because not everybody will develop post-traumatic growth so you have to be very sensitive about it and I think you can only begin to namely identify or sort of suggest it to someone when they probably are showing signs of it. Because, so, when they bounce in and they say, 'would you believe it, I've suddenly brought a boat or something, I'm never going back to the office', then it's an appropriate time to talk about it. But you absolutely can't say well now, first of all, we're going to clear up this PTSD and then after that you are going to develop post-traumatic growth, because it is not necessarily gonna be the case and then the poor soul will just feel that they've failed, or it wasn't for them or you know, you can imagine."

MH infers a need and desire to re-evaluate and a sense of frustration that they were not able to reach the re-evaluation stage of the EMDR protocol:

"I have often wondered, now when I say the whole thing, I have had people come and have made rapid progress but I'm not saying we've necessarily, I mean sometimes they then, they feel so much better they drop out, they don't come back and maybe consolidate that whole process. But I might have bumped into them."

NU is more specific in the need for re-evaluation in acknowledging PTG. The use of the word ‘obviously’ implies that this is a given, that re-evaluation is key, and then proceeds to expand, identifying the future template as a potential causal agent.

> ***“So in your opinion, are there any sort of specific aspects of the EMDR protocol that promote post-traumatic growth?***
>
> *Well, I suppose obviously the re-evaluation, but also the post future template type stuff. But of course often how you would use that, you know, somebody you’ve worked with, I don’t know, kind of anxiety performance type stuff and then you, your processing particular memories, then you’ve got the re-evaluation phase and you might use the future template, obviously, to think about going into giving a presentation or whatever, that’s one way of using it.”*

NU then alerts the reader to the fact that re-evaluation (here using the word ‘reflection’) is something that can be utilised during the EMDR process.

> ***“I mean just when you were saying that just now, do you think that post-traumatic growth is something that you would discuss with your clients in the sort of stabilisation psycho-educational stage or would it be something that you would sort of reflect with them at the end of a process?***
>
> *I suppose it is something I’ve probably reflected with them as we’ve gone along.*

While not cautious like FT in when one should mention PTG with a client, NU questions how one would promote PTG within the early stages of the EMDR process:

Cos I was just thinking just in my own experience of working with clients, I would often say one of the great things is we find that there is a desensitisation of symptoms etc and there is a reprocessing of how you relate to the world and how you see this but very rarely do I say it's very likely that your gonna really grown from this.

No, that's right. I suppose maybe in very early stages, you know, peoples, not necessarily goals for therapy, but you know, sometimes people say things like, you know, if only I could just sleep, you know, just get a night's sleep, or if only I wasn't so scared that I could get on the bus, you know, in a way that's implicitly a goal isn't it? But I suppose actively looking at how you might promote that at an early stage in therapy, I don't know?

Theme 5 - The need for more research

It becomes clear, on analysis of both the literature review and the interviews gathered in this study, that the understanding of the relationship between EMDR and PTG is in its infancy. The narratives show there is scope for more research and a yearning for more detailed conceptualisation. LG notes the need for research in determining the long-term effects of PTG and a curiosity if it holds:

"*Well I have often thought about longitude, what I'd like to see is, I've often thought, especially if somebody has made really good progress, like I thought, oh you know, if I met them in 5 years' time would that still hold? That's what I'd be very interested in. Have they, maybe, gone further even, grown from there….I think a longitudinal study, I'll be interested in to see if it captures both client populations of those who*

had gone the whole process and those who maybe dropped out before, just to see if it held."

In answering a question on whether the EMDR community should continue to investigate the link between EMDR and PTG, MH answers:

"*I think the community, the EMDR community and wider society would benefit greatly…..I suppose it's made me, I've just thought then […] about EMDR you know just being known for PTSD and maybe a study looking at growth or post-traumatic growth or an EMDR is a parallel to taking it beyond that really.*"

A similar response from FT even includes encouraging the researcher to create a specific methodology examining the links between EMDR and PTG:

"*So, although I'm sure there are some absolutely astonishingly great stories out there, I haven't had them reported back personally……post-traumatic growth is a sort of touchy subject because I don't know what the statistics are, if there are any on how many people who could be expected to develop post-traumatic growth. Have you any idea?…..Yes, I think my view is it will be very attractive if there was a sort of some kind of substantiated or plausible, chainable connection between the EMDR and positive post-traumatic growth……It could be some specific post-traumatic growth orientated EMDR methodology? If such a thing exists….*

Do you think sometimes that could exist?

Oh yeah, of course, you could develop it."

SE points to the fact that, in their experience, PTG is not a common feature on the UK EMDR forum for practitioners (Jicsmail) and that when it does, it is not vigorous

discussion. They then go on to state the need for research, with the implication that only valid research will lead to PTG being taken more seriously:

> *"It kind of comes up every now and again on Jicsmail but I don't see any concerted discussion of it really….It would need some research really; I think to get people's interest in it…..how did you survive? How did you get over this?…..Asking that question how did you survive? What strengths did you have? What abilities helped you?"*

NU refers to anecdotal evidence and a lack of organisation in gathering the evidence. During the process of the interview, it occurs to them that gathering PTG biometric data, as part of the therapeutic process, could be of value:

> "***So we have the case of conceptualisation at the beginning and the re-evaluation at the end, I mean is there a place to measure post-traumatic growth do you think, because there are questionnaires there?***
>
> *Yeah, I think that's an interesting, I think that would be an interesting –*
>
> ***I mean it just occurred to me while talking to you.***
>
> *Yeah, I definitely think that could be because, you know, it happens spontaneously and we probably, I'm sure if you speak to lots of clinicians people will have lots of anecdotal evidence to support that but it is not done in any kind of structured way.*
>
> ***Sort of gathering the biometrics of post-traumatic growth cos there is a questionnaire out there for it.***
>
> *Yeah, it has never occurred to me to use that. But it might be quite an interesting pilot or something to do, mightn't it?……So to do that in a more formalised way I think it would be really interesting to do that and I'd be, you know, if you were*

going to, I don't know, initiate something I'd be very interested to see where that would take us in EMDR."

The five themes highlighted above became evident after considerable integrative processing of the participant narratives. Whilst the strength of opinion in each narrative relating to each theme wasn't necessarily consistent, it can be seen that overall, these themes were the most dominant. The most prepotent major themes were the need for more research and the powerful nature of EMDR in inducing real, lasting change. The given definitions of PTG, asked via the question 'what does PTG mean to you?', were varied and less clear, with the notion that PTG is more than just a cure the most consistent and certain. It seemed at times that the participants weren't confident when talking about PTG, stumbling and scratching to find the words compared to other aspects of the interviews, evidenced by MH's rather inconsistent narrative compared to the more succinct speech in the remainder of the interview:

"*My take on it today because I think it's a, you know, life's a journey isn't it and what I might think 5 or 10 years back, I might have a different view on and also going forward. My first thought when you said that was surviving, survivability, but it's actually more than that. It's beyond that. I would, and I can only speak personally for me, I would like to see as, thinking about this following when you first made contact at an interview was about, I suppose making the most of life, making the most of what's offered to you really, sort of the survivability is kind of coming through the trauma really and it was traumatic grief that kind of led me to train really as a therapist in the first place.*"

It was important to add the word 'can, into the fourth master theme ('EMDR can have a part to play in promoting PTG'), due to the split in the participant's opinions. Two

of the participants, NU and SE, spoke of EMDR's causal connection to the facilitation of PTG, whilst FT and MH agreed that EMDR can have a part to play, with the caveat that other factors also contribute to the PTG process. It was noticed that neither FT or MH volunteered to speak about what the nature of those other elements could be, and this posits some interesting questions for future research, such as 'what are these factors? And are they independent to a therapy process?'.

The focus on the re-evaluation phase found in each of the interviews is an interesting pointer for future learning and wasn't expected or acknowledged by the researcher prior to starting the investigation. This theme was a major feature in all of the participant's narratives, with FT's concerns that it is the only appropriate place to discuss PTG with a client the most striking. Although not a concern for NU, it was noted that they had a preference for recognising and reflecting on positive change during and at the end of the process, with no concern for introducing the concept of PTG prior to, or during the assessment phase of treatment.

Some ideas were noticeable in their absence and contribute to the later research recommendations. These include the fact that there was no mention of collecting specific PTG biometric data at any stage of an EMDR process. There was no reference to the PTGi in all four narratives or the work of Tedeschi and Calhoun in three, with one (FT) only briefly mentioning their literature. There was very little mention of the potential link between the AIP model and PTG genesis in any of the interviews. It was almost as if this was dismissed or thought of as strange, as illustrated by NU:

> **"*So what I wanted to pick your brains about next is what is your perspective on the relationship between the AIP model underpins why and how EMDR works and post-traumatic growth?***

Between the AIP model and -

Post traumatic growth, do they sort of link or the relationship between the two?

