Exploring Ethnic Minority Clients' Experience of Online Eye Movement Desensitisation and Reprocessing Therapy for Trauma: An Interpretative Phenomenological Clients' Perspective

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Abstract

The COVID-19 pandemic has increased the demand for trauma-focused therapies that can be delivered online, including the Eye Movement Desensitisation and Reprocessing (EMDR) therapy. However, little is known regarding the impact of online EMDR (vEMDR) and even less is understood about the experiences of ethnic minority clients.

This study explored the vEMDR therapy experiences of six ethnic minority participants who completed vEMDR therapy for trauma. Data was collected using semi-structured interviews and analysed using interpretative phenomenological analysis (IPA).

The study revealed four group experiential themes: 1)'*Wagging a finger on screen'* – The online EMDR therapy is a compromise that pays off; 2) Creating trust, safety and connection: The impact of therapeutic relationships in EMDR therapy**;** 3) '*In my own space'*: The safety, comfort and convenience of online EMDR Therapy; and 4) Healing Through the Journey of EMDR: preferences, challenges, grounding, and transformation. The findings showed that despite initial scepticism and uncertainty, participants reluctantly engaged in vEMDR and found it a worthwhile compromise. The findings highlighted therapeutic relationship (TR) was crucial, fostering a sense of safety, connection, and trust. TR was strengthened when therapists were sensitive to race, culture and ethnicity-related issues. An effective TR was achieved online in this study. It showed that online EMDR therapy can be safe, comfortable, and convenient. The EMDR process was challenging, yet therapeutic benefits extended beyond trauma resolution to addressing other difficulties such as stress, anxiety and confidence, making the experience transformative and empowering.

These research findings cover ethnic minority clients' vEMDR therapy experiences in a way that prior research has not. The novel findings suggest that vEMDR can be safe and effective and can enhance therapy experiences. It can be implemented flexibly to reach a diverse population, including those with geographical, cultural, and linguistic needs. Research implications, limitations, and recommendations have been explored.

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Table of Contents

List of tables

List of Abbreviations

BH – Butterfly hugs
BLS – Bilateral Stimulation
BPS – British Psychological Society
CoP – Counselling psychologist
EM – Eye movements
EMDR - Eye Movement Desensitization and Reprocessing
TR - Therapeutic relationship
vEMDR – Online EMDR

Transcription Key

[…] is omitted texts.
… is a long pause.

Chapter 1: Introduction

This chapter presents the qualitative research I conducted, exploring the experiences of ethnic minority participants utilising online EMDR therapy. I begin by discussing the personal context that inspired this research, followed by my philosophical stance as a researcher. The chapter also highlights the significance of this study within the field of Counselling Psychology (CoP).

Personal Context

I have worked for a substantial time in a deprived area of East London, where the population is diverse, and a significant proportion of clients come from ethnic minority backgrounds. Many of these clients presented with complex, chronic, and severe mental health presentations, often rooted in various forms of trauma they had experienced throughout their lives. As a therapist who also belongs to an ethnic minority, I was deeply affected by their accounts of trauma. I could empathise with their suffering, understanding the unique impact that ethnicity, race, and culture had on their experiences, as I could relate to some of their experiences.

I have been working with Post-Traumatic Stress Disorder (PTSD) since attending Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) training a few years ago. I developed a keen interest in working with trauma and have been working with various trauma presentations since, including PTSD and complex PTSD. While TF-CBT proved effective for many clients, I found it challenging to work

with those who had complex presentations due to the intricate nature of their trauma and the added pressure of time-limited interventions, which often left me feeling less equipped to meet their needs.

Subsequently, to further develop my skills, I attended Eye Movement Desensitisation and Reprocessing Therapy (EMDR) training, joined a specialist EMDR supervision group, and began incorporating EMDR into my work with clients. At that time, one of my clients, who had been on my caseload for TF-CBT, was struggling with complex PTSD, and a chronic physical disability resulted from it. I was assigned this client because we shared the same cultural and linguistic background. Although there was not much progress in addressing his trauma with initial TF-CBT interventions, the impact of EMDR on him was surprising. I realised that EMDR could be particularly beneficial for clients with complex trauma. Since then, I have regularly utilised EMDR therapy in my clinical practice.

There are numerous challenges in engaging individuals from ethnic minority populations in therapy. These challenges include fear, stigma, trust issues due to past experiences of discrimination and mistreatment, perceptions of the medicalised model, miscommunication due to language barriers, and a lack of culturally sensitive adaptations in therapy (Meyer & Zane, 2013). Consequently, many continue to suffer from unresolved trauma and its impact. EMDR is a form of therapy where clients are not required to verbalise the details of their traumatic experiences. They do not need to engage in repeated exposure after the session (Shapiro, 2001) or worry about articulating their experience to the clinician. This prompted me to consider how EMDR might benefit this group and whether it could contribute to addressing the challenges faced by ethnic minority populations.

Since the pandemic, EMDR has been increasingly delivered online. However, there is a lack of research exploring clients' experiences with online EMDR (vEMDR) as a trauma therapy. Thus, I became interested in this research topic.

Researcher's position

Therapy is guided by a relational and humanistic value system, which seeks to investigate, clarify, and understand the client's emotional challenges, perspectives, and fundamental presumptions that arise from their engagement with others and the environment (BPS, 2019). This research aims to understand an individual's subjective experience of online EMDR therapy for trauma. I am guided by the humanistic principles of CoP, whose core value is the individual experience (BPS, 2017). The NHS values and cultures also influence me as I have worked there for many years.

Researchers' prior experiences**,** biases, and beliefs influence how they conduct research (Denize & Lincoln, 2005). Therefore, my socio-cultural background, as well as my experience of working within the NHS for many years, have contributed to shaping my beliefs and assumptions about trauma and EMDR therapy.

I believe that trauma and EMDR therapy exist in how individuals experience them from their own worldviews, influenced by their socio-cultural and historical context. I acknowledge that NHS therapy provision is based on evidence-based practice primarily rooted in the positivist paradigm. As an evolving CoP, my values are aligned with those of the humanistic value of CoPs, which focuses on

the subjective nature of lived experiences. As a trainee CoP, coming from an ethnic minority background, having prior experience working in the NHS, and providing EMDR therapy for trauma have all contributed to my values and assumptions. Therefore, upon reflection, critical realist ontology and constructivist epistemology seem to be more reflective of my position as a researcher. The research positioning will be discussed further in the methodology section.

Relevance to CoPs

Research is paramount to me as a trainee CoP, fulfilling the dual role of scientist-practitioner. It informs and advances the field while ensuring that I remain attentive to the specific needs of my clients and the participants involved in a project. This research seeks to understand the experiences of ethnic minority clients undergoing online EMDR therapy, employing Interpretative Phenomenological Analysis (IPA) (Smith et al., 1999). Gaining insight into their experiences may help develop culturally sensitive EMDR psychotherapy that is effectively delivered online. This would address the existing research gaps concerning ethnic minorities in EMDR psychotherapy. Ultimately, I hope this will contribute to enhancing therapy provision for ethnic minority clients, empowering them to play a role in shaping their therapy provision.

It is acknowledged that personal experiences, beliefs, and interests may have influenced the research process and the selection of the research topic. These factors may have shaped certain decisions, including identifying literature gaps, designing the interview schedule, and determining the themes in the analysis.

Therefore, transparency and reflexivity are crucial from the outset of this study, allowing the reader to form an independent opinion regarding the procedures, judgements, and encounters detailed in this work.

Chapter 2: Literature Review.

The literature review begins by defining the language related to ethnic groups, races, and cultures to establish a research focus. It then provides a definition of the current understanding of trauma. The review critiques previous research on EMDR and its online delivery, highlighting research limitations and controversies. It includes critical reflections on qualitative research, emphasising studies focused on online delivery and ethnic minority populations. The critical review will provide insight into existing literature concerning the research phenomenon. The research questions are then supported by a rationale, which offers a logical foundation in the field of counselling psychology and links the research questions to an appropriate methodological framework that will guide the study.

The literature search strategy:

The literature review began with searches in databases such as EBSCO, PsycInfo, PsycArticles, and Scopus to gather initial articles on EMDR research. Examining the references within these articles led to further searches, expanding the reference base. Priority was given to articles focused on the subjective experiences of ethnic minority clients. Initially, the search was limited to the past ten years but was later extended to the past twenty years due to limited findings. To address research gaps and align with a phenomenological approach, a targeted search was conducted on Google Scholar using keywords such as 'online EMDR', 'ethnic minority', 'client's experiences of EMDR', and 'qualitative research in EMDR' to find additional relevant journals.

2.1 Language used in defining ethnic groups.

The terms 'ethnicity,' 'race,' and 'culture' have been employed in this study to describe or represent the experiences of the ethnic minority group in relation to the research phenomenon. Therefore, it is critical to offer a clear rationale for the language chosen for the study.

The concept of 'ethnicity' refers to a social group with which an individual identifies or is associated by others based on specific common attributes, such as geographical location, ancestral heritage, cultural traditions, and languages (Bhopal, 2004). Ethnicity is a multifaceted and intricate concept that is subjectively defined and subject to alteration based on context and contextual factors (Bhopal, 2004).

Historically, 'race' classified individuals based on observable physical attributes like hair colour or skin tone, perceived as indicators of geographic and ancestral heritage (Aspinall, 2020; Bhopal, 2004). Today, race is considered a social construct rather than a biological one, acknowledging its social and political dimensions (Bhopal, 2004; Ford & Harawa, 2010). The term 'race' must be used carefully, as it has been misused for categorising and oppressing people (Lu et al., 2022). However, the contemporary interpretation has resulted in 'race' being utilised similarly to 'ethnicity,' which includes cultural and historical backgrounds and physical characteristics.

Ethnicity and race are multifaceted and complex, evolving over time and subject to varying interpretations (Bhopal, 2004). Although distinct, race and ethnicity are

conceptual constructs that often intersect and are sometimes used interchangeably (Bhopal, 2004; Afshrai & Bhopal, 2010; Aspinall, 2020).

Ethnicity categories are useful for investigating therapy responses, creating culturally appropriate health services, and considering socioeconomic and cultural factors influencing the therapy experience. Culture is viewed as a shared characteristic of ethnicity, encompassing beliefs, norms, and values (US Department of Health and Human Services, 2001). However, the research acknowledges that not all members of an ethnic or racial group share the same culture.

Ethnic minorities

The COVID-19 disparities report (GOV.UK, 2021) recommended that the UK government and the public refer to minority ethnic groups individually rather than using broad terms like 'BAME' (Black, Asian, and Minority Ethnic). The government suggests using 'ethnic minorities' to describe all non-White British ethnic groups, including white minorities such as Gypsy, Roma**,** and Irish Travellers (Aspinall, 2021; GOV.UK, 2021).

Although using ethnic categories can be problematic, they are essential for researchers to conduct systematic and comparable studies addressing social inequalities and injustices **(**Khunti et al., 2020). Research should focus on specific ethnic groups to acknowledge their unique histories and socio-economic differences (Khunti et al., 2020). However, a detailed analysis of specific ethnic minority populations risks drawing wrong conclusions if homogeneous

experiences are assumed. When focusing on specific groups is not feasible, such as with small sample sizes, using 'ethnic minority' is recommended to capture the diverse experiences necessary for achieving social justice and equality (Khunti et al., 2020).

Aligned with the current UK government recommendations (GOV.UK, 2021) on the terms 'minority ethnic' or 'ethnic minority', this research uses the term ‘ethnicity' to describe all ethnic minorities. It includes all individuals who identify themselves as ‘ethnic minority’ individuals. However, the research does not assume that everyone will have the same experiences of therapy or other factors, such as sociocultural, historical, or other contextual factors. It acknowledges that all individuals have their own experiences.

2.2 Introduction to Trauma

To provide a consistent description of trauma and its responses, scientists and researchers have refined the definition and perception of trauma in recent decades (van der Kolk, 2014). Herman (1992) argues that trauma overwhelms human adaptability and disrupts the typical system of care that provides a sense of agency, connection, and purpose. Psychological trauma causes significant suffering, functional impairment, and related psychological symptoms (van der Kolk, 2014; Gluck et al., 2021).

Trauma is widely acknowledged in mental health discussions. The DSM-5 categorises trauma as triggered by severe external events, including exposure to actual or threatened death, serious injury, or sexual violence, experienced

directly, indirectly, or through witnessing (American Psychiatric Association (APA), 2013, p. 271). The DSM-5 includes a wide range of symptoms for PTSD, such as intrusions, hyperarousal, avoidance, and negative cognitions and mood (Friedman, 2013). Unlike the DSM-4, which defined trauma as a 'threat to physical integrity' (APA, 1994, p. 427), the DSM-5 does not consider psychosocial stressors like relationship breakdown or unemployment as trauma (North et al., 2009; Pai et al., 2017). The ICD-11 (World Health Organisation, 2019) introduces complex post-traumatic stress disorder (CPTSD), requiring all PTSD symptoms plus three additional categories: three additional symptoms categories evidencing 'disturbances in self-organisation' (DSO): 1) affective dysregulation 2) negative self-concept; and 3) disturbed relationships (Bovin et al., 2021; Karatzias, 2018). Both DSM-V and ICD-11 have been criticised for not adequately considering cultural diversity in trauma reactions (Power et al., 2022).

Much research has been done since trauma and its consequences were recognised (Power et al., 2022). Contemporary trauma theorists have explored alternative conceptualisations of trauma**,** integrating racial, cultural, historical, societal, generational, and intergenerational effects and promoting a resilience-based approach to trauma recovery (Salovey & Sluyter, 1997; Williams, 2006; Bloom & Farragher, 2011; van der Kolk, 2014). Critics argue that the resilience-based approach often focuses on individual and community capacities while overlooking broader socio-political factors influencing these capacities (Garrett, 2016). However, a resilience-based approach can be effective when considering the factors influencing trauma and resilience within systems like families, religions, organisations, communities, and societies (Nugent et al., 2014).

The National Centre for Trauma-Informed Care (TIC) approach to healthcare delivery (SAMHSA, 2014) provides an alternative conceptualisation of trauma:

> *"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual well-being." (SAMHSA, 2014, p.7)*

SAMHSA (2014) defines trauma through three key components: the trauma event itself, which may not necessarily be life-threatening but can still impact our psychological or social well-being; it considers both micro and macro-level contexts and specifies that the way in which we experience an event is crucial in determining whether it is traumatic; and the subsequent effects of the trauma (Sweeney et al., 2018). This approach recognises that trauma can stem from threats to our social and psychological integrity, not just physical threats, which are suggested by the DSM-V definition of trauma.