I suppose"

There was scant mention of the potential insights around the potential causal mechanisms between EMDR and PTG hypothesised and explored in the literature review, suggesting another domain that could warrant future research. Only FT mentioned any causal links and there was no real sense of wanting to consider this further:

"I mean you might just say so when the kind of neural networks are restored or the blocks are removed or that kind of thing, you would expect the brain to just kind of flow more easily towards self-actualisation or whatever."

Other important themes related to the research question also arose but were not identified as being as important or as strong in their presence, or within the remit of the research question. Examples, such as EMDR vs. Neurofeedback (van der Kolk, 2015; van der Kolk et al., 2016), can be seen in the following Table 8.

Particpant	Theme	Quotation example
FT	EMDR not necessarily equipped to deal with complex PTSD	*"but I am a big believer in its efficacy for single instant trauma and I'm dubious about multiple incident, complex PTSD presentations."*
SE	The merits of EMDR vs. Neurofeedback for Peak Performance	*"neuro feedback is I think already far ahead of the game in existing peak performance"*
	Concerns with the validity of the AIP model	*"Although I'm not fond of the AIP model. I mean, I understand what it is etc. but I tend to think more in terms of memory consolidation and re-consolidation as a process."*

Particpant	Theme	Quotation example
NU	Creating a paradigm shift in mental health diagnosis	*"I suppose the other thing that I'm really interested in is there is a move within the British Phycological Society to, it's really questioning the whole diagnostic system of psychology but scientifically and philosophically it is regarded as deeply flawed and they are proposing a different framework called Power, Threat, Meaning framework."*
	The generalising effect of the positive cognition	*"Absolutely, and the very fact that the positive cognition is one of the elements is that it has to be generalisable, a generalising statement as opposed to, you know, I'm a good sister, I'm a good mother, I'm a good person, or I can succeed, I can be I control as opposed to I can be in control and drive safely, you know. The very fact that it has to be generalisable, in the same way that the negative cognition it may tap then into other areas, definitely I think that that's, you know, and the way that people. And what's always very exciting is when people, when you check out the positive cognition they want to make it a more powerful positive cognition, you know, the place that you started at the beginning of phase 3 and where you get to when you come to installation, that's always very exciting when people, yeah I really do believe I'm good enough, or I can be powerful, or I am powerful, you know, that's very exciting to witness."*
MH	The relationship between EMDR and person-centred counselling	*"Its almost symbiotic. I think you know, the AIP model, its adaptive is it, its constantly evolving and changing. I sometimes think about the fit with person-centred therapy actually because I do firmly believe that the relationship is significant really and underpins a lot of therapeutic work but on, it's funny how I'm connecting with my very first steps towards training as a therapist in that when I join the introduction to my job and they use, they talk person centred theory and it was about the sack of potatoes, I don't know if you've heard this […] and basically about those and Rodgers would talk about the actualising tendency in everybody really."*

Particpant	Theme	Quotation example
	Missed opportunities to mention EMDR and growth in the wider psychology profession	*"And do you know, including the EMDR therapist who's accredited, they've hardly spoken about EMDR. They hardly elaborated at all. And I think this afternoon I was just thinking gosh, they mention it but they don't, their experience of it but they don't talk about it.* ***Right. And what did that bring up for you? Were you disappointed or?*** *Missed opportunity, missed opportunity for growth really and bringing it forward."*

Table 8. Examples of other themes that arose in the analysis

Discussion

The purpose of this study was to explore the relationship between EMDR therapy and the generation of PTG. Important findings have been revealed that point to further research and a better understanding of the relationship, with some important insights, caveats and warnings identified. The literature review established that there are no qualitative studies exploring the link and the need for more work. It also came to light that crucial questions asked around the causal links between EMDR and PTG in the introduction have only just started to be explored, let alone be answered.

The double hermeneutic interpretation process of the IPA methodology (Smith et al., 2009) posits that the research results are constructed from the perspective of a researcher attempting to make sense of the participant's experience. All of the interviewees spoke of their experiences of working with EMDR and their experiences of witnessing PTG in their practices. Although there were varying details and strengths of understanding, it was noted that not one denied a link between EMDR and PTG and three of the participants (ST, MH

and NU) gave rich, detailed examples of PTG resulting from an EMDR process in their clients.

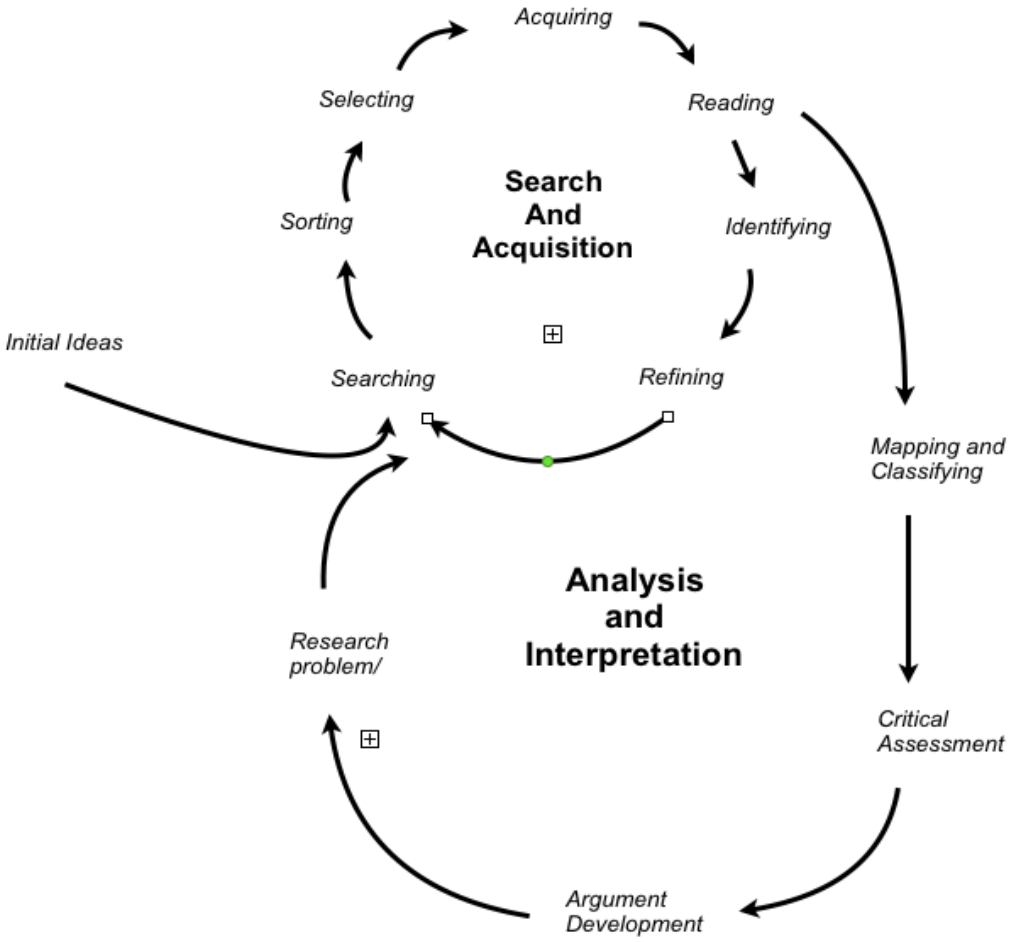

Figure 5. The double hermeneutic process

Personal Learning

There was great scope for personal learning through conducting the study. At the literature review stage, it became clear that there wasn't nearly enough depth to the data to formulate significant conclusions around EMDR and PTG, leading to the need for an open mind and caution at 'wanting to see what one wants to see'. The analysis of the data and

interpretation of the findings took place in the context of a researcher integrating and digesting the interviewees' experiences. Learning to re-read the transcripts, whilst attempting to avoid bringing any prejudice or prior convictions to the study, proved difficult at first. At times it was necessary to limit or remove long, descriptive passages to honour the IPA philosophy. IPA calls for an 'experience close' process (Smith, 2011) with the views and experiences of the interviewees respectfully described. Reflecting on the research process generated great admiration for the passion and care inherent in the interviewees' narratives, their willingness to participate in the study and their seriousness in responding and pondering the research aims.

Hearing disturbing and upsetting case studies, as well as detailed examples or real positive growth led to what seemed like a parallel process for the researcher. This journey echoed the participant's clients and led to further growth and optimism that recovery from trauma is not only possible but can lead to long-lasting change. Through experiencing the responses of the participants and visualising the positive turn arounds led to an increase in positive emotion in the researcher, increasing the sense of purpose in undertaking the research and furthering respect and gratitude to an industry that is committed to helping people blighted by tragedy and devastation.

Although there is some controversy surrounding EMDR (Greenwald, 1996), the researcher took pride in their own role as an EMDR practitioner and the real potential for healing found within the modality. There was a delight in hearing about the 'terrific', 'amazing' and 'wonderful' impact EMDR can have and great joy in hearing of the 'tremendous' changes following an EMDR process as these echoed the researcher's own clinical experience. One interview (NU) inspired the researcher to consider deepening the amount of data gathered at assessment and the re-evaluation phase by using the PTGI scale. This ability to gather some solid biometrics within the specific context of PTG and

EMDR has led to formulating future research ideas, including the addition of quantitative elements during both the assessment and re-evaluation phases of the EMDR protocol.

Pre-existing attitudes and standpoints were challenged and modified, leading to new ways of working in clinical practice. For example, FT's concern that real care must be administered around when best to discuss PTG (as a failure to identify it in a client post-therapy might lead them to believe that they had somehow failed) deepened the researcher's own empathic clinical skills and awareness. In fact, there was a continual deepening of learning throughout, from learning about potential theories on the genesis of PTG to a recognition that the clinical understanding of PTG is not widely identified. It was also noted that PTG is a definite and real phenomenon, its causal power is little understood and that the opportunity for more research is both exciting and necessary to move understanding along.

Research Design and Research Question Re-examined

IPA was found to have been an appropriate qualitative method for exploring the research question. It allowed an examination of the participants' experiences, with a rich data set acquired through the semi-structured interviews, providing for an open discussion between the researcher and the interviewees. Using a set of pre-prepared questions to prompt the discussion led to each of the participants discussing the aspects of their clinical experience that related to their understandings of EMDR, PTG and their potential connection. The small sample size was adequate to the task of providing an answer to the research study question and presented enough raw data for a serious and detailed analysis.

Limitations to the Study

This study has several limitations. The first is that the sample group was small in number and restricted to England and Wales. As there are different regional groups in the

UK and Ireland, as well as across Europe and the USA, it may well be that the degree of knowledge around PTG and EMDR could vary considerably and that a very different data set could have been gathered. The study could have been refined along the lines of selecting participants from a more select recruitment base, such as amongst the same service provider organisation or the same EMDR psychotherapy training alumni. It could also be argued that controlling the sample group to only include EMDR Consultants was a limiting factor, as there are thousands of very experienced psychologists and psychotherapists who have trained in EMDR (EMDR Institute, 2019) and have chosen not to become consultants. Participants from these alternate groups could add further rich data to explore in both this study and in further research.

There are limitations associated with using a single research method such as IPA (Haq, 2014). By its very nature, a phenomenological qualitative study such as IPA is not aspiring to define the truth or authenticate the meaning of a participant's experience, it is trying to understand how they can be built upon (Willig, 2013). The constructivist approach attaches importance to the many 'realities' participants will hold in their minds. It can be argued that utilising multiple methods of data collection and the application of triangulation would have both enhanced and added to the diversity and the fidelity of the study (Golafshani, 2003).

One of the criticisms noticed during the literature review was that many of the studies had limiting sample sizes, with only the RCT (Nijdam et al., 2017) having the explanatory power to lead to investigating causal connections. This same criticism could be levelled at this particular study. While IPA does have an emphasis on both the depth of the analysis and the amount of detail, this does restrict sample size and thus limits explanatory power and requires the need for further or concurrent studies to gain authenticity and validity (Frels & Onwuegbuzie 2013).

The researcher found it difficult to maintain the perspective required during IPA whilst concurrently aware that, in any interpersonal exchange, conscious and unconscious factors will be at play (Berne, 2016). This could include an unrecognised desire for there to be obvious connections between PTG and EMDR. There was always the potential that the participants wanted to please the interviewer or feared they were being judged for not 'knowing enough' about the subject (Rolfe, 2006). Although each participant was a highly qualified EMDR Consultant, their prior training could have influenced their interview style, resulting in different degrees of self-exposure and willingness to divulge, depending upon their clinical philosophy (Kapur et al., 1988; Lese & MacNair-Semands, 2000).

Finally, due to limiting factors such as geography, availability and finance, it was only possible to conduct one interview face-to-face, with the rest conducted via Skype. It is possible that this inconsistency in interview format could have influenced the results, and thus the implications in analysis and the discussion (May, 1991).

Recommendations for Future Research

Research that furthers the knowledge base, awareness, correlations and causality of trauma symptom relief deserves serious attention and is of tremendous value to the psychological community. This study, as well as adding to the current body of work, points in the direction for further studies to build upon, modify, refute and confirm some of the hypotheses, rough sketches and empirical observations observed so far. During the interview process, it became clear that none of the participants had a clear, psychologically defined concept of PTG, in line of what would be expected if they were discussing PTSD or other better-known psychological phenomena. Only one participant (FT) mentioned the work of Tedeschi and Calhoun, and this was in relation to a book on PTG:

"The one of the things that I know is that very few people know that there are even sort of biometric measures for it. So Tedeschi and Calhoun have come up with what's called the PTGI and I think that we're at the stage at the moment where we aren't even aware of that.

Yeah, actually, I'm just looking at my bookcase, there is probably a book you know of its just made me thinking about it. I've got a book, of course it is their book, Facilitating Post Traumatic Growth, a clinician's guide. I don't know how much it has to, are you familiar with it? I don't know how much it has to say about EMDR in it."

Not one participant mentioned the five domains of PTG (Tedeschi & Calhoun, 1995), knew about the ability to collect biometric data via the PTGi (Tedeschi & Calhoun, 1995, 1996) or mentioned any other experts in the field (Peterson, 2008; Seligman, 2012). It is unlikely that this lack of awareness is unique to the study's four participants and therefore a questionnaire study on the awareness of PTG and utilisation of the PTGi, not just within the EMDR community but also the wider clinical-psychology community, would be welcome.

In fact, FT had a welcome recommendation that merits investigation:

"It could be some specific post-traumatic growth orientated EMDR methodology"

To make this methodology a reality would require a foundation including but not exclusive to the following recommendations:

1. A wide-ranging questionnaire examining accredited EMDR clinicians' understanding and observations of PTG in their clinical practices.

2. A longitudinal study researching the long-term effects of EMDR on psychological growth is recommended to build upon the findings within this study. This could raise awareness of both EMDR as an effective modality and the potential for generating PTG.

3. Individual, detailed case-studies with PTG biometric data collected before, during and after treatment, creating a valuable form of mixed-method research.

4. Interviewing trauma clinicians experienced with working with alternative modalities to EMDR and investigating their experiences of PTG within their client base.

5. Further RCT, with larger sample sizes, researching EMDR compared to other modalities, in-line with Nijdam et al. (2017), such as TF-CBT, and their effects on PTG.

6. A repeat of this study in different national geographical locations such as the USA, continental Europe and Asia.

7. Encouraging and reporting on the impact and data gathered when utilising the PTGi in the assessment and re-evaluation phases of the EMDR protocol.

8. The introduction of control groups in future studies, with the goal of identifying causal connections within the therapeutic interventions in relation to the facilitation of PTG.

9. An inquiry, based on participant testimonials, into whether EMDR can go ‘deeper’ than alternate modalities in psychological healing.

Working with trauma is an intense and emotionally draining profession, requiring regular supervision, good self-care and continuing professional development. The acute nature of the work can lead to professionals leaving or seriously considering leaving the profession (Bride, 2004). Learning that not only is EMDR curative but that it can lead to

lasting, positive growth, could become an additional important and motivating factor in contributing to a clinician's resilience (Reivich & Shatte, 2002). The integration of PTG research into both EMDR training and continuing professional development events could elevate the understanding of PTG and its benevolent effect on clinical practice.

Conclusion

The purpose of this study was to explore the potential links between EMDR and the facilitation of PTG through the prism of the experiences of four highly experienced EMDR consultants. As well as investigating any causal links, theories and new directions for further research, the IPA process allowed for an investigation into how the consultants made sense of their practice within this particular research study's unique context. It is hoped that the study inspired each of the participants to further reflect upon the subject and integrate their thinking into their therapeutic communities.

Amongst the rich tradition of qualitative inquiry, IPA was chosen as the most applicable medium in which to investigate and answer the study's research question. The four highly experienced participants, via the semi-structured interviews, gave rise to comprehensive, abundant and detailed interpretations of their personal experiences and exposed any core-elements they found significant and far-reaching. The interviews were conducted either in person or via Skype, transcribed and following a lengthy analysis, five master themes were identified which were considered most valuable in answering the research question: 'EMDR is a powerful and efficacious intervention', 'PTG is more than just symptom relief', 'EMDR can have a part to play in promoting PTG', 'The re-evaluation phase is a key component in recognising and identifying PTG' and 'The need for more research is crucial for further understanding'. It is important to recognise that the results of the study are both in accord with and question the present body of literature, appending and establishing new ideas to be considered when discussing EMDR and PTG.

There are disadvantages related to the qualitative generalisations created from IPA studies. However, the results do point towards the establishment of some link between EMDR and PTG. In two cases the participants (NU and ST) declared that EMDR was a definite causal factor, in the other two (FT and MH) it was stated that EMDR can have a part to play but that there are other unknown factors that need clarification and understanding. These are important findings at this nascent stage of PTG/EMDR research and indicate that further inquiry would be welcome. While discussing the subject, the participants thought the subject was illuminating, important and worthy of discussion, and were excited in their narrative delivery. It was clear that moving their clients to a place of growth and positive health was their highest priority and all thought that EMDR made a considerable difference in reaching that goal. This was a source of great personal and professional gratification and knowing that they were making a difference was important to them.