The conceptualisation of trauma as disorders with identifiable symptoms has been criticised for pathologising typical adaptive reactions to extremely stressful situations (e.g., McHugh, 2007; Frances, 2013). People from different countries have unique ways of describing and managing their distress, such as cultural and religious practices (Tribe, 2013). Fassin and Rechtman (2009) explored cultural and political issues. They argued that understanding trauma and its effects on human suffering is limited when broader historical, cultural, and political contexts that influence individual suffering are disregarded. Reducing the link between

‘what happened’ and ‘what was experienced’ (Fassin & Rechtman, 2009, p. 281) by using clinical terminology or a predefined set of symptoms obscures the diversity and complexity of an individual’s experiences and their meaning-making in a collaborative history (Fassin & Rechtman, 2009). This definition of trauma aligns with the value of CoP and my ontological and epistemological position as a researcher.

Recognising the conceptual framework of PTSD has led to increased research into effective therapies. Due to its efficacy, EMDR is recommended alongside Trauma-focused Cognitive Behavioural Therapy (TF-CBT) as evidence-based psychotherapy for PTSD by the National Institute of Clinical Excellence (NICE) (2005, 2018), the World Health Organisation (WHO) (2013) and the UK Psychological Trauma Society (UKPTS) (McFetridge et al., 2017).

2.3. Introduction to EMDR

Eye Movement Desensitization and Reprocessing (EMDR) was developed in the 1980s by American psychologist Francine Shapiro (Shapiro, 1989). It has been widely used for trauma (Bisson et al., 2007, 2013; Chen et al., 2014; Khan et al., 2018; Novo Navarro et al., 2018; Bradley et al., 2005). Later, she formulated the ‘adaptive information processing (AIP) model (Shapiro, 2001) to make sense of what occurs during the EMDR processing. Unlike the normal memories processed and assimilated using an individual’s adaptive information, the model suggests that traumatic memories are stored dysfunctionally and isolated from the rest of the broader semantic affective network with original sensations, emotions and beliefs (Shapiro, 2001). The ‘unprocessed’ and non-integrated

memories cause psychological and physiological distress, leading to distortions in emotions, behaviours, and beliefs (Foa et al., 2000). Such memories are easily triggered by stimuli similar to the original event, preventing integration with adaptive memory networks (Shapiro, 2001; Shapiro & Laliotis, 2015). EMDR therapy processes these unresolved memories, enabling them to be encoded like other memories and linked with adaptive memory networks.

Memory processing in EMDR is achieved by activating the distressing memory through bilateral stimulation (BLS), such as eye movements, auditory sounds, tactile tapping, and butterfly hugs. The client recalls the worst part of the memory while simultaneously focusing on internal trauma memories (past) and external cues (present), then engages in BLS guided by the therapist. Dual attention to past and present is crucial for processing. EMDR not only desensitises but also reprocesses the memory, integrating associated cognitions with adaptive memory networks. Free association in EMDR therapy facilitates memory reconsolidation (Solomon & Shapiro, 2008; Shapiro, 2014).

A standardised eight-phase protocol employs EMDR therapy focusing on the past, present and future (Shapiro, 2001; Shapiro & Laliotis, 2015):

1. **History-taking and treatment planning:** It begins with comprehensive history-taking and treatment planning, which includes obtaining background information, assessing suitability for EMDR, and identifying potential target memories for processing.
2. **Preparation:** It involves providing psychoeducation using metaphors and helping clients develop resources for managing distress by fostering

stabilisation, self-soothing, and a sense of control. The goal is to establish trust and explain the EMDR process.

3. **Assessment:** The assessment phase involves the client identifying a specific target memory, associated negative belief (what it means about them), desired positive belief, the current validity of the positive belief, bodily sensations, emotions, and the level of distress linked to the memory.

4. **Desensitisation:** This phase involves processing the memory using BLS toward an adaptive resolution. The therapist guides the client through sets of BLS while the client focuses on the traumatic memory, pausing briefly to discuss what arises. This process continues until the memory is no longer distressing. The client can raise their hand (the 'Stop' sign) to pause processing at any time, providing a sense of control.

5. **Installation**: This phase involves strengthening the positive belief and fully integrating it into the memory network.

6. **Body scan**: This phase involves scanning and processing any residual bodily sensations linked to the target memory.
7. **Closure:** The therapist conducts a final debriefing, ensuring the client is calm, stable, and grounded in the present moment at the end of the session, regardless of whether the processing of the target memory is complete or incomplete

8. **Re-assessment:** After a reprocessing session, the next session begins with an assessment of the treatment's effects to ensure the patient's distress level remains low and positive cognition remains strong. Future targets and treatment directions are established, and the treatment plan is reevaluated as needed.

Phases 3 to 6 are unique to EMDR therapy.

2.4 Evidence-based for EMDR

EMDR is effective for treating PTSD in adults and children, as shown by numerous studies and meta-analyses (Shepherd et al., 2000; Davidson & Parker, 2001; Bradley et al., 2005; Novo Navarro, 2018; Bisson et al., 2007, 2013; Chen et al., 2014; Khan et al., 2018). It has a significant effect size compared to control conditions and is as effective as CBT (Cuijpers et al., 2020; Moreno-Alcazar, 2017; Gillies et al., 2013; Cusack et al., 2016). Beyond PTSD, EMDR is used for other mental health issues, as adverse life experiences and traumatic memories can contribute to these disorders. EMDR helps process these experiences in conditions such as bipolar disorder (Novo et al., 2014), sexual abuse survivors (Jaberghaderi et al., 2004), memory-related distress and conduct disorders (Soberman et al., 2002), and eating disorders

A systematic review of EMDR RCTs by Valiente-Gómez et al. (2017) found EMDR to be effective for various mental health issues. Multiple RCTs confirmed its efficacy for depression (Malandrone et al., 2019), anxiety and panic disorder (Faretta & Dal Farra, 2019), and chronic pain (Tesarz et al., 2019). EMDR was

also found to reduce psychosis and PTSD symptoms and is considered a safe and feasible intervention (van den Berg et al., 2015a, 2015b). However, Cuijpers et al. (2020) noted in a meta-analysis that while EMDR was more effective for PTSD than other therapies, it had a higher risk of bias, and there were insufficient studies to pool outcomes for other conditions like depression, anxiety, and pain. They recommended larger-scale RCTs for these conditions.

Additionally, research on cost-effectiveness shows EMDR requires fewer sessions (Ironson et al., 2002; Lee et al., 2002; van der Kolk, 2007), is more efficient (van Etten & Taylor, 1998), and produces faster effects (Shapiro, 2014). Power et al. (2002), one of the most significant comparisons with most extended follow-ups, found EMDR to be 50% quicker, yielding results in 4.2 sessions compared to 6.4 for exposure-based cognitive restructuring. Similarly, Mavranezouli et al. (2020) found EMDR to be the most cost-effective among ten different therapies for PTSD, including TF-CBT and medication.

Before discussing debates around EMDR, it's important to consider research limitations in the literature. The most recent systematic review and meta-analysis by Cuijpers et al. (2020), which included 76 studies, noted that nearly all had some risk of bias, wherein a researcher may unintentionally or selectively influence results. This high risk of bias is a significant weakness (Cuijpers, 2016), and findings should be interpreted cautiously. Most studies had small sample sizes, some with as few as 10 participants, and poor quality, including issues with sequence generation, randomisation concealment, excessive heterogeneity, and lack of EMDR integrity or fidelity (Lee & Cuijpers, 2013). The long-term effects of EMDR were not adequately studied, and some studies had publication bias and

selective reporting. These methodological flaws raise doubts about the validity of EMDR's effects. Previous research also highlighted these issues; for instance, Herbert et al. (2000) labelled EMDR a ‘pseudoscience’, noting that many researchers conduct confirmatory exercises. Recent studies have observed similar flaws, indicating that EMDR research is still far from the RCT ‘gold standard’ (Salkovskis, 2002) and recommending further high-quality, robust RCTs with longer-term follow-ups.

2.5 Controversies of EMDR

EMDR has faced significant criticism from the scientific community since its original development, with ongoing debates about its mechanism (Herbert et al., 2000; McNally, 2013). Despite the substantial evidence base for EMDR, key questions remain unresolved (Davidson & Parker, 2001; Lee & Cuijpers, 2013; Logie, 2014).

One major controversy is whether EMDR works through the same mechanisms as TF-CBT, particularly via exposure to traumatic memories (Herbert et al., 2000; Salkovskis, 2002; Lee et al., 2006). However, critics argue that habituation, a key principle of exposure, is incompatible with EMDR (Rogers & Silver, 2002). Spector (2007) rejects the idea that EMDR and TF-CBT are both exposure treatments, noting that EMDR involves short bursts of exposure followed by free association, unlike the prolonged, undistracted, and uninterrupted exposure required in TF-CBT (Perkins & Rouanzoin, 2002; Foa et al., 1999). Additionally, EMDR does not involve detailed descriptions of the event, directly challenging beliefs, or assigning homework (WHO, 2016; Landin-Romero et al., 2018).

Therefore, the argument that EMDR and TF-CBT share the same mechanisms is flawed due to fundamental differences in their underlying mechanisms of action.

Another debated question is whether eye movement (EM) is necessary for EMDR (Davidson & Parker, 2001; McNally, 2013; Logie, 2014). Davidson and Parker (2001) conducted a comparison study and meta-analysis of 13 studies, finding EMDR effective but showing no significant difference in outcomes with or without EM, suggesting EM might be unnecessary. However, Lee and Cuijpers (2013) criticised this study for treating all studies equally without weighting them by the number of participants and for using a fixed-effects model instead of a random-effects model. A more recent meta-analysis by Lee and Cuijpers (2013) found that eye movements might contribute to EMDR's effectiveness, but a subsequent meta-analysis (Cuijpers et al., 2020) did not validate this, likely due to different inclusion criteria, such as focusing on mental health research instead of experimental trials with healthy subjects. Additionally, many studies in the meta-analysis had moderate bias, significant heterogeneity, and lacked long-term impact, which may have affected the results.

Though the role of EM in EMDR is controversial, studies have found that other forms of BLS, such as tactile taps and auditory tones, can also reduce emotional vividness (van den Hout et al., 2011b; de Jongh et al., 2013). Nijdam et al. (2012) suggest that BLS may respond faster than other psychotherapies. Shapiro concluded that dual attention, rather than EM specifically, might be key to effect change (Shapiro & Laliotis, 2015). Dual attention involves focusing on the worst memory while engaging in BLS, which may reduce the memory's vividness and

emotionality due to limited working memory capacity (van den Hout et al., 2011). The working memory hypothesis is the most supported explanation for EMDR's effectiveness (van den Hout et al., 2011; Maxfield et al., 2008).

Since the COVID-19 pandemic, support for using other BLS methods in online EMDR therapy has grown. Traditional EM was not feasible for therapists, leading to the temporary pause of EMDR. However, EMDR UK (2020) quickly developed guidelines for using alternative BLS methods, notably butterfly hugs (BH) (Artigas et al., 1998, 2013), for online EMDR, which supports the dual attention and working memory hypotheses (Maxfield et al., 2008). The following section reviews online EMDR therapy, highlighting this shift in delivery methods.

2.6 Online EMDR therapy

Before the COVID-19 pandemic, EMDR was administered in person due to insufficient evidence for remote delivery. However, during the pandemic, therapists adapted EMDR for online treatment to continue care during lockdowns and social distancing. Online therapy, or teletherapy, is not new, and studies suggest it is as effective as face-to-face therapy (Hilty et al., 2013; Langarizadeh et al., 2017; Barak et al., 2008). Remote therapy may reduce dropout rates by minimising travel time, reducing income loss, and increasing flexibility (Farrell et al., 2022; McGowen et al., 2021; Thase et al., 2020; Langarizadeh et al., 2017). As a result, NICE (2021) published remote therapy guidelines and approved many evidence-based digital treatments for various mental health conditions, though none specifically for trauma-related presentations.

TF-CBT delivered via phone and videoconferencing has been shown to reduce PTSD symptoms (DuHamel et al., 2010; Knaevelsrud & Maercker, 2007). However, the study by Knaevelsrud and Maercker (2007), which focused on military and veteran males, may have limited transferability. Olthuis et al. (2016) reported that CBT for PTSD performed better than the waiting list control with a modest effect size in a meta-analysis. Two meta-analyses (Sijbrandij et al., 2016; Lewis et al., 2019) found similar outcomes for internet-delivered CBT for PTSD. The most substantial effects came from eight-session or more therapist-guided therapies (Sijbrandij et al., 2016). Due to limited evidence, Lewis et al. (2019) recommended caution in using online therapy, as only a few studies have examined therapist-led online trauma therapy. They found that online therapy had similar effects to face-to-face therapy, such as prolonged exposure (Acierno et al., 2017) and cognitive processing therapy (Morland et al., 2015; Ashwick et al., 2019), suggesting that therapist presence is crucial for online trauma therapy.

While some studies have found that online therapy does not affect the TR (Ghosh et al., 1997; Backhaus et al., 2012; Fluckiger et al., 2018), others argued it may be due to the loss of non-verbal cues (Glueckauf et al., 2002; Greene et al., 2010; Berger, 2017; Aafjes-van Doorn et al., 2021). The TR process may vary depending on the therapy style, clients' surroundings, or distractions (Shephard et al., 2006). However, some believe that TR can be formed and maintained online to create safety (Knaevelsrud & Maercker, 2007; Geller, 2021).

Despite the growth of online therapy, few studies have explored the efficacy of vEMDR (Thepaut et al., 2020). Lenferink et al. (2020) identified one study by Spence et al. (2013) in a systematic review, which tested web-based EMDR and

internet-delivered CBT. The three-month follow-ups showed symptom decreases with minimal therapist involvement, but the study had a small sample size, no control group, and lacked detailed descriptions of the therapies, making it unclear which caused the outcomes or if it was natural recovery. Further research could explore how the therapist's active or minimal engagement affects results.

Since the pandemic, interest in online EMDR research has grown, with some studies showing vEMDR's usefulness for depression, anxiety, and PTSD (Lazzaroni et al., 2021; Tarquinio, 2021). However, these studies were unreliable due to small sample sizes and a lack of control groups. McGowan et al. (2021) examined the efficacy data of 93 patients provided by 33 self-selected therapists, who demonstrated clinically relevant and statistically significant symptom reductions in children and adults. Gatekeeper biases may affect the outcome as self-selected therapists submitted the data. Another study by Perri et al. (2021) compared internet-based EMDR and CBT for health professionals and COVID-19 or lockdown trauma victims, showing improvements in depression, anxiety, and trauma symptoms and the effects were maintained after one month. However, without a waiting list, a control group and the presence of ongoing trauma potentially influenced the outcome.