Implications for EMDR

This study is a valuable addition to the existing knowledge base on EMDR and PTG and contributes to a small body of evidence already published. The powerful narratives contained in the four interviews are rich in detail and provide valuable insights. It provides the potential for increasing the scope of continuing research within the field and points in exciting new directions. Key findings, such as the need for more research on finding any causal links between an EMDR process and the facilitation of PTG, or expanding the role of re-evaluation in EMDR to include PTG, add value and originality to the current body of published work.

However, this needs to be acknowledged within a specific context: the participants were recruited only from England and Wales, there were only four participants (in-line with IPA good practice) thus limiting conclusive connections, and being a qualitative study rules out any confirmation of causal connections. Holding this in mind, it is crucial to reflect upon

the possibility of very different results if another cohort group had been interviewed. Perhaps ‘official' PTG concepts and the work of Tedeschi and Calhoun, amongst others, would be much better understood and related to during the interview process. Due to the nature of the PTG research and its recent reach into the psychological consciousness, it may be that interviewing more recently qualified practitioners would have resulted in more detail or signalled a different approach. Those who study Positive Psychology (Seligman & Csikszentmihalyi, 2014) may have approached the subject in a very different context. In fact, FT states at one point during the interview that:

> *“I suppose it was when I was doing the masters in positive psychology, I remember them making a big deal out of being very cautious talking to clients about it (PTG) because it can so easily, you know, it’s like can so easily just be turned to sort of the Christmas that never comes. So, that obviously stayed with me.”*

There is a sense of resistance to EMDR in the mainstream of clinical psychology that could be holding back potential research (Farrell et al., 2013). Therefore, there is an argument to be made for the EMDR community to prove and show its integrity with the undertaking of further high-quality research. This should include potential RCT, correlation studies, more qualitative research (such as with different cohorts and outside of the UK), evidence-based understanding of its effectiveness and its capabilities, and a determination to investigate the precise mechanisms at play and ultimately its causal factors. The exciting implications of linking EMDR to PTG could work wonders in furthering EMDR’s acceptance into the mainstream and more importantly supply clients with a new sense of hope: that not only is EMDR curative, it can also facilitate real lasting, future growth.

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Appendix A.

Example of one of the interview transcripts (FT).

FT Audio [40:39]

First of all, I just wanted to ask you, is, what, you know as an experienced clinician which you most certainly are and in particularly within this context the fact that you are an EMDR consultant. It takes a while to get to. But what was it that attracted you to EMDR as a modality or an intervention or however you see it?

Originally it was because there wasn't, there really didn't seem to be anything that was addressing trauma in anything like an effective way. I mean when I started training which was goodness knows only when, sort of 1994 or something like that, I, it was, obviously it was totally unheard of, it had only just been invented and I was intrigued because it sounded so nuts. So what interests, so I suppose what, but before that what interested me about it was the fact that conventional talking methods just didn't seem to be all that useful basically.

When working with trauma in particular?

Well yeah, I mean, well it was more like you come across somebody, you'd realise that they had PTSD or trauma and then you wouldn't have thought to do with it because if you hadn't actually trained, I did train, I went on to train in trauma focussed CBT but that was after so at the time with just conventional ration motive behaviour therapy, it was just not, there was nothing useful to bring to bear on the problem. So that's when, so when I read about it, I think I first of all, I think I brought randomly Laura Parnell's book which was called something like Healing at the Speed of Eyesight or something or other. So, one of her very earliest books and all of that really did was tell you just how marvellous the EMDR was but it didn't tell you anything about it, how to do it or anything remotely useful it just said it was terrific. So, anyway that was enough to pique my interest so that's how I got into that.

And then did you find it terrific?

Yes, completely and utterly. It's been transformational.

So, it's the actual fact that it is in your experience efficacious it -

In my experience it is tremendous but it, but I am a big believer in its efficacy for single instant trauma and I'm dubious about multiple incident, complex PTSD presentations.

Right. So, you think that's partly to do with, I mean I've noted that supervisees of mine etc confuse PTSD in developmental trauma for example and how developmental trauma, I often just say that like PTSD is what's happened to you and developmental trauma is what didn't happen to you. And therefore, EMDR cannot work on a nothing.

No and I, so, I agree with your point of view and I'm looking into doing some more training or confidence attending on EMDR and attachment disorder because it seems to be so popular at the moment because, but I'm just, I am slightly sceptical about it. I do think that in a way Francine shapiro's idea that this was a tremendously useful tool that could be bolted on to other useful therapies which is what her original starting point and that may have changed over time whilst she was alive, but I think it's a pity in a way that that's just got lost and EMDR has decided to expand and become the therapy with the answer to absolutely everything rather than just stick to what it was good at.

Sure, I get you. OK. So, when, so what's your, understanding of post traumatic growth?

Post traumatic growth arrases from, well post traumatic growth sort of begins, it begins its sort of take off a bit like an aircraft going down the runway as a person's PTSD is cured. So, there are a couple of snags with this because of course particularly in my practice which was very medico legal orientated so as soon as somebody got better, they were no longer scoring, you never ever saw them again. So, although I could discern and think yes, I can see that you're going to make some fundamental changes to your life and you're not going to get on the 7:45 to East Croydon every morning after all. Actually, I've had very little reportage because I never see them again.

Right. And you don't see them again because probably it's the implication there that they are doing well.

Yeah, they are fixed, they are done and obviously go into the sunset and some will adopt very different attitudes and lifestyles and so on and some less so and some will just decide that they really need to see more of their family and less of their office colleagues. So it comes in absolutely every gradient of effort but I see every, I certainly used to see very little of it because as I say as soon as somebody was declared cured that was the end of it and these days, I still don't see very much of it. I see more of it than I used to because the type of client and patient I see who somehow they are not all, they are not the medico legal bunch that I used to see, they tend to be more self-funding types and therefore they are quite inclined to come back after their trauma is cured. But another thing is, the people that get sent from consultant psychiatrist's, as soon as, I think they tend to see the fact my job as treating someone for trauma and as soon as they think right that's if he's done his bit, I don't see them again either. So, although I'm sure there are some absolutely astonishingly great stories out there, I haven't had them reported back personally.

I mean I know that part of the protocol, if you follow the standard protocol there is a sort of follow up section isn't there that I know that if you are in a sort of working with insurance etc, they give a certain amount of sessions so there an opportunity to ask present, future, follow up, future templates and all that sort of thing, but -

No, all that sort of very enjoyable personal phycology orientated side is just not on the cards either in the medico legal funded bit or where people are, a lot of people are just pleased they've got better and their own funds aren't gonna take them an awful lot further either. So, there's not very much of it around in my particular bunch that I tend to see. But I do know, but antidotally you know I'll get a Christmas card from some of them or this or that and so I, in that way I often hear great things about how their lives have changed and how they are going, that they have changed their focus and so on and so forth.

So, post traumatic growth is more than just think you know, its new or?

Oh, but yes, well post traumatic growth is more than being cured because its sort of taking someone from -6 to 0 and then from 0 to +6. There's as positive phycology kind of likes to frame it. So the snag about it is that you have to be careful because not everybody will develop post traumatic growth so you have to be very sensitive about it and I think you can only begin to namely identify or sort of suggest it to someone when they probably are showing signs of it. Because so when they bounce in and they say would you believe it I've suddenly brought a boat or something, I'm never going back to the office, then its an appropriate time to talk about it. But you absolutely cant say well now first of all we're going to clear up this PTSD and then after that you are going to develop post traumatic growth because its not necessarily gonna be the case and then the poor sole will just feel that they've failed or it wasn't for them or you know, you can imagine.

So, it's along the lines of it's a retrospective process at best? In the same way that like, I don't know if you have witnessed this but you know I'll have a client who will come in and say "god I didn't even realise till two days later that I went up in the lift and I haven't been in a lift in", that sort of retrospective acknowledgement or something.

Yes, yes so that's true. I wouldn't call that post traumatic, I mean I don't know if you're just using that as example of retrospective reporting, yep no that's true. I would, that would happen.

Yeah. I think the post traumatic growth would be, you know I went up in the lift and then I made a decision that I'm gonna ditch half my friends and really focus on the good people in my life and written a card to granny and – so I mean so, one of my questions that is on my list but you've kind of already answered you know is post traumatic growth something you witness in your EMDR practice and you've kind of already said that.

Yes.

But what is your perspective on the relationship between the AIP model and post traumatic growth?

I am not sure about that because post traumatic growth I think, well I suspect arises from many kind of different humanistic elements so a much greater bundle of threads than the AIP model would suggest so it actually really is talking about religious belief or I don't know, religious belief is an obvious one but all kinds of other things that have got very little to do with that kind of model of brain function.

But do you think there is any connection say, the inability to, you know, I often refer to adaptive capacity in the context of the AIP model then when the links are being made then it allows the person to make some connections.

It would do in theory. I mean I can see how in theory it could do. I mean you might just say so when the kind of neural networks are restored or the blocks are removed or that kind of thing, you would expect the brain to just kind of flow more easily towards self-actualisation or whatever. Which you know is plausible but if I decide that from now on I'm gonna not wear shoes and socks at all over a weekend, which someone has done before, I very much doubt that's got much to do with the AIP model.

Right. So, what I'm hearing that you're saying which I think is true is that it can be part of the post traumatic growth but there are many other factors that -

yeah, to me it would make sense to say that it would be a kind of a restored healthy brain function would be a contingent part of moving on to flourishing because you couldn't do it otherwise.

Yeah. But you wouldn't be able to, I mean if you take some of the worst-case scenario patient or clients, you know they literally cannot function. They cannot, you know, the PTSD is so much they can't think straight at all and the AIP model that the dysfunctional memory networks if we can sort them out then they will be restored to,

they often use the word [16:35] **in the EMDR literature that you know, the base of functioning and then that will in turn allow you to maybe grow from that.**

Well yes and now you've got the basic wiring that gives you a chance.

Yeah. Absolutely. So, do you think there are any specific aspects of the EMDR protocol that would promote post traumatic growth?

Do I? let me think about that. I think indirectly, you because what you often get is a client or patient ending up with the belief that they've fixed their own brain and they're feeling better through their own healthy brain function rather than through a medication or whatever. I think that is bound to be quite a powerful springboard to a brain which goes right, well, now what can I do to make my life on earth a more joyful.

Sure.

So, to put it within the framework of the protocol, it would sit somewhere in the explanation that healthy brain function, it would sit within the very kind of democratic idea that this is not about big therapists telling you what to do then little client doing what they are told. It's more you're fixing your own brain and I'm showing you how you're gonna do it. So, although I couldn't pinpoint any one of the 8 stages that would really truthfully reflect that I think that it could be very powerful the implicit in the process.

OK. Absolutely. So there's the implicitly, what about something like the insulation of positive cognition?

Right. Yeah. So the installation of a positive cognition could, let me think, well, I suppose the thing is there are installations of positive cognitions and there are installations of positive cognitions so if you had someone lets just say your bog standard car accident and the positive cognition is it's over and I'm safe, that really doesn't go very much further than well thank goodness for that's over and I'm safe. So that and that sits within the cure of the PTSD. If they came back for a further, for further sessions and it was explored you know, outside the context of them just getting better but within the context of flourishing, then that's

how you do it. Yeah that's what I'm saying. Then that's how you would do it. But I wouldn't see it, I wouldn't think that the positive cognition in the framework of, certainly within the framework of a single incident trauma would do a great deal more than just fix the trauma but that said, of course that's a massive thing.

Yeah. I mean when you're saying that, suddenly came to mind about the different domains of the cognitions as well. So, one about being safe which will come from a road traffic accident. Maybe, as you said its still a big thing, would be less of a big deal than maybe a complete reprocessing around I'm shameful or I'm bad.

Yes. So, if the all cognitive shift was as an identity level issue, so I've gone from I'm shameful to oh I'm absolutely not shameful or I'm damaged to I'm fine as I am, then more would follow from that. That sounds pretty sound to me.

And what about something like the future templates? Do you think they -

Yes. Well should do but if they, I mean if EMDR was going to do anything, have any kind of mechanism to try to evoke or grow or stimulate post traumatic growth, imaginative future templates or resource rich future templates would be the thing that you would do to do it I would think.

Right, yeah. Is there an example that you could think of? Have you ever had any experience of that in your?

I'm just trying to think. Nothing springs to mind. Although, well I suppose, well, a future template lets think of somebody who has an eating disorder and so we're setting them up with the cognition I can be calm and relaxed around food and or I can prepare meals and not give it a second thought, that kind of thing. That I certainly, that's the sort of thing I would use myself. That comes up but in rather an informal off-piste kind of way.

Yeah. And then you think that yeah that would have an effect.

Yeah that would have an effect but whether or not you could sort of, whether or not you could, I'm going to use the phrase dignify it but because I cant think of a better one, whether

or not you're going to dignify that with lift off to post traumatic growth or whether it stays a bit further down the scale as just the clearly obvious appropriate positive cognition to get someone over their eating disorder, I'm not sure.

OK. Yeah. So how do you think the, sort of EMDR community could address the promotion of post traumatic growth within its unit or?

Well I think its jolly difficult because not for everybody because going back to what we were saying earlier, post traumatic growth is a sort of touchy subject because I don't know what the statistics are, if there are any on how many people who could be expected to develop post traumatic growth. Have you any idea?

The one of the things that I know is that very few people know that there are even sort of biometric measures for it. So Tedeschi and Calhoun have come up with what's called the PTGI and I think that we're at the stage at the moment where we aren't even aware of that.

Yeah actually I'm just looking at my bookcase, there is probably a book you know of its just made me thinking about it. I've got a book, of course it is their book, Facilitating Post Traumatic Growth, a clinician's guide. I don't know how much it has to, are you familiar with it? I don't know how much it has to say about EMDR in it.

I'm not even sure if there is any EMDR in it.

No. I think I probably brought it hoping that there would be and then found that there probably wasn't.

I think its we're at a stage where there is a way, there could be an essential cause or factor or not, it's worth looking at. I don't think we're at any stage of saying x amount of people having EMDR will develop post traumatic -

No. it's just that I remember and I can't remember, I suppose it was when I was doing the masters in positive phycology I remember them making a big deal out of being very cautious

talking to clients about it because it can so easily, you know, its like can so easily just be turned to sort of the Christmas that never comes. So, that obviously stayed with me.

I mean there's five, in my literature review there's five peer review pieces of literature that even mention the EMDR and post traumatic growth. One of them is just a recommendation of nurses working with veterans and it just implies that post traumatic growth will happen if you work with PTSD either with EMDR or trauma focussed CBT. Then there is another one that is quite a famous study, it's actually the focus is nothing to do with post traumatic growth, they just happen to take post traumatic growth biometrics and it showed no significant increase. It showed the increase but nothing significant. And then there are two papers on some very disasters in South Korea. They showed very clear post traumatic growth opposed to the EMDR. But then they're not running clinical trials but they are pretty decent studies. And there is one random clinical trial that compared what's called BEP and the both interventions showed a significant increase in post-traumatic growth following targeted intervention. So it could be that there are a few modalities that, you might find something similar with trauma focussed DBT.

There might be, I don't know, I really don't know. I mean I think that probably because the likelihood or predictability of who will experience post traumatic growth and who wont and the extent to which its developed is so hazy I don't, I would not expect any one approach of anything to be able to say this is likely to be a more significant assistant than another. I just don't think, I don't think its likely to be sustainable because the whole thing is so unreliable. And also, I mean there are people who get post traumatic growth and then they have sort of total post traumatic growth recidivism and it all wears off again and they get back on the 7:45 to East Croydon.

And is that something that you've seen in your own clients?

No, it's something I've heard of because you see unfortunately my clients, this remains a problem for all my client group mainly. I don't see very much of them. But I am aware of x clients who decided to pack it all up and retire only to decide to start working again two years later kind of thing.

Yeah. OK. Just from doing this interview, what's been your experience and what's, so anything that's like either been reformulated or come up new or anything you're seeing differently or -

From this discussion?

Yes, from having this discussion.

Well it's reminded me of what an interesting subject it is. That's definitely true and it's reminded me that I think I ought to pay, look out for it a little more. It does sort of put it back on the top of my notepad, its one of those things to look out for that had rather kind of gone into the general miasma of lost focus where everything eventually goes sooner or later.

Sure, I mean one of the reasons that I, you know I'm passionate about positive phycology and more so highly respectful of the EMDR. I've always been interested in this sort of link and that the sort of only real, sort of not the only real because I'm setting myself up there. What I mean is, it seemed like an interesting area to start with because what's the EMDR originally known for, dealing with post traumatic stress disorder and there not the things you often see in the literature of positive phycology, your post traumatic growth and seeing the, you know, the lot of the Seligman research of people developing post traumatic growth kind of on their own as well.

Yes, I think my view is it will be very attractive if there was a sort of some kind of substantiated or plausible, chainable connection between the EMDR and positive post traumatic growth. But I would be surprised. But I wouldn't be surprised, I'm not surprised in the sense that when EMDR what it does what it claims to do cures someone of PTSD that

they've got fresh new functioning neuro networks etc, etc you know you've got them on their starting blocks for the potential but what then gets them off down the track? It could be some specific post traumatic growth orientated EMDR methodology? If such a thing exists.

Do you think sometimes that could exist?

Oh yeah of course, you could develop it.