Bursnall et al. (2022) explored the implementation and acceptance of vEMDR using surveys with 562 EMDR therapists and semi-structured interviews with some participants to understand the online responses. Despite initial resistance, four-fifths of therapists expected to continue online treatment after a year. However, technical issues and disparities in treatment access were noted as younger, wealthier, and more educated people tended to use online therapy, and

the study lacked client perceptions of their vEMDR experience. This study aims to address that gap.

The demand for evidence-based remote therapy for mental health, especially PTSD, has increased. Although research is limited, quantitative evidence suggests EMDR can be effectively delivered online, but further qualitative research is needed.

2.7 A qualitative approach in EMDR research

While EMDR has a strong evidence base for treating various problems in adults and children, research has primarily focused on quantitative studies. Recently, patient-centred care has become a priority in shaping healthcare services to protect patients' rights and choices in their care (NHS England, 2023). However, only a few qualitative studies have been conducted, mostly focusing on therapists' experiences, with only a few single case studies examining client experiences.

Notable studies on client experiences include those by Ricci and Clayton (2008) and Marich (2009, 2010, 2012), though ethical issues were noted, such as involving a former client in Marich's (2009) study, and the lack of clarity on theoretical orientations in Ricci and Clayton's (2008) study, which may have influenced the outcome. Recently, Every-Palmer et al. (2023) used thematic analysis to investigate the experiences of ten forensic mental health patients with PTSD and psychotic disorders undergoing EMDR as part of a clinical trial. The

study found EMDR to be safe, effective, and empowering in forensic contexts, and it was regarded as empowering.

Edmond et al. (2004) conducted a well-designed study, which was included in Shapiro's (2018) book and reviewed by Whitehouse (2019) and Marich et al. (2021). Using a mixed-method design, Edmond et al. (2004) explored the impact of EMDR and traditional therapies, interviewing forty predominantly white females from an earlier study. Participants found EMDR to resolve their trauma effectively but described it as reasonably procedural. Edmond et al. (2004) concluded that the EMDR method is the main component of change, not the TR. However, the study lacked credibility checks, such as multiple qualitative analyses and member checks (Whitehouse, 2019).

Contrary to Edmond et al. (2004), Marich (2012) suggested that therapist-client interactions influence therapy effectiveness. Marich (2012, 2021) argued that therapists providing orientation to therapy by responding to clients' doubts and queries in EMDR help establish safety, with adequate preparation and attention to the TR being crucial. Shapiro (2001) similarly emphasised that core elements of EMDR, like AIP conceptualisation, being with the client during processing, and client feedback on their distress, demonstrate equal interactions between the method, client, and therapist. This highlights that a good TR is essential for the method to be effective (Parnell, 2007). Whitehouse's (2019) systematic review of five studies supported this, dispelling the debate about whether the method or therapist drives change in EMDR. The review's insights contributed significantly to EMDR's practical application and were recognised by Health Education England (HEE) in the national training curriculum (HEE, 2021). Shipley et al.

(2022) expanded the review to thirteen studies, finding EMDR frequently reported as positive and transformative but recommended further research on negative experiences detailed by the authors.

Although limited, qualitative studies and reviews have provided valuable insights into clients' experiences. Edmond et al. (2004) emphasised the importance of qualitative research in capturing the nuances of clients' perceptions, which may be lost in quantitative studies. Qualitative research allows participants to openly share their experiences, offering a deeper understanding that quantitative methods cannot provide. However, only one study (Burnsnall et al., 2022) has examined vEMDR clients' experiences, and two other studies (Lipscomb & Ashley, 2021; Mbazzi et al., 2021) have explored the experiences of ethnic minority clients in face-to-face EMDR.

2.8 EMDR for Trauma Research in Ethnic Minorities

The Psychotherapy field has often overlooked the significant influence of cultural and societal factors on an individual's mental health, particularly in multicultural societies where systemic oppression and socioeconomic inequality severely impact mental health and trauma (Nickerson, 2022).The Adverse Childhood Experiences (ACE) study (Felitti et al., 1998) significantly contributed to trauma recognition and therapy (Nickerson, 2022). ACE research includes physical, verbal/emotional, and sexual abuse, as well as household dysfunctions like parental divorce, domestic violence, incarceration, substance abuse, and mental illness (Zhang & Monnat, 2021). These adversities are known risk factors for long-term mental and physical health issues. However, the original ACE study sample

was predominantly white, educated, and employed, limiting its relevance to diverse communities (Zhang & Monnat, 2021). The study overlooked cultural trauma and socioeconomic context (Nickerson, 2022), but later research incorporated cultural trauma and found that stigma and oppression significantly reduce life satisfaction (Stagor, 2009). The study noted that cultural, environmental, and socioeconomic factors place Black, Hispanic, and Asian youth at higher risk of ACEs (Felitti et al., 1998; Grollman, 2012)

Culturally based trauma and adversity are distinct to an individual's cultural background and systemic oppression, including discrimination, microaggressions, and racism (Saunders, 2022; Nickerson, 2022). Despite this, there is little evidence-based therapy research for trauma survivors among ethnic minorities (Gillum, 2008), reducing the efficacy of therapeutic interventions. Many therapeutic protocols take a ‘one-size-fits-all’ approach, ignoring the unique cultural experiences and needs of racial/ethnic minorities, perpetuating marginalisation and inequality that exacerbate trauma's impact on these communities (Gillum, 2008).

Establishing a trusting TR between ethnic minority clients and therapists has been challenging due to actual or perceived cultural biases or differences (Walling et al., 2012), which can impact the therapeutic process and outcomes. Traditional interventions have been less effective due to factors like language barriers, cultural differences, prejudice, and racism, contributing to the isolation of these groups from mainstream society (Owen et al., 2014). Different ethnic groups show varying patterns of ACE exposure, and the impact of trauma may differ across racial and ethnic groups in therapy-seeking individuals (Zhang &

Monnat, 2021; Ghafoori et al., 2012). This underscores the importance of ethnicity and cultural sensitivity in trauma therapy and interventions. Owen et al. (2014) emphasise that for therapy to be effective, standard treatment protocols must be flexible and adapted to meet the needs of diverse populations.

EMDR is recognised globally as an effective trauma therapy. Researchers and practitioners have suggested adaptations to the EMDR protocol to enhance its effectiveness for diverse populations (Nickerson, 2017, 2022; Mbazzi et al., 2021; Limbshops & Ashley, 2021). These adaptations have been implemented worldwide, such as in Ethiopian adolescent refugees (Smyth-Dent et al., 2019) and low-resource settings. The EMDR-IGTP (Integrative Group Treatment Protocol) has significantly reduced PTSD and anxiety symptoms in children and adults (Artigas et al., 2014; Jarero & Artigas, 2012; Wong, 2018). This concept has been further developed by therapists in Europe and the United States (Amara, 2017; Hartung, 2017; Masters et al., 2017; Nickerson, 2017). In Iraq, Farrell et al. (2020) provided therapy using both the standard and B2T protocol, with 90% of participants choosing B2T, stating they would not have engaged in therapy otherwise. Nickerson (2022) highlights that the B2T protocol offers culturally sensitive material, control, and privacy, addressing the need to avoid revealing shameful memories. In a recent qualitative study, Mbazzi et al. (2021) used thematic analysis to investigate adaptations of the standard EMDR protocol in five African countries, with twenty-five therapists participating. The study suggests using culturally relevant language (e.g., we-oriented communication), cultural interpretations of NC and PC, incorporating cultural activities like dance and music into resourcing exercises, selecting BLS methods (as EMs were sometimes viewed as 'witchcraft'), and using culturally appropriate scales for

evaluating cognition and emotions. The findings underscore the importance of culturally sensitive EMDR practice and training (Mbazzi et al., 2021).

Nickerson suggests similar adaptations (2017, 2022), emphasising that cultural competence in EMDR therapy requires understanding the client's cultural context, using culturally relevant metaphors, and pacing to maintain engagement. He provided guidelines for each phase of the EMDR standard protocol, offering numerous examples of culturally informed procedural adaptations for working with diverse clients. For example, culture-specific target selections and resource development are recommended. In phase 3, Nickerson (2022) notes that different cultures may respond differently to typical questions about the target image, NC, emotions, and memory-related physical sensations. The 'I' statement may feel unusual, while the 'we' statement might resonate more. Therapists should be culturally aware and adaptable in phases 3-6, recognising that some cultures describe emotions as bodily sensations. Instead of pushing for specific descriptions, therapists should meet clients where they are.

Nickerson (2022) argues that an intercultural approach in therapy promotes social justice, empowerment, and the recognition of power, privilege, and position within the therapy room. This approach involves understanding not only traumas but also clients' strengths and resilience. To fully grasp the impacts of traumas, such as multigenerational and historical microaggressions and racism, intercultural therapists must listen patiently and curiously to clients' stories while acknowledging their own biases. Nickerson (2017, 2022) emphasises the importance of cultural competence in EMDR therapists, enabling them to skilfully adapt the standard protocol while adhering to Shapiro's (2001) AIP model and

meeting the goals of each phase. Nickerson (2017, 2022) stresses that to develop a deep understanding of cultural contexts and practices to meet the unique needs of clients from diverse backgrounds, therapists require training in cultural competence, building culturally sensitive therapeutic relationships, and integrating cultural considerations into assessments, case formulations, and treatment plans.

EMDR research has largely overlooked clients' lived experiences (Lipscomb & Ashley, 2021). Lipscomb and Ashley's (2021) study explored the experiences of EMDR among four African American clients using a qualitative interpretive method (Elliott, 1999) and an in-depth case study approach. The study placed these narratives within the broader context of systemic racism and its impact on mental health. The researchers employed an anti-oppressive Critical Race Theoretical Framework to gain insight into how systemic racism may have influenced the clients' experiences in therapy. They also provided practical recommendations for therapists to improve their practice with African American clients, highlighting the importance of cultural sensitivity and acknowledging the historical trauma and systemic oppression faced by this group.

Despite the small sample size, limited transferability, and the risk of subjectivity and bias, this study has been valuable in reducing gaps in EMDR research regarding the lived experiences of ethnic minority clients, particularly African Americans. It has contributed to cultural sensitivity and inclusivity in the EMDR psychotherapy field and opened opportunities for further research and discussion on adapting mental health practices for diverse populations, acknowledging the complexities of race, culture, and historical trauma.

A similar study with a more diverse population is needed to examine the cultural appropriateness of EMDR treatment from clients' perspectives. This research aims to address this gap, potentially enhancing the knowledge base for a more informed, effective, and culturally sensitive approach to EMDR therapy.

2.9 Research implications of theory and practice

This review identifies three key knowledge gaps needing further exploration. First, the literature highlights the need for cultural adaptations in therapy to enhance engagement and efficacy. Ethnic minorities experience higher levels of trauma related to race, culture, immigration, and transgenerational issues (Lipscomb & Ashley, 2021). The ‘one-size-fits-all’ Western-focused EMDR psychotherapy and research have largely overlooked these aspects. Research focused on ethnic minority clients to better address cultural and diversity issues.

Secondly, using different forms of BLS in EMDR therapy remains debatable despite various quantitative studies. Although there is no clear evidence supporting remote EMDR therapy, therapists worldwide have been delivering it via videoconferencing since the pandemic, using different BLS methods. However, no study has explored clients' perceptions of these various BLS forms. Investigating clients' experiences with different BLS methods could help address the controversies surrounding EMDR (Marich et al., 2021).

Finally, the therapeutic relationship is central to any therapy approach (Beutler et al., 1994), with a well-established client-therapist alliance significantly contributing to therapeutic outcomes (Hoverth, 2000). Previous studies suggest

that only 15% of therapeutic success is linked to the specific approach used, while the rest depends on the TR, placebo effects, client expectations, and external factors (Lambert, 1992). However, EMDR research has primarily focused on eye movement, often overlooking the importance of the TR.

Edmond et al. (2004) noted that EMDR places less emphasis on the TR, a sentiment echoed by Marich et al. (2021), who stressed the importance of clinicians attending to the TR. Establishing a strong TR is crucial, especially in remote therapy, to ensure client safety and engagement in EMDR (Fisher, 2021). However, the literature presents conflicting reports on the impact of online therapy on TR. Some studies suggest the quality of TR is not compromised (Ghosh et al., 1997; Fluckiger et al., 2018) and that therapist presence positively contributes to outcomes in online trauma-focused therapy (Sijbrandij et al., 2016; Spence et al., 2013). Others, however, indicate that the relationship is indeed affected (Backhaus et al., 2012). This discrepancy requires further exploration, particularly as difficulties in forming a trusting TR between therapists and clients have been noted (Wallings et al., 2012).

2.10 The rationale for this study

Quantitative findings provide evidence of EMDR's efficacy and address criticisms of its mechanism, but they do not fully explain how or why it works. Quantitative research can overlook clinical evidence that doesn't align with statistical results, potentially leading to the falsification of hypotheses. Psychology acknowledges that not all human experiences can be quantified. According to Heidegger (1962), society, culture, and history shape individuals, making them unique. People bring

rich and influential experiences to therapy, which can impact the therapeutic process. Therefore, the understanding of EMDR therapy must extend beyond experimental evidence of its process and outcomes.

Counselling psychology embraces a pluralistic approach, positing a close link between therapy methods and the therapeutic relationship (Cooper & McLeod, 2011). A distinctive feature of counselling psychology is its role in bridging the gap between the science of psychology and the practice of counselling, navigating the tension between being a 'scientist-practitioner' and a 'reflective-practitioner' (Strawbridge & Woolfe, 2010). This approach promotes integration between evidence-based scientific practice and the real-world challenges of working in a complex environment facilitated through ongoing dialogue between clients and therapists. Counselling psychologists gain valuable insights by exploring individuals' lived experiences.

Rooted in humanistic theory, inspired by Rogers (1951) and Maslow (1962), counselling psychology's core value is understanding the subjective experiences of ‘self’ and ‘others’. While EMDR research has focused on its effectiveness, it has often overlooked the perspectives of the clients it serves. By conducting this research, I aimed to bridge the gap between quantitative and qualitative research in EMDR therapy, thereby strengthening the connection between theory and practice in counselling psychology.

Therefore, a qualitative study was proposed, considering the identified research gaps and aligning with counselling psychologists' philosophical and scientist-practitioner approaches.

2.11 The research aims and questions

Given this background, the purpose of this study was to explore how clients from ethnic minority groups experienced the BLS and other components of EMDR therapy conducted online. The qualitative research also investigated non-specific factors, including the therapeutic relationship and their impact on EMDR in the context of online delivery.