Yeah that's true. And its interesting as like you mentioned you did a masters in positive phycology and when you were doing that did you hear of or see any connections between just kind of positive phycology and general, I mean I don't know when you did your masters in positive phycology.

It must have been 5 years ago, I think.

OK so as you know positive phycology is if we wanna call it a movement or a branch its expanded, I think I read something the other day that over 20% of all phycology journals now are positive phycology and so it's had this huge expansion in a very short amount of time. But I was wondering if there are other sort of other connections between the EMDR and has such a wide umbrella positive phycology but, it you know, either when you are doing a masters you are in your own experience, you know, because CBT is very much a big part of positive phycology as in a lot of the interventions are CBT based.

Yeah completely.

I was wondering if you had ever come across or, this has just come to me in the last 5 minutes. I was just wondering if there is anything you have ever come across or seen that interventions with it, you know maybe acknowledged in the positive phycology field that were EMDR based. I mean I know that -

Not that I remember.

Not that you remember. Peak performance is something that I'm very interested in now.

Yeah. So peak performance and developing that although which it kind of rather proves a point that there are people who will aim to make EMDR relevant to absolutely anything that anybody's willing to pay for. There has been EMDR to improve your golf swing but neuro feedback is I think already far ahead of the game in existing peak performance.

I mean it seems that the peak performance protocols are all actually an integration of neuro feedback, some bio feedback and then using the EMDR or other interventions to remove, kind of blocks or what they call micro traumas. I read a paper on someone who is freaking out in the orchestra and actually they had some unresolved trauma, EMDR was used in that sense.

Yes, that's very David Grand isn't it. That's exactly, in fact I remember getting to a David Grand think in New York where he used exactly that example, in fact he took some musician performance and did exactly that with them and then got them to play it and say how they felt about it and of course they felt completely marvellous.

Because that's the example that's pitched for a presentation, not the one that it made no difference to.

No, I mean he wield these, I think I saw it also with a couple of actors who he managed to find who all of a sudden found astonishing new depth in their role.

I don't know David Grand actually, so -

He's American and he's, obviously he's American and he was one of the earlier doctors. In fact, I think it was him that branched off and made up brain spotting.

Ah that's right I think I've got that book on my shelf.

Yes, I'm pretty certain, in fact I'm certain that's David Grand. So he made up brain spotting possibly because he couldn't find his desired market share or special angle on EMDR but he certainly gave it a good go with EMDR for the performing arts and all that business. So, this was about 15 years ago I would think.

So, […] I just wanna say thanks so much for agreeing to do this and its been a pleasure to talk with you and your feedback would be incredibly useful

Oh good, well I hope so and let me know how you get on. It would be jolly nice to bump into you again before too long […].

Appendix B.

Interview consent form

Interview Consent Form

Research project title: *The Link between Eye Movement Desensitisation and Reprocessing Therapy and Post-traumatic Growth: an Interpretative Phenomenological Analysis of the experiences of EMDR consultants*

Research investigator: Joshua Dickson

Research Participants name:

The interview will take approximately an hour. We don't anticipate that there are any risks associated with your participation, but you have the right to stop the interview or withdraw from the research at any time.

Thank you for agreeing to be interviewed as part of the above research project. Ethical procedures for academic research undertaken from UK institutions require that interviewees explicitly agree to being interviewed and how the information contained in their interview will be used. This consent form is necessary for us to ensure that you understand the purpose of your involvement and that you agree to the conditions of your participation.

Would you therefore read the accompanying information sheet and then sign this form to certify that you approve the following:

- the interview will be recorded and a transcript will be produced
- you will be sent the transcript and given the opportunity to correct any factual errors
- the transcript of the interview will be analysed by Joshua Dickson as the research investigator
- access to the interview transcript will be limited to Joshua Dickson and academic colleagues and researchers with whom he might collaborate as part of the research process
- any summary interview content, or direct quotations from the interview, that

are made available through academic publication or other academic outlets will be anonymized so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is not revealed
• the actual recording will be destroyed once the transcript has been created
• any variation of the conditions above will only occur with your further explicit approval

Quotation Agreement

I also understand that my words may be quoted directly. With regards to being quoted, please initial next to any of the statements that you agree with:

Interview Consent Form

I wish to review the notes, transcripts, or other data collected during the research pertaining to my participation.

I agree to be quoted directly.

I agree to be quoted directly if my name is not published and a made-up name (pseudonym) is used.

I agree that the researchers may publish documents that contain quotations by me.

All or part of the content of your interview may be used;
In academic papers, policy papers or news articles
In an archive of the project as noted above

By signing this form I agree that;

1. I am voluntarily taking part in this project. I understand that I don't have to take part, and I can stop the interview at any time;
2. The transcribed interview or extracts from it may be used as described above;
3. I have read the Information sheet;
4. I don't expect to receive any benefit or payment for my participation;
5. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure the effectiveness of any agreement made about confidentiality;
6. I have been able to ask any questions I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

_____

Printed Name

_____

Participants Signature Date

_____

Researchers Signature Date

Contact Information

This research has been reviewed and approved by the Worcester University Research Ethics Board. If you have any further questions or concerns about this study, please contact:

Dr Derek Farrell CPsychol, PhD, CSci, AFBPsS
Principal Lecturer in Psychology, Programme Director - MSc EMDR Therapy I University of Worcester, Psychology, Henwick Grove, Worcester WR2 6AJ I (01905 542443 I
*d.farrell@worc.ac.uk

Appendix C.