The primary research question was:

How do ethnic minority clients experience EMDR online?

The lines of the query were explored through two sub-questions:

- How do they make sense of the various components of EMDR?

- How do they experience other therapeutic factors, such as the therapeutic relationship?

Chapter 3: Methodology

3.1 Chapter Overview

This chapter will outline the study's methodology and explain why I chose Interpretative Phenomenological Analysis (IPA) as the methodological approach. I will also link these methodological choices to my underlying ontological and epistemological stance. Following this, I will detail the research process, including participant selection, recruitment, data collection and analysis, ethical considerations, reflexivity, and the criteria used to evaluate the quality of the research.

3.2 Ontological and epistemological position

The research process is rooted in a philosophical paradigm encompassing the researcher's interrelated beliefs and assumptions about the social world (Ponterotto, 2005; Denzin & Lincoln, 2000). These assumptions shape the study's design, including the selection of instruments, participants, tools, and procedures (Denzin & Lincoln, 2005). They reflect the researcher's perspectives in four key areas: ontology (the nature of being), epistemology (the nature of knowledge and the relationship between the 'knower' and 'would-be-knower' (Ponterotto, 2005, p. 128), axiology (the researcher's values), and methodology (the research process and procedures) (Ponterotto, 2005, p. 128-131).

Ontology is concerned with exploring the nature of being (Denzin & Lincoln, 2005). Ontologically, I align with critical realism, a perspective introduced by

Bhaskar (2016, 1997). Critical realism proposes that while an objective being exists, our understanding of it is influenced by subjective experience (Mahoney & Vincent, 2014; Pilgrim, 2020; Willis, 2022). Critical realism, as a transcendental framework, rejects methodological individualism and the universal existence of knowledge (Denzin & Lincoln, 2005, p. 13). It posits that while the world exists independently of human perception, our knowledge of it is socially constructed (Denzin & Lincoln, 2005). Critical theorists further argue that individual experiences are shaped by factors such as ethnicity, culture, gender, and social and political values, focusing on how power dynamics influence an individual's experience of being (Ponterotto, 2005). Their work aims to emancipate marginalised groups by addressing the social, economic, and political factors that contribute to discrimination, oppression, and marginalisation, thereby advocating for greater equality and justice (Ponterotto, 2005).

As highlighted in the literature review, there is limited research on the experiences of ethnic minority individuals undergoing EMDR therapy or vEMDR for trauma. Therefore, this research focuses on exploring these individuals' subjective experiences, aligning with the critical theorists' emphasis on understanding marginalised perspectives. I identify as a critical realist, believing that an objective being exists independent of perception, yet it is experienced differently by each individual. While I acknowledge that the concepts of EMDR therapy for trauma are well-established, I recognise that individual experiences of their trauma and their experience of therapy are inherently subjective. Thus, a critical realist ontological approach aligns with my views.

Furthermore, I align with constructivist epistemology, agreeing that knowledge is constructed by individuals through their interactions with their social, cultural, and historical contexts (Schwandt 1994; Hansen 2004; Moon & Blackman, 2014). From this perspective, the knowledge of trauma and therapeutic experiences in EMDR or vEMDR therapy is formed through individual and collective meaning-making processes influenced by socio-cultural factors.

This constructivist approach assumes that there are multiple ways of knowing, each shaped by individuals' unique social and cultural contexts (Sciarra 1999). Constructivism adheres to a ‘subjective epistemology’ (Denzin & Lincoln, 2005, p. 24), offering a perspective for understanding individuals’ subjective experiences of vEMDR for trauma. Constructivism, influenced by phenomenology and hermeneutics, holds that meaning is embedded in the interpretation of language and social constructs, which must be brought to the surface through deep reflection (Schwandt, 1994; Sciarra, 1999). Sociocultural factors influence the experience of vEMDR therapy and trauma. A constructivist epistemology rooted in meaning-making within individual, social, and cultural contexts aligns well with the research focus on individuals' lived experiences. The constructivist emphasis on meaning-making through subjective experience aligns with the research focus on understanding participants' lived experiences of trauma and therapy. It recognises that each participant constructs their own knowledge of their experiences, influenced by their cultural background, personal history, and social position (Willig 2012).

Additionally, constructivists advocate for a 'transactional and subjectivist stance,' emphasising the dynamic relationship between the researcher and participant, which is essential for capturing and describing the participant's lived experiences and the phenomena under investigation (Ponterotto, 2005, p. 131). In terms of axiology, constructivism assumes that the researcher's values, biases, and experiences are inseparable from the research process. Therefore, a constructivist epistemology is fitting for my research, as my views are deeply influenced by my prior experiences as both an ethnic minority and an EMDR therapist. Thus, Reflexivity is essential to ensure that my research remains ethically sound and critically reflective.

In summary, I adopt a critical realist ontology and constructivist epistemology, necessitating a qualitative research methodology aligned with these foundations (Willig, 2012). Therefore, Interpretative Phenomenological Analysis (IPA) is suitable for capturing participants' lived experiences within their socio-political and historical contexts, their complexity and diversity are ethically represented. Throughout this process, I will remain mindful of my own values, beliefs, and biases, particularly those shaped by my experience as an EMDR therapist. I aim to ensure an ethical and nuanced representation of participants' experiences by maintaining a reflexive stance throughout the research process.

3.3 Rational for Choosing IPA

Consideration of other methodologies

The research question must be consistent with the data collection method to ensure that the data produced is suitable for analysis (Willig, 2012). The chosen methodology must also align with the researcher's ontological stance (understanding of the nature of being) and epistemological perspective (understanding of the nature of knowledge) (Ponterotto, 2005; Larkin, 2015). As a researcher in counselling psychology, I carefully considered my ontological and epistemological position when selecting the research methods.

Other approaches like discourse analysis (DA), narrative analysis (NA), and thematic analysis (TA) were considered but were discounted. DA takes a social constructionist view that language exchanges in a social context produce phenomena (Smith et al., 2009). It examines language as a behavioural aspect rather than a way to understand an individual's subjective experiences and meaning-making (Smith et al., 1999). Therefore, DA was rejected because it did not fit the research purpose or its epistemological position.

NA has traditionally been employed to interpret participants' experiences through the stories they construct rather than the experiences themselves (Willig, 2013). Its social constructionist theoretical orientation conflicted with my research objective and my critical realist ontological stance.

TA was considered because of its compatibility with a critical realist framework and its similarity to IPA in identifying themes. However, compared to theoretically

oriented approaches like Grounded Theory (GT) or IPA, TA may lack the depth of insight, structured guidance, and interpretative credibility (Braun & Clarke, 2013). I found IPA's analytical methods to be more logical and aligned with my epistemology. IPA places emphasis on case-wide themes and individual experiences, making it a more suitable choice for my research aim of exploring participants' in-depth, subjective reports of their experiences.

Rejecting Giorgi's (1985) descriptive phenomenology (DP) was challenging, as it is well-suited for exploring subjective experiences. DP posits that individuals can transcend their subjectivity by 'bracketing' parts of consciousness to show the world (Husserl, 1970; Langdridge, 2007). However, Heidegger opposed this view, arguing that we are inseparable from our views, and our perceptions and experiences are intrinsically linked to the phenomena under investigation (Heidegger, 1962; Langdridge, 2007). It seems unsuitable since it investigates the more general structure of the phenomena rather than individual subjective experiences. In contrast, IPA seeks interpretation, not description (Langdridge, 2007).

IPA acknowledges that research outcomes are shaped by the researcher's interaction with the data through a reciprocal interpretative process called double hermeneutics (Willig, 2013). Using IPA was most aligned with my epistemological view, which said that the data could give us information about phenomenological content by looking into how people subjectively understand their experiences and where they think they fit in the world (Smith et al., 2009). Originally introduced as an approach in experimental psychology to explore subjective experience (Smith, 2015), IPA has been widely used in healthcare research, contributing valuable

insights (Pringle et al., 2011). In this study, I believed that participants' accounts of their experiences would provide a meaningful understanding of how they make sense of vEMDR for trauma.

In summary, my choice of IPA was guided by the phenomenological focus of my research, my ontological stance as a critical realist, and my constructivist epistemological position.

3.4 Overview of IPA

IPA is a qualitative research approach designed to create a detailed narrative of an individual's lived experience (Smith & Osborn, 2015). It recognises that this process is inherently interpretive, requiring researchers to make sense of how participants themselves make sense of their experiences (hermeneutics). Before making interpretive claims, participants' lived experiences are explored in detail using their own words (Smith & Osborn, 2015). Through the epistemological framework and research question, IPA may incorporate sociological, linguistic, and cultural factors that shape meaning. Participant interviews provide data rather than predetermined hypotheses since the methodology emphasises subjective experience. I will now describe IPA's theoretical foundations.

3.4.1 Theoretical foundation of IPA

Phenomenology: IPA is a phenomenological approach involving an in-depth investigation of participants' lived experiences. Rather than seeking objective knowledge based on established scientific theories, IPA aims to understand how individuals perceive and make sense of their experiences in their own words (Smith & Osborn, 2015a), which contradicts the universal laws and the nature of seeking objective knowledge of traditional scientific inquiry (Milton, 2010). Larkin et al. (2006) claim that IPA acknowledges socio-cultural contexts shape subjective experiences. Through semi-structured interviews, the researcher adopts an 'insider perspective' to access the participant's world to acquire their narrative (Conrad, 1987) but cannot do it wholly or directly (Smith, 2015). Gaining access to and understanding the personal worlds of others requires a dynamic, interpretative process where the researcher uses their own conceptions (hermeneutic) (Smith et al., 2009; Smith, 2015). This is consistent with Heidegger's (1962) interpretative or hermeneutic phenomenology.

Hermeneutics:

IPA is intellectually connected to hermeneutics, the theory of interpretation (Smith, 2015). It suggests that humans inherently seek to make sense of their experiences, with access to these experiences being mediated by what participants disclose (Smith et al., 2009). IPA involves a double hermeneutic process wherein researchers interpret the participants' interpretations of their own experiences (Smith et al., 2009). This dual role requires researchers to interpret their own conceptions while also striving to understand the participants'

experiences. Recognising the inherent challenge that one cannot completely step into another's shoes, researchers engage in a continuous interpretative effort to empathise with and coherently articulate the participants' nuanced experiences (Smith, 2015).

Idiography: IPA incorporates idiography alongside phenomenology and hermeneutics, emphasising detailed, case-by-case analysis rather than broad generalisations (Smith et al., 2009). Idiography focuses on the individual as a complex and unique being (Larkin, 2015), aiming to deeply understand their world by carefully examining their narrative and considering a broader context. This approach captures what is distinct and concrete in each participant's experience, while respecting their unique perspective (Willig, 2017; Smith, 2015). IPA researchers use specific data to illustrate their findings, acknowledging that these interpretations represent just one possible understanding (Smith, 2015).

3.4.2 Characteristics of IPA

Three critical characteristics of IPA epistemology, language and context. I am going to discuss those characteristics now.

Epistemology: IPA is grounded in an interpretative or hermeneutic phenomenological epistemology, guided by several critical assumptions (Larkin & Thompson, 2012). One assumption is that ‘an understanding of the world requires an understanding of experience’ (Larkin & Thompson, 2012, p. 102). Researchers do not access experiences directly but through intersubjective meaning-making processes, constructing meaning from participant narratives

that are deeply rooted in linguistic, relational, cultural, and physical contexts (Larkin & Thompson, 2012; Pietkiewicz & Smith, 2014). Consequently, an idiographic approach is crucial for delving into specific, detailed accounts. Interpretation is unavoidable at every stage (Larkin & Thompson, 2012). Researchers must be reflexive, recognising their own experiences and assumptions in shaping these interpretations while striving to stay aligned with participants' perspectives. IPA also posits that the subjective knowledge produced contributes to the psychological understanding of a phenomenon (Eatough & Smith, 2017).

Context: According to IPA, the interview setting determines how experience is communicated. This means that researchers unintentionally influence how experience is communicated during the interview. To accurately capture the central content or 'melody' of participants' narratives and the essence of their experiences, researchers must be acutely aware of the participants' sociocultural and linguistic backgrounds (Shinebourne, 2011). Similarly, the researcher's context must be treated with the same reflexivity; they must recognise their own assumptions and experiences, understand the complex interplay between the participant, researcher, and interaction contexts, and acknowledge their role in generating interpretations (Eatough & Smith, 2017).

Language: IPA uses language to interpret and communicate human experiences, unlike other methods, such as discursive analysis, which uses language to construct knowledge (Smith et al., 1999). IPA assumes that participants can explain phenomenological material, their understanding of their experiences, their orientation and engagement in the world, and how they

interpret it through language and articulation (Smith et al., 2009). Metaphors and other languages can also link descriptive and conceptual interpretations, deepening the interpretation and making it easier to communicate the research's relevance (Smith et al., 2009).

3.5 Ethical Consideration

Ethical approval for the study was obtained from the Ethics Committee of the University of East London (UEL) (Appendix A & B). The study adhered to the guidelines set by the BPS Code of Human Research Ethics (2021) and the University of East London Code of Practice for Research Ethics (2015).

The BPS (2021) code outlines four core principles: respect for the autonomy, privacy, and dignity of individuals, groups, and communities; scientific integrity; social responsibility; and maximum benefits and reducing physical and psychological risks for participants. In alignment with the first principle, participants were informed about the nature of the questions during the initial phone conversation and were provided with detailed information (Appendix E) to make an informed decision. Participants were also given the option to withdraw without penalty within three weeks of the interview to ensure valid consent. Identifying information was removed to protect data, and electronic data was securely stored on the UEL OneDrive, accessible only to the researcher and supervisor.

The second principle (BPS, 2021) mandates that psychologists ensure and uphold academic and scientific standards and integrity. I maintained high

research quality by being transparent about the study's aims, my limited capacity as a researcher, and potential risks and challenges. I carefully considered my personal and professional responsibilities as a psychologist and how the study could benefit individuals and society for the 'common good,' thereby promoting social responsibility, the third principle (BPS, 2021). To maintain quality, I engaged in self-reflection and supervision to critically evaluate my personal and professional research commitments and maintain quality.

Two potential risks were identified in adherence to the fourth principle (BPS, 2021), which focuses on maximising benefits and minimising physical and psychological risks for participants. The first was the possibility of psychological distress, pain, or discomfort during the study, which involved interviewing participants who had received EMDR for trauma. Although it was assumed that participants had achieved psychological stability post-therapy, there remained a risk of re-traumatisation during the interview, as recalling their therapy experience could potentially trigger distress (Van de Veer, 1998). I clarified to participants that, as a researcher, I could not offer professional therapeutic support or advice. Throughout the interviews, I was mindful of showing sensitivity to the participants for signs of distress, frequently checking in with them to ensure they were comfortable continuing. Fortunately, no participants became distressed during the interviews. All participants were offered a debriefing session following the interview to minimise any aftereffects. Additionally, they were provided with information about relevant psychological services (such as Mind, Crisis helplines, and their local Talking Therapies) should they wish to access further support.