Examples of the coding process

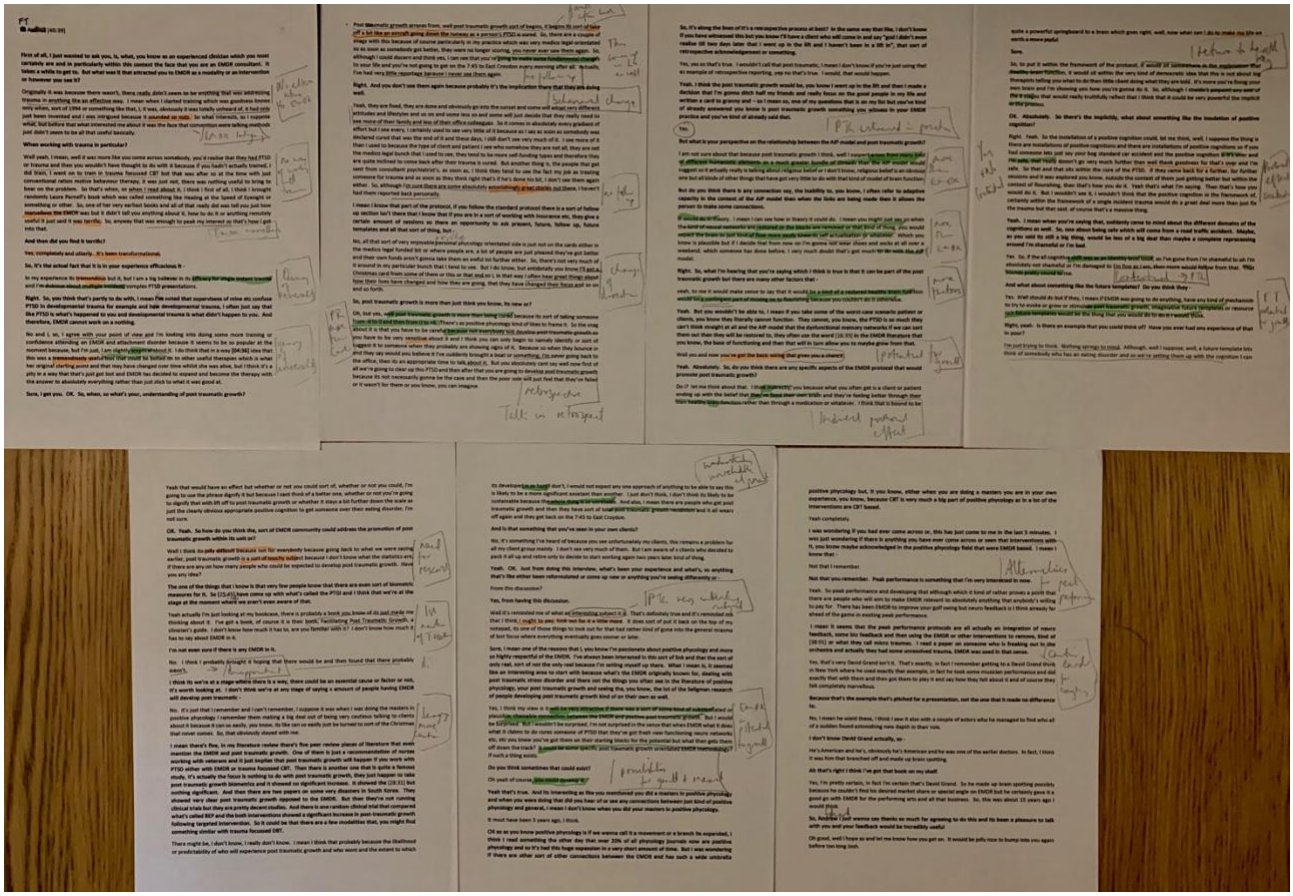

Figure 1. FT transcript coding

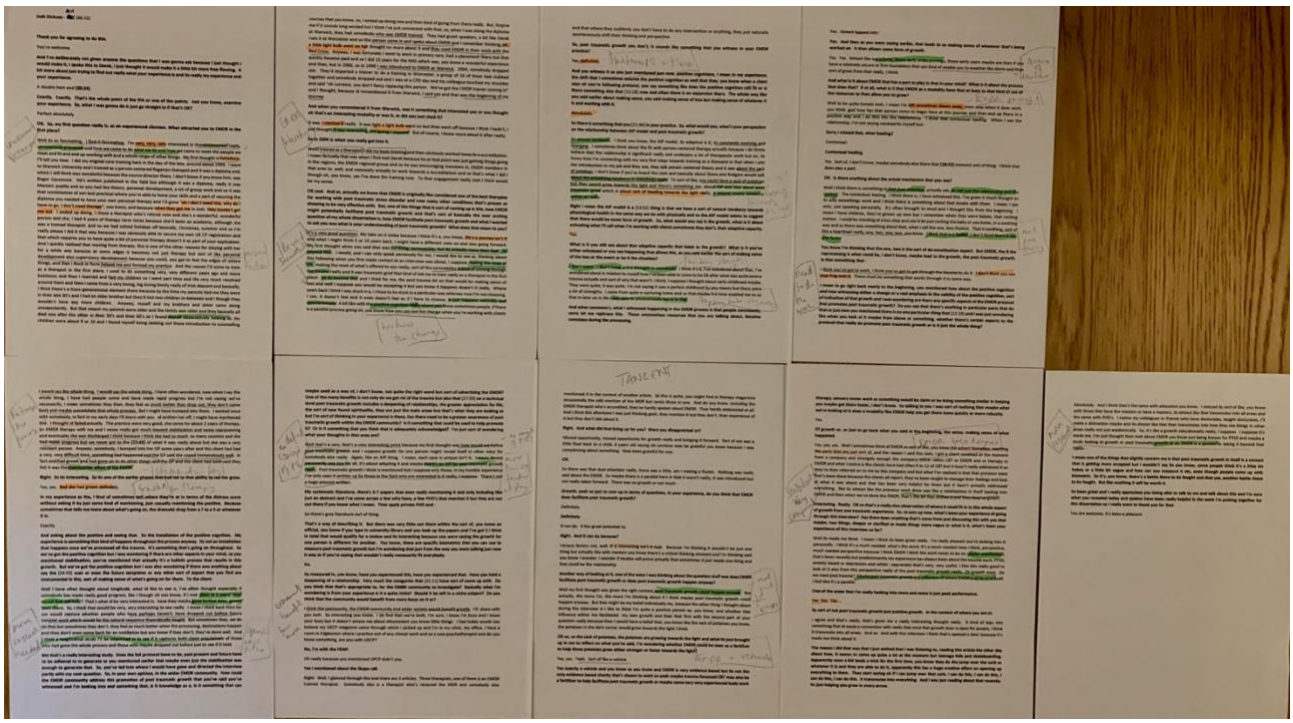

Figure 2. MH transcript coding

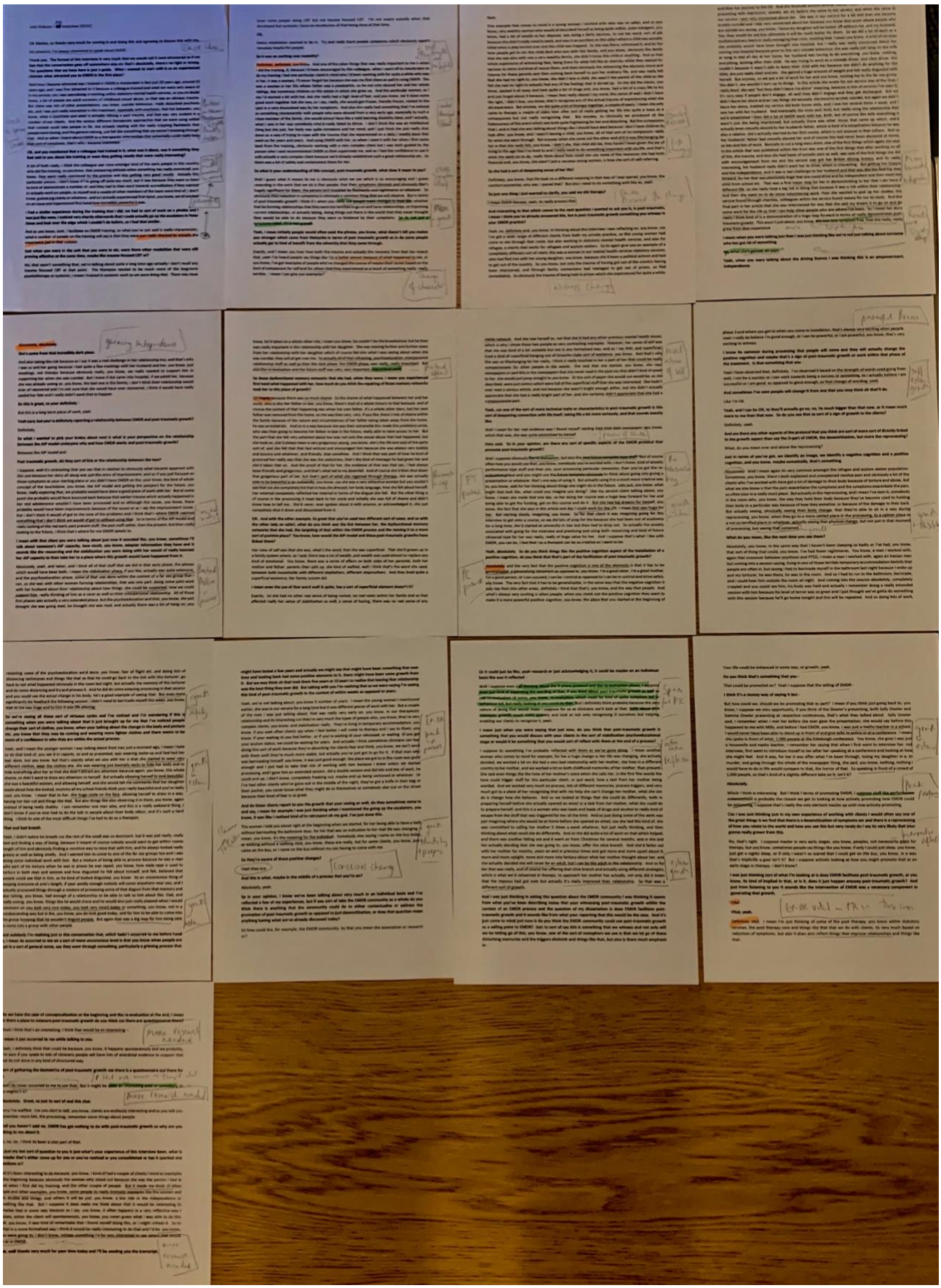

Figure 3. NU transcript coding

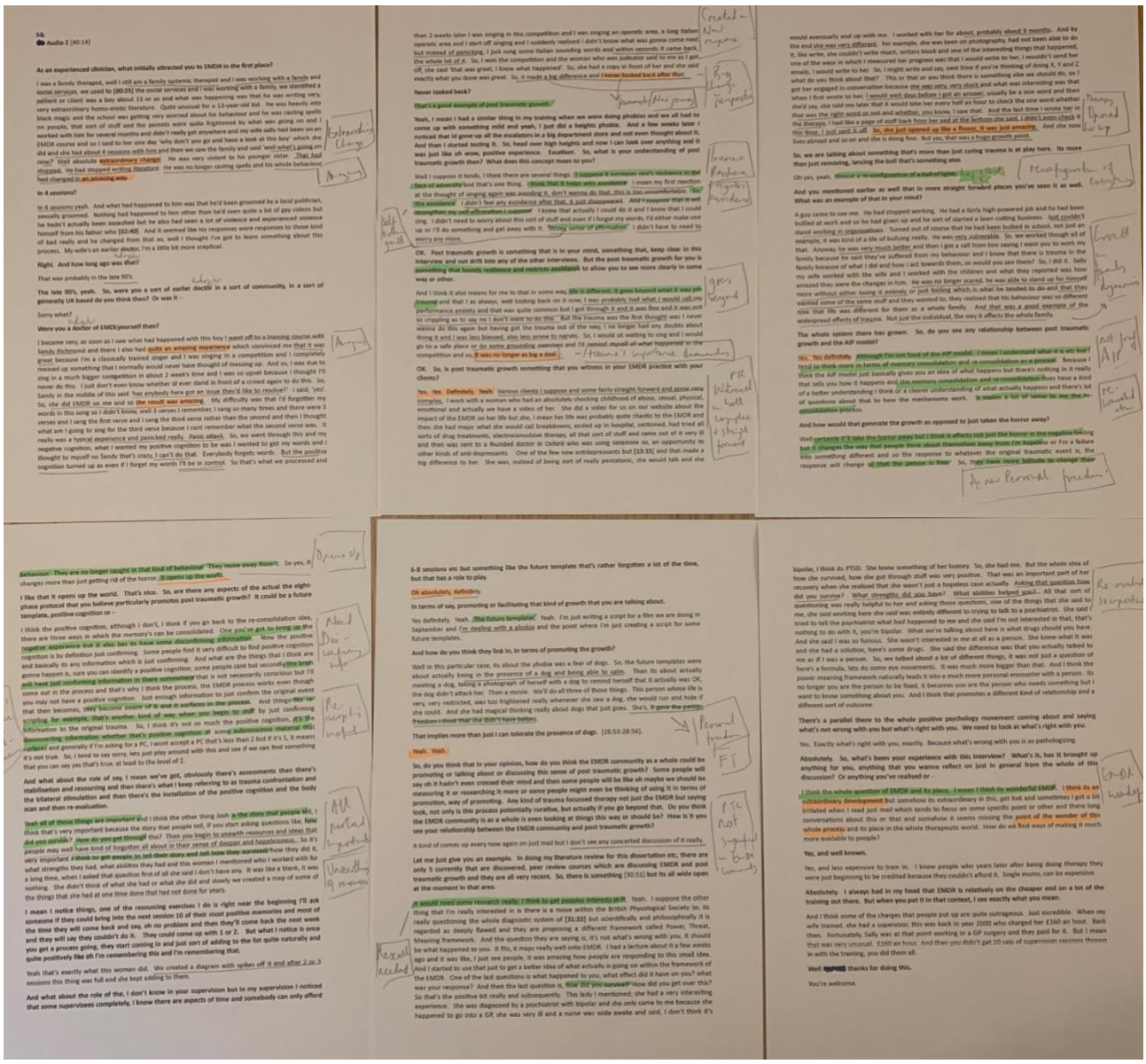

Figure 4. SE transcript coding

Appendix D.

Ethics Approval

ETHICS CHECKLIST FOR STUDENTS (approved February 2013)

This form is intended an an initial checklist for students proposing to undertake ANY research.

Student:	Joshua James Dickson
Email:	DICJ1_17@UNI.WORC.AC.UK
Instititute:	School of Psychology
Student Status:	Current Student
Supervisor:	Derek Farrell
Tutor:	
Module Leader:	Matthew Jellis
Documents	MPSY4005 001 Research Proposal.docx
Project Title:	The Link between Eye Movement Desensitisation and Reprocessing Therapy and Post-traumatic Growth: an Interpretative Phenomenological Analysis of the experiences of EMDR consultants

No.	Question	Answer
1.	Does your proposed research involve the collection of data from living humans?	Yes
2.	Does your proposed research require access to secondary data or documentary material of a sensitive or confidential nature from other organisations?	No
3.	Does your proposed research involve the use of data or documentary material which (a) is not anonymised **and** (b) is of a sensitive or confidential nature **and** (c) relates to the living or recently deceased?	No
4.	Does your proposed research involve participants who are particularly vulnerable or unable to give informed consent?	No
5.	Will your proposed research require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited?	No
6.	Will financial inducements be offered to participants in your proposed research beyond reasonable expenses and/or compensation for time?	No
7.	Will your proposed research involve collection of data relating to sensitive topics?	No
8.	Will your proposed research involve collection of security-sensitive materials?	No
9.	Is pain or discomfort likely to result from your proposed research?	No
10.	Could your proposed research induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	No
11.	Will it be necessary for participants to take part in your proposed research without their knowledge and consent at the time?	No
12.	Does your proposed research involve deception?	No
13.	Will your proposed research require the gathering of information about unlawful activity?	No
14.	Will invasive procedures be part of your proposed research?	No
15.	Will your proposed research involve prolonged, high intensity or repetitive testing?	No
16.	Does your proposed research involve the testing or observation of animals?	No
17.	Does your proposed research involve the significant destruction of invertebrates?	No
18.	Does your proposed research involve collection of DNA, cells, tissues or other samples from humans or animals?	No
19.	Does your proposed research involve human remains?	No
20.	Does your proposed research involve human burial sites?	No
21.	Will the proposed data collection in part or in whole be undertaken outside the UK?	No
22.	Does your proposed research involve NHS staff or premises?	No
23.	Does your proposed research involve NHS patients?	No

Details of Research
Outline the context and rationale for the research, the aims and objectives of the research and the methods of data collection
The research into the links between Post-traumatic growth and EMDR are limited in their scope, recent in terms of publication and do not specifically address the research question. As well as a lack of research, studies related to EMDR and PTG are not yet sufficient in facilitating customised therapeutic interventions for the use with clients. This will continue to be the case until a deeper comprehension of the role of therapy in the facilitation of PTG is discovered. An expansion of research is necessary to deepen our hold on the apparatus of enabling and supporting PTG through evidence-based, psychological interventions. This project aims to add to both the research evidence and to help deepen the understanding of the link between an EMDR process and the facilitation of PTG. The purpose of this research project is to critically examine and comment on how certain individuals make sense of their experience of the link between EMDR and PTG. This particular connection between EMDR and PTG has not been comprehensively investigated. The literature search reveals only a small number of articles mentioning or investigating a relationship at all, bringing a clear need to discern if, as a therapy, EMDR promotes PTG as well reducing symptoms of trauma and depression. These cumulative elements suggest the merit of undertaking further research in order to examine the causal effect of EMDR in the facilitation of PTG. As such a qualitative review would be a welcome addition to the limited range of literature available, investigating the following question: Is PTG a natural, phenomenological process or can we target it specifically with EMDR?