Second, while no psychological distress risks were anticipated or experienced by the researcher, a plan was in place to review and reflect in supervision and use personal therapy space for any issues that might have arisen. The appropriate risk management protocol would have been followed, with the possibility of referring participants for further therapy if needed. Although my role was solely that of an interviewer, my background in therapy could have been beneficial in grounding participants to assess their psychological needs during the interview process and to refer them for further support. However, this involvement was not necessary.

Ethical dilemmas regarding the researcher's affiliation with participants and the potential power imbalance during the interview process must be carefully managed (Willig, 2013). As an EMDR therapist, I faced a dilemma about how much information to disclose, which could influence the interview process and raise concerns about credibility. To mitigate power imbalances, my association with them was purely as a researcher, with no prior affiliations.

Offering incentives is another complex issue that might influence participants' willingness to engage in the study, potentially creating a perception of coercion (Grant & Sugarman, 2004). However, considering that people are often busy and may need to miss work to attend an interview, a modest incentive can serve as a token of appreciation for their contribution, though it may not fully compensate for their time. Additionally, incentives can enhance the perceived value of research (Mkandawire-Valhmu, 2009). I consulted with the ethics committee before submitting the proposal to discuss the potential impact of incentives on supervision. We agreed that certain incentives, such as gift vouchers, were

appropriate. In the context of psychological research, offering incentives is considered ethically acceptable if it does not compromise the voluntary nature of participation (BPS, 2021). Therefore, Amazon vouchers were provided as a reward for participants.

3.6 The research design

Sampling

IPA explicitly recommends homogenous sampling for the study to capture specific experiences as specific people encounter them (Smith et al., 2009). Therefore, IPA employs a purposive sample to identify a more closely defined group for which the research topic holds relevance (Smith & Osborn, 2015a). Consequently, to improve the study's transferability, an effort was made to ensure that the sample was homogeneous (Pietkiewicz & Smith, 2014). Considering the research gap, the sampling criteria stipulated that participants must identify themselves as an ethnic minority individual, aged 18 years or older, and not need to meet any diagnostic criteria. However, everyone would have experienced trauma to attain relevance to EMDR psychotherapy and CoP practice. Participants' lived experience with the phenomena under investigation is a fundamental aspect of IPA (Landbridge, 2007). Therefore, they would have completed EMDR therapy via video conferencing before the interview. Purposive sampling was employed for this study, but it was restricted due to participants' self-selection.

Shapiro and Forrest (2004) suggest that trauma memory processing may continue even after therapy concludes. Therefore, a six-month period was initially

designated to allow for retrospective reflection on the therapy's efficacy. This approach could have provided insights into the longer-term effects of EMDR. However, this criterion proved challenging for recruiting participants, so it was modified to require only the completion of therapy. Thus, the homogeneous criteria were fulfilled by including participants who had experience with vEMDR therapy for trauma.

Sample size

Smith et al. (2022) recommend recruiting six to ten participants for Professional Doctorates. I initially aimed to recruit at least seven participants to allow for potential dropouts. A sample size of seven was considered appropriate to ensure sufficient depth in exploring my research question while remaining small enough to focus on each interview's unique aspects (Braun & Clarke, 2013). However, due to recruitment challenges, I ended up with six participants.

Recruitment

Following the research ethics approval, the study leaflet (Appendix D) was advertised on social media platforms, and multiple presentations were made to EMDR therapist groups, including EMDR UK. An information sheet (Appendix E) detailing the research and inclusion criteria was provided to participants. Participants signed a consent form with information on their right to withdraw from the study (Appendix F).

Between October 2022 and March 2023, six participants were recruited through EMDR therapists across the UK. I had to rely on the goodwill of others for support.

Therapists responded to my communications through Jiscmail and the Black and Asian Therapy Network (BATN). A pilot interview was conducted to assess the feasibility of the interview schedule and the participants' ability to provide detailed accounts of their experiences (Willig, 2017). The data from this pilot interview was included in the study as it produced rich, valuable insights.

Introduction to Participants

Six participants were included in this study. Each participant was assigned a pseudonym to ensure anonymity, and any potentially identifiable names were altered in the transcripts. All participants had received online EMDR therapy for trauma and had completed therapy before the interview. Demographic information was collected during a screening telephone call before the interview. The demographics are presented below:

Table 1: Demographics and the relevant information of the participants

Pseudonym	Age	Pronoun	Ethnic group	Other relevant information
Annie	47	She/her	South Asian British	• Received 10 sessions of EMDR online for trauma over 3-6 months. • Other issues – anxiety. depression, CPTSD, EUPD, emotionally unstable personality disorder (EUPD • Was unemployed, had a physical disability
Poppy	45-50	She/her	African-European British	• Received 8 eight longer sessions of EMDR online for PTSD and CPTSD over 3 months. • Was working in the police.
Samina	25	She/her	South Asian British	• Received 16 sessions of EMDR therapy online for childhood and transgenerational trauma over a year

				• In psychotherapy trainee.
Reah	28-33	She/her	South Asian British	• Received 16 sessions of EMDR therapy online for trauma, anxiety and depression. • Working as a doctor
Chloe	32	She/her	Asian and Black African British	• Received many sessions of EMDR online for childhood trauma for over one year. • Working in an office.
Christina	46	She/her	Black British	• Received 8 sessions of EMDR therapy online for childhood sexual abuse in the NHS. • Was working in media.
• *All participants were 2nd or 3rd generation British-born ethnic minority individuals.*				

Only Christina attended therapy within the NHS, and all other participants attended therapy in private practice.

Recruitment Reflexivity

As an EMDR therapist, I initially assumed that recruiting participants would not be too challenging, given my access to various EMDR therapists' networks. However, after four weeks of advertising through initial strategies like word of mouth, peer groups, the EMDR UK newsletter, and social media, no participants were recruited. I often received feedback that therapists do not have ethnic minority clients, highlighting inequality in access to therapy. Additionally, therapists generally lose contact with clients after therapy, making the six-month post-therapy criterion a limiting factor for recruitment. I also reflected on the possibility that potential participants might not have time for an interview and considered how issues of power and trust could affect participation. Trust, fear, and stigma make it difficult for ethnic minority clients to engage in therapy (George et al., 2014) and even more challenging to investigate (Chamberlain & Hodgetts, 2018). Furthermore, researchers' prejudices, along with historical instances of systematic abuse and mistreatment, contribute to their wariness in participating in research (George et al., 2014). I discussed these recruitment challenges with my research supervisor and decided to remove the six-month post-treatment criterion, requiring only therapy completion to increase participant access. Initially, I offered a £25 voucher, considering that incentives might enhance the study's perceived value (Mkandawire-Valhmu, 2009). However, finding a balance between offering sufficient incentives without coercion was a dilemma. Gross & Fogg (2001) suggest that incentives should be adequate to respect participants' time and effort while encouraging participation, so I increased the reward to £50. This adjustment, combined with the relaxed post-therapy time requirement, improved recruitment. Despite this, participants

expressed that their primary motivation for participating was altruistic, aiming to contribute to research and knowledge, making the incentives secondary.

Following criteria amendments and UEL ethics committee approval (Appendix C), I re-advertised within targeted groups and networks such as EMDR UK and the Black and African Asian Therapist Network (BAATN). To address power and trust issues, I focused on building rapport with participants by using personalised language and introducing myself as an 'insider' (e.g., ethnic minority researcher). I was transparent about my research aims, professional responsibilities, and accountability (e.g., BPS guidelines). To ease concerns, I provided my UEL credentials and my supervisor's information, assuring them of data confidentiality and safety. Additionally, I offered flexibility in data collection, including options such as audio calls with a voice changer for anonymity, and provided transcripts for their review, along with the option to receive study results if interested.

The pilot interview was reviewed in supervision and deemed to produce valuable data that would have otherwise been missed, so it was included in the data analysis. No participants withdrew their consent from the research.

3.7 Data Collection

The advertisement was emailed to all potential participants. After receiving the information sheets (Appendix E), they attended a brief screening call to confirm eligibility. During the call, I explained the research aims, clarified any concerns, and discussed their voluntary participation and right to withdraw. Demographic information was also collected during the call. Participants needed an internet

connection and Microsoft Teams for the interview. One participant opted for audio-only recording, so the Mac laptop's internal voice recorder was used. Interviews lasted between 49 and 127 minutes.

The interview schedule

Smith et al. (2009) recommend using semi-structured interviews for IPA to capture rich personal experiences from participants. The process for developing an IPA semi-structured interview schedule involves several steps. Smith and Osborn (2015a) suggest carefully considering the subjects to be covered and formulating pertinent questions, along with potential prompts and probes. They also emphasise the importance of the wording and delivery of these questions. Following the advice of my supervisor and lecturers, I practised the interview schedule with fellow trainees and made adjustments accordingly. The questions were developed based on the research topic, objectives, and gaps identified in the literature, with prompts included to help participants delve deeper into the phenomena and their meanings.

The interview schedule was structured into three segments comprising 15 research-related questions (Appendix H). Questions 1 to 6 centred on the overall vEMDR therapy experience, including aspects related to the platform, beginning with an open-ended inquiry about online EMDR to encourage participants to reflect on their vEMDR experience. Questions 7 to 10 delved deeper into specific EMDR components, such as BLS, to better understand their experiences. Subsequently, questions 11 to 14 aimed to explore their therapeutic relationships

during therapy. The final question allowed participants to discuss any additional significant aspects of their vEMDR experience before concluding the interview.

Pilot interview

Pilot interviews are beneficial for inexperienced researchers as they allow them to practice conducting interviews, become familiar with the schedule, and verify timings to ensure readiness for the actual interviews (Smith et al., 2009). These preliminary interviews also provide an opportunity for researchers to receive feedback on the tone and style of the interview, confirm the clarity of the questions, ensure that participants can express themselves freely, and collect relevant data on the phenomena under investigation (Smith et al., 2009).

Before primary data collection, I rehearsed asking the questions loudly and sequentially with my peers to gain confidence, which led me to revise and rephrase some questions. I journaled about the process and my biases and assumptions, which further prepared me for interviews with the participants. I also conducted a pilot interview with a participant, during which I inquired about my tone, questioning method, the readability of the material and debriefing sheets and the clarity and consistency of the interview schedule. The feedback indicated no issues, so no adjustments were necessary. However, the interview provided valuable data, which was included in the final study.

Conducting the interviews

Interviews took place on Microsoft Teams from November 2022 to January 2023. Some participants needed to reschedule due to work or personal commitments, so I remained flexible. Despite my efforts to be clear and concise, I sometimes asked lengthy questions, likely due to nervousness and the pressure to conduct the interview correctly. While participants generally understood the questions, occasional clarifications or prompts were necessary. I frequently asked for more details and summarised the conversation to understand their experiences better. The interview schedule guided me, but I also adapted spontaneously to what participants shared. I remained aware of my dual role as both an insider (ethnic minority) and an outsider (EMDR therapist and researcher), as well as the assumptions and biases that come with these roles. Taking breaks and revisiting the interview schedule helped me stay focused. After the interview, participants received a debriefing document (Appendix G) via email, which included information on accessing psychological support if needed.

3.8 Data Analysis

Data preparation

The data were compiled according to the procedures outlined by Smith et al. (2009). Each interview was transcribed verbatim using Microsoft Teams' transcriber and Microsoft Word's voice-to-text feature. Password-protected recordings were played with QuickTime Player, requiring repeated listening and viewing to ensure every word was accurately documented. Non-verbal

utterances, such as significant pauses and laughter, were noted as crucial for interpretation (Smith & Osborn, 2008). After multiple readings and accuracy checks, the transcripts were imported into Microsoft Word. Identifying information was anonymised on a case-by-case basis. While the transcripts will be submitted with the thesis for examiner review, they will not be included in the research repository.

Process of analysis

For the data analysis, I adhered to the guidelines proposed by Smith et al. (2022). This section will outline the analysis process to ensure transparency in my research.

Step one: Reading and re-reading

I read and reread one transcript for this step following Smith et al. (2022) IPA guidelines. I immersed myself in the participants' stories by listening to and watching the interview's audio and video recordings. Repeated transcript readings helped evoke the participant's voice, enriching the analysis (Smith et al., 2022). I noted my initial thoughts and impressions on the left margin of the transcript as I read, listened, or watched. Recording my initial views allowed me to concentrate more on the data at hand (Smith et al., 2009). The comments also assisted me with subsequent analysis, prompting me to reflect on my role in the interpretation. They encouraged me to examine whether my focus was driven by the participant's comments or influenced by my perspective.

Step two: Exploratory noting

As Smith et al. (2022) suggested, I added an ‘exploratory notes’ column to the transcript. While keeping an open mind, I took descriptive notes to capture the participant's meaning by recording the content or substance, aiming to identify a phenomenological focus (Smith et al., 2009). I employed Smith's three-layered interpretation approach: descriptive notes, reflecting the participant's content; linguistic notes, focusing on language use, such as repeated phrases, metaphors, and cultural context; and conceptual notes, addressing deeper psychological and discourse issues. I reached the conceptual notes after connecting the linguistic and descriptive comments and interpreting the participants' meanings (Smith et al., 2022).

I initially struggled with IPA, questioning whether I was doing it correctly and what ‘good enough’ meant. Smith (2004) acknowledges that first-time IPA interpretations may tend to be more surface-level rather than forcing meaningful insights. IPA begins with participant accounts and moves from descriptive to interpretative (Smith et al., 1999). As a novice researcher, I asked my supervisor and colleagues to help me understand, develop, and reflect on my ideas and unpick how my bias and experience may have impacted my data interpretation (Smith et al., 2009). I realised the importance of trusting myself and acknowledging that biases are part of the meaning-making process.

Step three: Developing experiential themes

The next step was to create experiential statements from the exploratory notes, focusing on concisely capturing the participants' narratives' key elements (Smith et al., 2022). According to Smith and Osborn (2008), selecting terms that are unique to the object spoken yet high level enough to allow for theoretical connections across different situations is important at this stage. I tried to write comments on the participants' experiences, their meaning-making, and my interpretations. While summarising the key sections' details, the full transcript naturally had an impact. Following the hermeneutic cycle, where 'the whole is understood in light of the part, and the part is interpreted in light of the whole' (Smith et al., 2022, p. 89), I moved between the text and my notes to build interpretive confidence, ultimately identifying the best experiential statements summarised the contents.

Step four: Searching for connections across experiential statements

The next step involved clustering the experiential statements based on significant connections. This process required analysing the patterns and relationships between the statements and grouping those that were aligned. I used Microsoft Word to map these interconnections, actively identifying and documenting links. During this analysis, I focused on comments relevant to the core research question and excluded those outside the study's scope. I frequently revisited the original transcripts to ensure my interpretations aligned with the participants' expressions, carefully considering both commonalities and differences (Smith et al., 2022).

Step five: Naming the personal experiential themes (PETS) and consolidating and organising them into a theme

Clustering the experiential statements was followed by creating meaningful PETS. A table was created showing the individual's experiential themes and subthemes, including the transcript page numbers and relevant quotes for each experiential statement. I found all phases challenging, particularly steps 4 and 5. Supervision was frequently utilised to stay close to the phenomenon, help identify connections between clusters, and develop the PETS.

Step six: Continuing the individual analysis of other cases

The next step involved moving on to the subsequent case for analysis. Smith et al. (2022) emphasised the importance of treating each case individually to uphold IPA's idiographic commitment and ensure that each participant's experience is fully represented. I applied the same analytical steps to the remaining five transcripts.

Step seven: Working with personal experiential themes to develop group experiential themes (GETS) across cases

The final step involved identifying commonalities and differences among PETs to establish group experiential themes. Smith et al. (2022) emphasise that understanding and examining contributing convergence and divergence is crucial while recognising both shared and unique aspects of participants' experiences during cross-case analysis. Initially, I collected all PETs and searched for

commonalities across cases, annotating them to highlight group themes and commonalities. Following Smith et al. (2009), I focused on recurring themes to enhance rigour. Although significant variation existed, themes often manifested differently among participants. After comparing PETs, I included group themes that emerged and reassigned or combined similar sub-themes to a new theme where necessary. This higher-order analysis centred on sub-themes and experiential claims.

After refining these themes, I compiled a table with four group themes and twelve sub-themes (Table 1). According to Smith (2011) and Smith et al. (2022), a theme should be evident in at least two-thirds of participants. I regularly consulted with my supervisor throughout the process to refine and rearrange themes at each step of the process. I created a group theme through reflective reading of the text and recordings, ensuring they align with the idiographic focus of individual voices (Smith et al., 2009).

3.9 Reflexivity

IPA emphasises reflexivity, as interpretation is crucial to the integrity of qualitative research (Smith et al., 2009; Finlay, 2008; Willig, 2013). As described by Salzman (2002), reflexivity involves the researcher's ongoing awareness and evaluation of their influence on the research process and its outcomes. Smith (2015) and Willig (2013) highlight the importance of maintaining a reflective journal in IPA. This promotes data transparency and coherence, allowing the researcher to critically assess their interactions with participants' lived experiences from data collection to the end of research.

Having worked with ethnic minority clients in East London for several years and my experience as an EMDR therapist has influenced my understanding of participants' narratives. This background likely introduced my own biases and expectations into the interviews (Willig, 2013). My familiarity with online EMDR led me to affirm participants' responses with comments like ‘good’ or ‘great’, which may have influenced their answers. While I attempted bracketing (Creswell & Miller, 2000) to minimise these biases, I recognise that fully eliminating them is impossible. Therefore, I acknowledged this potential influence and kept a reflective journal throughout the study to help minimise its impact.

I kept a reflective journal and diary notes throughout the research process, which proved especially helpful during data collection and analysis. The diary captured my reflections on interactions with participants and my biases and assumptions. I also assessed how my interview approach, including question style and tone of voice, might have influenced the process.

Despite my efforts to maintain a researcher’s role during interviews, it was challenging to avoid slipping into a therapist’s role, particularly when participants displayed intense emotions. For example, one participant became emotional while discussing her inability to afford EMDR therapy for her daughter. As a mother, I empathised with her concerns and felt the urge to support her, though doing so would have created a conflict of interest. During the post-interview debriefing, I provided her with information on seeking further support, which she appreciated.

Data processing required continuous reflexivity to stay present in participants' experiences. I was aware that my understanding of EMDR and my preconceptions might influence how I analysed and interpreted the data. However, I made a conscious effort not to impose my theoretical knowledge of EMDR on participants' experiences. Engaging in supervision discussions about my assumptions and biases helped me stay grounded in the data.

Although I was an ‘outsider’ with authority as a researcher and EMDR therapist, participants may have seen me as an insider. ‘Insider’ because, as an ethnic minority researcher, I wanted to understand and encourage their perspectives. Phrases like ‘you would understand that’ and ‘you know’ suggested they considered me as one of them. While I related to their experiences, I focused on actively participating and gaining insight from their perspectives, which may have helped reduce the interview's power imbalance.

I actively practised reflexivity throughout the analysis to maintain transparency (Finlay, 2008). Regular self-reflection and personal therapy regarding my role in the research process further facilitated this transparency.

3.10 Appraising the quality of the research

In addition to using reflexive journals, the study's validity was evaluated according to Yardley's (2017) four criteria for qualitative research: sensitivity to context, commitment and rigour, coherence and transparency, and impact and importance.

Sensitivity to context:

Context sensitivity involves understanding the interview's socio-cultural, political, linguistic, and historical background, research question, and each participant's distinct narrative. I selected a homogeneous sample of individuals who received vEMDR therapy for trauma to ensure this sensitivity. However, I acknowledged that their experiences could vary due to the nature of trauma and their unique perspectives on life events. This awareness allowed me to start researching ethnic minority clients' vEMDR experiences in the first place. Throughout the literature review, I considered both the cultural context and my own biases, reflecting on how these influenced the analysis. I approached the research with curiosity and openness, integrating the participants' perspectives into the study.

Commitment and Rigour:

Yardley (2017) defines commitment as prolonged participation, data immersion, and methodological competence. Researchers' efforts to engage with the data carefully and responsibly can reflect the commitment and rigour of the study. This involves thoroughly interpreting each interview. I ensured rigour and trustworthiness in data collection and analysis by following Smith et al.'s (2022) IPA approach. Throughout the process, I reviewed each stage with my supervisor, discussed with my peers, analysed my epistemological perspective, questioned my decisions, and received feedback on my submissions, recruiting materials, interpretations, and analysis. My supervisor challenged me to clarify concepts, avoid ambiguity, and ensure the analysis was clear, concise, and

relevant to the study. I was required to demonstrate how the themes connected to my research topic and to support them with quotes to avoid assumptions.

Coherence and Transparency:

Yardley (2017) defines coherence as the alignment between the researcher's philosophical stance, the research question, and the investigation and analysis process. I critically examined my epistemology and positioning to ensure IPA was coherent and aligned with phenomenological and hermeneutic principles (Smith et al., 2009). For transparency, I detailed every part of the research process in my thesis, including participant recruitment, interview structure, procedures, and analysis techniques (Smith et al., 2022). I discussed recruitment and data-collection amendments in supervision, considering their ethical implications and supporting evidence. By thoroughly discussing my methodology and linking it to the literature review and study rationale, I enhanced the transparency and coherence of my work. The reflective journal also helped ensure that the research process was rigorous, coherent, and transparent.

Impact and importance:

According to Smith et al. (2009), absolute validity is defined by the study's influence, relevance, interest, or value. I highlighted the significance and relevance of exploring ethnic minority clients' vEMDR experiences in Counselling Psychology and other psychotherapies. This research contributes to the body of EMDR knowledge, potentially enhancing therapeutic practices for diverse populations, creating new research opportunities, and promoting the

dissemination of findings. The impact of this research will be discussed in the next chapter.

3.11 Summary

The present chapter discussed my epistemological stance, outlined IPA as the selected methodology, and detailed the data collection, preparation, and analysis processes. I also reflected on my efforts to uphold the quality of this study through reflexivity.

Chapter 4: Analysis

4.1 The overview

This chapter summarises the findings of an IPA study that involved conducting semi-structured interviews with six individuals who had completed EMDR therapy online for trauma symptomatology. The research identified twelve corresponding subthemes for four Group Experiential Themes (GETs). By expanding out to provide an overarching group theme, the hermeneutic cycle of IPA then zooms in to capture the idiographic experiences of the individual participants. To maintain transparency, participant quotations were incorporated alongside my interpretation of each subtheme within the research. The methodology chapter outlines the IPA data analysis guidelines I have adhered to.

4.2 The Themes

The table 2 below presents the GETs and the corresponding sub-themes:

Table 2: Group themes and sub-themes

1. **Theme 1**: '*Wagging a finger on screen'* – The online EMDR therapy is a compromise that pays off	
	Subthemes
	1.1 Sceptical at the beginning but, '*anything's worth a go'* 1.2 *'Handcuffed to a chair'* - intense and overwhelming processing but contained by the end 1.3 Face-to-face was not an option but online was worthwhile
2. **Theme 2**: Creating trust, safety and connection: The impact of therapeutic relationships in EMDR therapy	
	Subthemes
	2.1 Holding and containment by therapists provide a sense of safety and control 2.2 Sensitivity to culture and ethnicity increased connectedness 2.3 Therapists' attunement was present even through the screen
3. **Theme 3:** '*In my own space'*: The safety, comfort and convenience of online EMDR Therapy	
	Subthemes
	3.1 A safe and comfortable environment ensures feeling at ease in therapy 3.2 Spares *'the nightmares*': Convenience and accessibility of online therapy
4. **Theme 4:** Healing Through the Journey of EMDR: preferences, challenges, grounding, and transformation	
	Subthemes
	4.1 Preferred methods of bilateral stimulation: The comforting butterfly hugs 4.2 Navigating through the confusing and challenging process of EMDR 4.3 The tangible processes: Grounding facilitates change 4.4 '*No longer handcuffed'*: Emotional freedom and transformation of mindset

Theme 1: '*Wagging a finger on screen'* – The online EMDR therapy is a compromise that pays off

This overarching theme encapsulates the participants' journey from initial scepticism to a cautious willingness to engage with EMDR therapy. It reflects their evolving attitudes, starting with doubt and gradually transitioning to openness, which ultimately proved beneficial. The theme is explored through three sub-themes: initial scepticism, the intensity of EMDR sessions, and their preference between online and face-to-face therapy.

1.1 Sceptical at the beginning, but '*anything's worth a go'*

This sub-theme presents the participants' initial doubts about the efficacy and the EMDR process. The quotes illustrate a common feeling of scepticism, with descriptions of the therapy as being 'silly', 'strange', 'nonsense' and 'waste of time', and that was further strengthened by the unfamiliarity of the EMDR to them.

Christina, initially sceptical, states that she was puzzled by the form of BLS used in EMDR, which she described as '*wagging a finger on a screen*', yet it worked for her. She appeared to be surprised by the beneficial effects of the BLS. Christina's quote emphasises the 'foreignness' of the technique to her:

> *''I did think to myself, what is this that she is doing that she thinks could help me? Wagging a finger on screen for me to follow. What is this? It just it didn't make any sense to me at all. But but it worked." (Christina, page 75)*

Annie echoed this sentiment, expressing doubt over the technique's efficacy:

> *"I mean… the tick tick thing you know, I didn't think it was gonna work. Yeah." (Annie, page 2)*

Rhea's reflection on the presumably illogical nature of the sessions emphasises her initial scepticism and discomfort, which she ultimately came to terms with. The fact that she is '*almost preaching about it*' and explaining it to others amplifies her positive experience.

> *'It was strange to begin with […]. Like I've I thought if somebody could see what, see me now, they probably think I was going mad. But. I got used to it very quickly […] . And so yeah, […] actually, when I was telling people I was doing EMDR and the tapping. […] I was kind of explaining it to other people as well and like kind of preaching about it.' (Rhea, page 64)*

Samina's explicit expression of doubt regarding the effectiveness of the therapy further implies her confusion regarding EMDR therapy.

> *'So I was a bit like dubious about it. I felt uncertain about whether it was going to have any impact.[..] I didn't know that much about it in comparison to how much you know about the other types of therapy.' (Samina, Page 39)*

The comment above highlights the lack of prior information or unfamiliarity with EMDR, further amplifying the scepticism. The unfamiliarity is evident in Annie's

reference to the therapy as 'the tick-tick thing,' highlighting a gap in understanding. The narratives from Chloe and Christina also reveal a common thread of strangeness and scepticism, a combination of unfamiliarity and doubt regarding the efficacy of the therapy.

> *'[…] I never heard of it before. So it's completely new to me. Umm and I was a bit sceptical, trying to understand what she was trying to make me do it on the first session.'(Chloe, Page 51)*

> *'I never heard about it before.' (Christina, page 74)*

Poppy's concerns add another dimension to this scepticism: the fear of re-traumatisation. Her apprehension about '*bringing up the blocked memories*' and the potential failure of the therapy could lead her to relive those memories, highlighting her fear of worsening rather than resolving her trauma. However, her statements indicate that she felt more receptive and engaged over time.

> *'[…] I was very aware of the fact that. If you bring those to the surface and the EDMR doesn't work now what you're left with is those memories that you blocked out and you are reliving […].' (Poppy, Page, 20)*

Despite their initial reservations, participants continued with EMDR therapy. It seems that participants' decision to go with an unfamiliar therapy was influenced by various factors, such as trust in their therapist, previous ineffective treatments, and the lack of alternatives, which led them to feel *'anything's worth a go.' (Annie, page 2).*

‘I've had very bad experience with mental health teams and don't get any support from them whatsoever Umm […],’ (Annie, page 1)

‘I tried cognitive behavioral therapy before which didn't work for me at all.’ (Christina, Page 80)

‘ […] there was a part of me that just thought, this is a load of nonsense, and this is a waste of time. But I persevered because I trusted her…’ (Christina, Page 77)

Furthermore, their additional knowledge and information about EMDR and their reluctance to talk about their trauma also appeared to have been determining factors in their choice. Their additional knowledge of the EMDR also impacted the participants' engagement with therapy.

‘so I tried other sorts of therapy in the past, but not it worked for me, so before I had EMDR, I kind of gave them that that I didn't wanna talk about the situation head on.[…], I was told by therapist that I don’t have to talk […] first session but I need help with anyway..[…] It definitely made me stay.’ (Chloe, page 51)

‘I'd read that the research behind it was really good, […]’. (Samina, Page 39)

‘so my therapist explained to me about sort of processing the memories and moving them from one place to another in the brain. And that's how the

bilateral stimulation helps […] And yeah, I feel like that helped.' (Rhea, page 64)

'[…].she sent me a lot of information by e-mail, on lots of stuff over that during the course of treatment. Yeah. She was really helpful.' (Annie, page 3)

'because I watched some some examples on YouTube with experience therapists […] So and the people that have done it had been successful with regards to you know, the statistics […]' (Poppy, page 17)

Despite their initial scepticism and doubts, they made a cautious compromise and stayed in therapy, which proved worthwhile.