Who are your participants/subjects? (if applicable)
The research intends to purposively sample four to six UK based EMDR Consultants in line with current sampling suggestions (Brocki & Wearden, 2006). This purposive, heterogeneous sample group has been chosen as EMDR consultants are considered to be experts in their field, highly experienced and extremely knowledgeable, having gone through a thorough accreditation process over a minimum of six years following the completion of their training and having presented with a minimum of one hundred clients in clinical EMDR supervision.

How do you intend to recruit your participants? (if applicable)
This should explain the means by which participants in the research will be recruited. If any incentives and/or compensation (financial or other) is to be offered to participants, this should be clearly explained and justified.
The study will try to recruit participants via the UK & Ireland EMDR Association and the interviews will take place face-to-face, lasting approximately one hour with a restructuring accorded should the needs of the interviewer and respondent change.

How will you gain informed consent/assent? (if applicable)
Where you will provide an information sheet and/or consent form, please append this. If you are undertaking a deception study or covert research please outline how you will debrief participants below
An information sheet and consent form will be emailed to the participants prior to the interviews. Hard copy will be brought to the interview for the participants to read and sign.

Confidentiality, anonymity, data storage and disposal (if applicable)
Provide explanation of any measures to preserve confidentiality and anonymity of data, including specific explanation of data storage and disposal plans.
The interview data will be audio recorded and transferred to a laptop. The data will be encrypted and the laptop will require security passcodes to access.

Potential risks to participants/subjects (if applicable)
Identify any risks for participants/subjects that may arise from the research and how you intend to mitigate these risks.
The only risk that I can see is that the participant might accidentally reveal the name or identity of one of their clients. This can be mitigated by reminding the participant before the interviews start and if necessary editing any information out of the interview transcripts that might be construed as breaking anonymity. As the participants are experienced therapists with high levels of accreditation I believe that this is very unlikely.

Other ethical issues
Identify any other ethical issues (not addressed in the sections above) that may arise from your research and how you intend to address them.

Published ethical guidelines to be followed
Identify the professional code(s) of practice and/or ethical guidelines relevant to the subject domain of the research.
The ethics code of practice as set out by the EMDR UK & Ireland Association.

Ethics Application Approved

solehelp@worc.ac.uk

Wed 30/01, 11:36

Joshua Dickson

Reply all

The ethics application for Joshua James Dickson has been approved by Derek Farrell.

To view the application on your SOLE page click here.

*Do not forward this link on as it will allow the recipient to access your SOLE page.

Appendix E.

Dissertation Tutorial log-book

Date	4.10.18
Duration	30 minutes
Issues Discussed	Nature of qualitative interview (IPA), relationship to the systematic literature review, suggested reading
Actions	Read up on IPA
Date	20.2.2019
Duration	n/a
Issues Discussed	Cancelled by supervisor. Awaiting feedback from three previous assignments.
Actions	Book another tutorial
Date	26.3.2019
Duration	15 minutes
Issues Discussed	Structure and approximate word counts.
Actions	Re-do literature review. Start contacting potential interviewees.
Date	1.5.19
Duration	10 minutes.
Issues Discussed	Interview consent forms.
Actions	Interview EMDR Consultants.