1.2 '*Handcuffed to a chair'* - Intense and overwhelming processing but contained by the end

This subtheme encapsulates participants' experiences of an EMDR trauma processing session. Participants described their experience as intense, overwhelming, physically draining and exhausting. Still, their accounts indicate this short burst of intensity worked for them as they felt contained by the end of the processing session, and they felt a difference, which made it worthwhile to go through.

Christina describes her overwhelming experience of the trauma processing session metaphorically, as being *'handcuffed to a chair'* and forced to watch

‘*a clip of film’ repeatedly without taking her* eyes off the screen, meaning she had to confront the memories by paying constant attention to them. While resisting her typical escape strategies, this and all the sensory details seem draining and challenging. However, she seems to appreciate that the intense process of repeated watching slowly improved, indicating that going through the pain to gain was worthwhile for her.

> *‘[…] You're given a clip of film, right? Which is an experience of your life. You have to press play, right? And you have to sit down, square on, in front of that screen and look at it. […]But you are forced to sit there; It's like somebody has literally got you handcuffed to a chair and you're forced to sit there with your eyes open and look at the screen. [] You can't take your eyes off the screen. So that's hard. It's really hard. But you realize that as you constantly play this thing in your head over and over again that through the therapy that is given to you, that you’re, it’s slowly, can’t explain it, like it slowly gets better.’ (Christina, page 79)*

Similarly, Annie describes the intensity as ‘*dragging up so much’* that bringing all the emotions connected to the traumatic memories to the surface was difficult. It appears that the anticipation of this intensity led her to feel anxious, requiring her to mentally prepare herself before the session. It highlights the physical and emotional intensity of the session. Despite knowing the overwhelming nature, she persevered to go through that again to *'deal with'* the difficult memories, and she felt better and calmer afterwards. These insights suggest that, for Annie, enduring this intensity was worthwhile because she believed it would be effective in the end and she would feel more contained.

'Sometimes it was difficult, very difficult. Uh. […] I would get very nervous, you know, because I knew if I had something […] I needed to deal with, I'll bring it up. I would get very nervous. Sometimes I would have like a glass of wine […] But yeah, so yeah, it could be quite intense sometimes, you know, because dragging up so much and bringing it to the whole of all the experience and the emotions that you felt about it. […]' (Annie, page 6)

' I would feel much better and much calmer after the EMDR sessions that when we had those you know, I would feel more calmer afterwards […]' (Annie, page 6)

Along with overwhelming emotions, Samina also experienced physical effects during the session, leaving her drained and exhausted, needing time to recover. She expresses the necessity for fifteen minutes to reconnect with her body and allow it to *'go back into its rhythm', indicating* the elevated physical and emotional intensity *during the process.* However, her sense of feeling grounded and noticing a change afterwards underscored its positive impact.

'[…] I definitely felt overwhelmed with emotion, I think, particularly after my EMDR sessions. I needed like maybe 15 minutes or some time to just destress after the therapy session. To kind of bring myself back into my body and feel more settled, almost because it does bring a lot up. And so it's like allowing your body to go back into its rhythm almost.' (Samina, page 44)

'[…] So, yeah, definitely feels more like something physically has happened to you, you know, you feel tired, and you feel kind of drained and exhausted, but you feel something has changed after, like grounded almost yeah.' (Samina, Page 44)

Likewise, Rhea articulates that EMDR therapy is more demanding compared to alternative therapeutic modalities, leading to heightened levels of physical and mental exhaustion. According to her, her therapist observed that she was feeling exhausted and advised her to pause EMDR during the session. This implies that the EMDR session is '*quite taxing'*, meaning it involves considerable physical and emotional strain, which requires her to show great perseverance and commitment to engage. Nevertheless, she highlights that while EMDR demands significant mental and physical effort both during and after the session to process the traumatic experiences, a substantial portion of the therapeutic process is completed in the hour-long session, indicating its effectiveness within a short time.

'I did find it quite intense. So the. I've had CBT before twice and I've had sort of general counselling before […] I found this more intense. I found it more physically and mentally draining. I feel tired by the end of the session. […] there was one time where I had some physical health problems going on […] he was kind of just like. You look, you look drained. […], not the right time to do EMDR today [..] also a lot of the work in EMDR has done in the session, whereas CBT I feel like there's a lot of homework and a lot of stuff to take away. So, it breaks it up a little bit. But kind of intensively just doing that one hour of sitting and processing things and going back

through some horrible things and you know it is quite taxing. Yeah. It's not for, you know, you have to be quite committed to get through it." (Rhea, page 66-67)

Chloe seems surprised by the degree of intensity of the EMDR processing. She recounts instances in which her therapist acknowledged the intensity of her overwhelming emotions and provided her with time to collect herself. However, despite the distress she experienced throughout the EMDR session, she emphasises that by the end of the session, she felt better, underscoring the subtheme of intense, but it pays off.

'Yeah, I had moments where I'd have to stop and I there moments when I would have to cry and just take a minute and take breathers. But my therapist, she was very good at acknowledging that she could almost tell when we may be gone a bit too far and I need a minute […]. So yeah, the intensity. I don't think I expected it to be the intensity at the beginning […] I started to really feel it by the end of it feel better,[…]'. (Chloe, Page 54)

Poppy highlights that the individual is actively engaged rather than 'just sitting down and talking'. She identifies this engagement and the *physical experiences a*s the distinctive features of EMDR that contributed to her belief in its efficacy. Poppy's statements indicate that the EMDR session was physically intense, which she believes made it effective.

'[…] it involves physical activity and it's not just sitting down and talking […] this one is actually it involves a physical element which is completely

different to all the other therapy out there to.[…], that influences my belief in that it does, it does work because you are feeling physically that you have to put your own effort into it rather than expecting a counsellor to sit down and take you through guidance of what they know, […]' (Poppy, page 31)

1.3 Face-to-face was not an option but online was worthwhile

This sub-theme captures participants' perceptions of attending online EMDR versus face-to-face therapy. Attending online was the only choice they had during the COVID-19 pandemic. Regardless of their initial preference for online or face-to-face, participants' accounts suggest that online therapy was acceptable to them, making it a worthwhile compromise. This will be further explored in the upcoming theme 3.

Poppy's statements below indicate her unhappiness about attending online therapy, as she felt she had no choice. Despite this lack of option, she seems to have reached some degree of acceptance, and her comments that it wasn't a 'deterrent' and it was 'fine' indicate that the compromise to attend online therapy turned out to be acceptable for her.

'[…] it's online..umm.. it's just something that we had to do […] so, it wasn't, there's not a deterrent and it was okay. […] So it was just something that I had to do and it's not after it wasn't whether I really liked it or not […] ' (Poppy, page 36)

Christina similarly states that online therapy was the only option available to her at the time; otherwise, she would have favoured face-to-face therapy delivery. Her quotes, however, imply that face-to-face therapy would not have altered her experience because she had a competent therapist. Her expression of a '*win-win situation'* and that she was '*lucky*' imply that her engagement in online therapy was also beneficial, despite her preference for in-person therapy, underscoring the compromise was beneficial.

> *' I could only do what we could do due to the circumstances of COVID. So that that was it really. But I would have to preferred to have done it in person.' (Christina, page 75).*

> *'[…] 'Okay, so my therapist, that I had was very good. So, because of that, it was a win-win situation for me. I think I just got very lucky. […]. I don't think it would have altered because she is so skilled at what she does.' (Christina, page 75)*

Samina's statements indicate her perceptions of online therapy as better and a good enough alternative to in-person therapy, as the therapist could be seen on the screen. However, it felt somewhat different to her compared to in-person, indicating that she would have preferred in-person therapy. The fact that she describes her online therapy experience as '*valuable*' indicates that she considered the compromise worthwhile.

> *'[…] so I much preferred it is having like a zoom. Uh, like, actually being able to seeing another person than having it on the telephone? And it felt.*

Almost how do I describe it, kinds of like a good enough equivalent like to.. in terms of like a good enough version of therapy when the pandemic was happening, if that makes sense. And so that it almost feels different to it being in person. But I still find it really valuable […]'. (Samina, Page 40)

In contrast, Rhea and Chloe seem to prefer online therapy over in-person. Rhea articulates that online therapy was equally effective. Chloe identifies a few practical difficulties associated with technical issues, but they had a negligible impact compared to its benefits. The positive experience of online EMDR is emphasised by her saying online was '*perfect*' for her, which indicates it was worthwhile.

'[…] I actually prefer it online. […].I actually quite like having it online and felt like it was it just as beneficial as if I'd done it face-to-face.' (Rhea, Page 71)

'So, this was actually perfect way for me personally. […] I think it went so much better doing it on a camera. I mean a few issues with signal as you can see sometimes have issues with my teams and stuff, but other than, fine, when it did work.' (Chloe, page 51)

When comparing her experience with in-person therapy, Annie had a perspective comparable to Chloe and Rhea's. It appears that she had a better experience with online therapy since she was not distracted, which might not be possible when sitting in a room elsewhere. This indicates that online proved to be a worthwhile experience for her.

'I found it better actually than sitting in a room somewhere and you know .. being distracted by other noises and things. And you're more comfortable and you open up more.' (Annie, Page 7)

Theme 2: Creating trust, safety and connection: The impact of therapeutic relationships in EMDR therapy

This theme provides insight into how participants experienced their relationships with their therapists and how the qualities of these relationships helped them feel a sense of trust and safety throughout their online EMDR therapy. Generally, they felt held and contained by their therapists and established a sense of connection and sensitivity to ethnicity, contributing to their therapy engagement. The essence of the theme has been described in three sub-themes which are described below:

2.1 Holding and containment by therapists provide a sense of safety and control

This subtheme encapsulates how participants found their therapist's ability to contain them. Participants reported finding their therapist to be resilient, providing a sense of holding and containment. They generally described their therapists as attentive, friendly, calm and controlled. Their accounts suggest that their therapists helped them feel a sense of connectedness and resilience, creating that sense of holding and containment, ensuring trust and safety.

Samina's statements highlight her appreciation for a therapist capable of bearing and withstanding the distress expressed during the session without becoming overwhelmed. She values a resilient therapist who could serve as a support system and maintain a balance between giving her therapeutic space while maintaining control and offering guidance throughout the process. Her statement that she wouldn't be as open or honest and as willing to share the difficult experiences shows that she had confidence in her therapist's ability to hold and contain her, signifying the trust and safety needed to open up and talk about her trauma.

> *'I think I would have been very hesitant because I have obviously a lot of experience with trauma. I'd be very hesitant bringing it to a therapist. I didn't feel like could hold that or be able to deal with it, which is the issue I had with my old therapist, who would like if I was sharing something, she would cry instead of like being present for what I need and so for me that it was really important for me to have someone who could hold the capacity of what I was sharing and be able to manage it and also to feel like there's a mutual like she can be in control or mos […] Like obviously me having control in that space, but then being able to guide me almost and support me on that journey to be kind of a wall, almost to support a support system, so definitely yeah. […] I wouldn't be as open or honest. And as willing to go into more darker or more difficult spaces or memories. Would be hesitant to, uh, which is […], putting too much on another person, almost so that was really important for me to have someone who I felt could be resilient almost.' (Samina, page 46)*

The participants also noted the therapist's reassurance and guidance. For example, Poppy's statement indicates that despite some hesitation and challenges, her therapist provided guidance and reassurance through various exercises and got her to relax and refocus in therapy. This implies the sense of feeling grounded and held in therapy, creating a sense of holding and containment.

> *'He just, just because he had to continuously, not well, wouldn't say, he reassured me… but get me back into the exercises to be relaxed and to be focused. Just all of his prompts and listen to him and do what he was saying.' (Poppy, page 32)*

Participants' accounts also highlighted an informal conversation between most participants and their therapist, which fostered a sense of connection and enhanced the therapeutic alliance. As Rhea stated, a friendly conversation regarding the therapist's daily life made it more relatable and facilitated a positive therapeutic relationship. She perceived her therapist as approachable, motivating, and relatable, reflecting a power balance in their therapeutic relationship dynamic rather than a '*paternalistic kind of relation'*. This informal 'banter' also made Rhea feel instantly connected to her therapist. Her therapist's relaxed approach seemed to create a sense of comfort, trust, and safety by holding and containing the therapeutic space.

> *'Yeah. From the very beginning, I think it helps that he was northern and kind of. Yeah, I could just relate to him because he's just, you know, tell me about his kids and all the stuff going on and, ''[…] when your therapist*

is, is relatable and, you know. It doesn't. It doesn't come across like a paternalistic kind of relationship. I find it so much better, you know, having that kind of friendly banter and that friendly conversation and you know, obviously within mean within the limit. But yeah, I just found that really from the beginning. I just kind of immediately was just like. This person's gonna be really good for me.' (Rhea, page 68)

Similarly, Chloe values her therapist's '*calm*' and '*controlled*' approach, implying she felt comfortable enough to engage in her deep personal conversation. When she described that her '*anxiety would kick in big time*', it meant that her anxiety would be out of control and that she would drop out of therapy as she previously had done. She highlights that her therapist would recognise when she felt overwhelmed, which indicates her attentiveness provided that comfort. Chloe also appreciates how her therapist navigated the balance between *taking and giving control*, which seemed to empower her and give her a sense of agency in the therapeutic process. This appears consistent with Rhea's perception of a balanced-powered dynamic in the therapeutic relationship where she felt held and contained by her therapist, as the subthemes aim to capture.

'Yeah, I know I would have just given up the therapy, to be honest. That's what I've done in the past…[…] I basically when it's so personal, there's no way I could have those conversations with someone and feel yeah, confident and calm, cos my anxiety would kick in big time. So yeah, definitely. If she wasn't the way she was, .. like calm and attentive, made feel at ease… like I said… she's kind of like take control sometimes and

give me back some control over it, which was helpful… I'd probably wouldn't finish it, to be honest.' (Chloe, page 58)

Christina's statements below indicate it was essential for her to feel a sense of safety and connection with her therapist to engage in therapy, which illuminates that she had that holding and containing space where she felt safe enough to engage.

'[…] Connection with my therapist is very important, otherwise I wouldn't have wanted to proceed. Me personally, I don't wanna do that. Because it's too it's too much. You have to make sure that you feel safe in a safe environment. The person can be very nice, but if they don't click with me, I wouldn't want to do it with them, no.' (Christina, 'page 81)

While others appreciated an informal chat, Annie says her therapist stayed focused and attentive, which she values, as it seemed she got the best out of her session. Not leaving '*on a cliff-hanger'* indicates that she felt overwhelmed during the session, and by checking in during and before ending the session, the therapist ensured her safety. This underscores her feeling held, contained, and safe by her therapist.

'She didn't drift off or start talking about her own shopping list or anything. You know what I mean? She was very focused and the and the sessions were put together nicely like, you know. And so it we got everything, everything done, you know, in those sessions […] and she didn't leave

you at the end of the session like you're on a cliff-hanger, you know. It was nice that it she closed off properly […]' (Annie, page 7-8)

2.2 Sensitivity to culture and ethnicity increased connectedness

This subtheme captures how participants experienced therapists' understanding and sensitivity towards issues relating to their ethnicity or culture. Some participants, including Samina and Christina, emphasised that having a therapist from an ethnic minority helped them have a deeper level of connection with them. However, participants' experiences show that their therapist's understanding and sensitivity to cultural issues helped them establish a deeper level of connection and openness with their therapists, thus contributing to trust and safety in the therapeutic relationship.

Samina appreciates that her therapist was a '*person of colour*' and was able to inherently recognise cultural and racial issues without needing to explain or prompt. In this context, she gives an example of '*white guilt'*, a term that refers to the feelings of guilt some white people may experience when confronted with the consequences of racism and racial injustice. When she says that her therapist was '*attuned to that experience*', it seems to mean that her therapist was sensitive and responsive to the complexity and nuances of Samina's racial experience. This underscores a deeper and more nuanced relationship between her and her therapist, increasing that sense of safety, trust, and connection. Her statements also highlight that it is essential that her therapist understand racial and cultural issues, as well as generational and intergenerational issues that impact their clients, further implying the importance of a therapist's cultural competence.

'[…] without me having to say it, which was really important for me to have that recognition like saying ohh you know, ohh that's their white guilt coming up or something like that. So, she's attuned to that experience. Definitely. Yeah. I didn't ever have to explain things, which I think would be my main concern if I didn't have a person of colours of therapist.' *(Samina, page 47)*

'This is their cultural, intercultural way of doing EMDR. […], I was talking about my medical experience with trauma, part of that is also the experience of medical racism, which is part of intergenerational trauma, so interwinds together. Uh, so I think it would be really important for me to have a therapist who not only understands about, like, racism and the experience of being an ethnic the generational impact of that on me as a person of colour too.' (Samina, page 48)

Christina echoes similar experiences with her therapist. When she says, '*that would have eaten in with my hour*', she illuminates that having a therapist from a comparable background who had a shared understanding of her trauma recognised certain ethnic nuances and variations and her trauma without explaining it and connecting deeper. She further emphasises that if trauma is linked to race or culture, the therapist must be from an ethnic minority to understand the intricacies fully, indicating the significance of understanding the generational and intergenerational impact of trauma. This signifies that cultural sensitivity and understanding facilitated a deeper connection and a good therapeutic relationship.

‘There’s certain things that they would not have been able to understand culture-wise. The therapist I had, she had this understanding of my trauma, because of her background. I mean, don't get me wrong, I could have tried to explain and then I would have had to sit there explaining. I don’t know how much that time that would have eaten in with my hour which is limited time already within regards to the therapy to help them to understand and hoping that they would understand that certain things. So I, I do think it would have made a difference if she was, if she or he was white.’ (Christina, page 83)

‘So, if it is connected in the person's therapy, if it is needed, if there is a relation to ethnicity, with regards to their trauma, whether it's racism or whether it's just a better understanding of culture, then that person will have to be of an ethnic minority to be able to help with the healing of the individual that is seeking the therapy I think it is a must, a must. It's imperative.’ (Christina, Page 83)

Rhea and Annie report that although their therapists were white, they felt understood by them; for example, Annie states that she was not expecting her therapist to understand some of her cultural issues. However, she stresses twice that she understood her, underscoring that regardless of their ethnic background, her therapist showed her understanding and sensitivity, thus increasing the sense of connectedness and trust in her.

‘[…].Also being you know, because me being from a minority background, you know, I wasn't sure she would understand some of the things you

know, but she seemed to understand it. She seemed to understand it. [..], [..] and then I trusted her.' (Annie, page 9)

It appears from Rhea's statement that unlike some of her previous experiences with white therapists, who might have appeared out of touch or made it clear they did not understand her perspective, her experience with this therapist was different. She values her therapist's knowledge, openness, and willingness to listen and learn, even though they didn't have a shared experience. This implies that genuine curiosity and sensitivity to cultural issues and nuances led her to have more trust and a deeper connection with them, thus forming a good therapeutic relationship.

'[…] he's actually very knowledgeable about things and yeah, it didn't feel like, you know, you probably have had this experience multiple times, but you speak to a white person about something and you just kind of get that feeling that they have no idea what you're talking about. […] He was very understanding, very open and. Yeah, just very willing to learn from me as well. In terms of my issues, in terms like being from an ethnic background and I think that's what made it such a nice relationship is that he was always willing to kind of understand my side of things and listen to me as well as kind of teaching me and helping me.' (Rhea, page 70)

According to Chloe's account, she and her white therapist had a positive therapeutic relationship. However, the therapist appeared to have been unable to completely understand her unique cultural dynamics relating to her rigid upbringing. She said she wished she had a therapist who could relate to and

understand those challenges more deeply, indicating that a sense of trust and connection could have been formed better and deeper if her therapist had a better understanding and approached them in a culturally sensitive way.

> *'[…] I mean, in terms of culture as well in the way I was brought up. Now you're saying I do have memory of, not disagreement, but I don't. Again, I don't think she related to how I was brought up in a such a strict household. And for my father's point of view being black Caribbean, how harsh they can raise their children, I think there was a bit of a not disagreement, but she just didn't quite understand where I was coming from in terms of my mentality of how I've been brought up in that way. So in hindsight, I think it would be quite important if you could get a therapist that can relate on that kind of level, I guess, yeah.' (Chloe, page 59)*

2.3 Therapists' attunement was present even through the screen

This subtheme encapsulates how the participants experienced their therapist online and how their sense of attunement with their therapist contributed to their trust, safety, and connections even through the screen. From their accounts, participants seemed to have a high level of attunement, contributing to their sense of safety and connection and, thus, to a good therapeutic relationship even online.

Samina articulates that she found her therapist grounded and attuned; they could notice the verbal and non-verbal nuances even though it was online. Her expression '*couldn't be more attuned'* indicates a high level of attunement with her therapist that would not change if it were face-to-face. Her additional

emphasis on possibly finding it harder if it were a different therapist suggests that the sense of attunement facilitated overcoming the potential online block, contributing to trust and safety.

> *'It feels really kind of a grounding and very attuned. I think in general I would have with a different therapist. I would have found it very difficult to have just done online therapy only, but because she's very good at reading, almost noticing the difference in my body language or my tone of voice and things like that, she's able to pick up things that you would normally be able to pick up in the room. Almost. But I think it would be harder to do that online for most people, yeah.' (Samina, page 49)*

Rhea also reports a similar experience with her therapist being with her throughout the process and being able to recognise her distress through the screen, indicating a positive therapeutic relationship on the screen.

> *'I did feel like he was there with me throughout the whole process. You know, he could see if I was getting upset. You know, he would say encouraging things as I was. You know, if I was getting upset.' (Rhea, Page 71)*

Similarly, Christina emphasises the importance of that sense of connection and attunement in her statement. She says the therapist had a great presence, as she knew how to work and connect through the screen, underscoring the essence of the theme.

‘When I say great presence, to be able to help, to be able to know how to work through the screen because if they don't there's no point […] she had great presence so that’s the reason. When I say great presence, she was able to, we were able to have that connection through the screen.’ (Christina, page, 81)

Annie's description of her non-clinical setting, sitting with a cup of tea to attend therapy, indicates that she feels comfortable and relaxed enough to engage in the session. This could mean that she feels closer, warmer, and more open in her interactions with her therapist, as opposed to feeling an impersonal or closed relationship, as a '*clinical*' setting might indicate. Her statements imply that she could focus and engage in an informal conversation without distractions, giving her better attunement, a sense of connection, and a better therapeutic experience even on the screen.

‘You know, be calm and sit and talk and have a have my cup of tea and you know and. And it was. Uh, not so clinical. If if you like, it felt better because it wasn't so clinical, which helped with the relationship and. Yeah.[…]’ Annie, Page, 12)

‘’You know, so she and there was no distractions or anything like that. So it was very easy to talk to her on the on screen. Yeah […]’’ (Annie, Page, 12)

Chloe expresses that she feels uncomfortable during video calls, but her therapist has created a safe space for her by minimising her anxiety and taking steps to

ensure her privacy. The therapist noticing her anxiety and putting effort into making her feel comfortable might have contributed to a sense of closeness and connection with her therapist, indicating therapeutic attunement and a good therapeutic relationship even on the screen.

> *' […] I don't really like video calls usually. So, it was gonna be a little bit of anxiety of being on the camera, but she was fine. She would sit somewhere quiet and it would just be her. I wouldn't see anything else. She'd made sure that I wouldn't see like anything back. I would feel like it was just me and her. And I found that was fine.' (Chloe, page 60)*

Theme 3: '*In my own space'*: The safety, comfort and convenience of online EMDR Therapy

This theme represents participants' perceptions of their experience of attending EMDR therapy. Participants described their online therapy experience as positive and beneficial. They generally described their experience of attending EMDR therapy online as '*comfortable*', '*safe*', and '*convenient*', enhancing their experience positively. The following section presents the theme as two sub-themes:

3.1 A safe and comfortable environment ensures feeling at ease in therapy

This subtheme captures how online attendance contributed to a positive therapy experience. Participants' accounts show that they found online therapy

attendance comfortable and safe. Most participants described feeling safe, comfortable, and easier to talk to as they were in their own environment.

Samina articulates that attending online sessions afforded her a sense of safety and enhanced bodily control. Her statements indicate that being in her environment alleviated her anxiety associated with visiting the therapist's office, providing her with a sense of comfort, safety, and control, which underscores the essence of this subtheme.

> *'I think the benefit for me of it being online was that it's me having control over my body almost as opposed to a therapist. There's an element of safety. Then it's about your in your own space. You're in your own home. You're the one making the movement or the changes that are happening.' (Samina, page 41)*

Similarly, Rhea expresses a positive attitude towards online therapy, emphasising her appreciation by describing it as useful. She expresses that she felt more comfortable and less hesitant when attending online EMDR from her own space, in contrast to the office environment, which she believed would induce discomfort. This again indicates the increased sense of safety and comfort that comes with attending online therapy.

> *'[…] having the feature of being able to do video chat really works really well because you know, I actually felt more comfortable being in my own environment doing it. Whereas if I was going to an office or something, I*

think I would feel a lot more sort of hesitant and a bit more uncomfortable […] I found it really useful […]' (Rhea, page 67)

Annie expressed comparable sentiments and elaborated, stating that she found therapy at home more comforting than just sitting in an empty room in the therapist's office. It seems that attending online had reduced her anxiety, and she felt safe and in control of her thoughts and feelings, enabling her to talk more openly, implying an enhanced therapy experience.

'[…] You're not just sitting in an empty room. You know type of thing and it was a lot easier for me to talk. Because of my anxiety issues, and think about something and talk about it…I felt more comfortable doing that from home because of my anxiety.' (Annie, Page, 12)

Chloe echoed a similar sentiment. Her statements below indicate increased comfort as online attendance reduced her anxiety about attending in person.

'[…] from my experience, the anxiety of going to meet to go and do this was the problem. So being at home and just being able to put on the laptop, dial in and have the session and then be in my own house after to kind of wind down and chill out and stuff was a lot more comfortable for me […] I think it was better for me doing it remotely.' (Chloe, 61)

Poppy also expresses her views that attending from her own environment is more comfortable and safer in some respects than being physically in the therapist's environment, indicating the same safety and comfort that others have indicated.

'It's safer in some aspect. Do something online because you're not physically in the environment of that person, maybe[…]' (Poppy, page 36)

'*it felt safe. It felt comfortable*.' *(Poppy, page 36)*

3.2 Spares *'the nightmares'*: Convenience and accessibility of online therapy

The subtheme encapsulates participants' perception of their online attendance as convenient. Participants reported that attending therapy online was convenient in many ways. It, like Samina, saved her travel time and money.

For Samina, attending therapy online was convenient. She highlights some benefits of attending online, such as finding therapists, travel time, and cost. The tone of her statements implies that these factors could be stressful and be the reasons for potential hindrances to attending therapy. Her sentiments indicate that online therapy is convenient and enhances the therapy experience.

'[…], the convenience of having it online is better for me, because it means I don't then don't have to, you know spend extra £10 commute into central London, find therapists, all of that adds up and up in time. I think that's why it's more convenient for me to do online' (Samina, Page 40)

For Rhea, it seems that going online increased her opportunity to access a good therapist regardless of geographical location, which otherwise might not be possible, indicating convenience.

> *'I don't think I would have been able to meet my therapist or work with my therapist because he was based in Manchester. So the fact that I could do it online and benefit from such a good therapist and from, you know, EMDR with him. I just think that without online, I wouldn't have been able to do that.' (Rhea, page 71)*

Furthermore, participants report that online therapy reduces the complexity resulting from their anxiety or depression. For example, for Chloe, it seems that online attendance made a significant difference, as she felt that her anxiety would have affected her engagement in therapy if she were to commute for in-person therapy. Her statements underscore that online therapy increases access and attendance at therapy, compounding the convenience.

> *'Yeah, I think doing online again for me, for the comfortability side of it just made a hell of a difference. I like I said, I'm not sure how I would have dealt with it having to go a commute and do face to face. I couldn't say that now, but for my experience I've not enjoyed that. So doing it remotely was perfectly fine for me and quite comfortable.' (Chloe, page 61)*

Annie also echoes the convenience and importance of online therapy attendance. Her describing it as a '*nightmare'* indicates a high level of stress associated with attending in person. She asserts that the option of not going anywhere, meaning

attending online, reduced her anxiety and minimised the risk of non-attendance, which could be associated with her mood's unpredictability. This highlights that online attendance increased by minimising anxiety and stress, as it was more convenient.

> *'It would have been a nightmare […] And allowed me to do those sessions and finish those sessions without my anxiety getting in the way too much. Whereas I would have like as the run up to the appointment happened, I would have worked myself up into a bit of a tizzy and then it. I don't think I would have carried out every session I think only missed one session and I can't remember what it was. […].[…] you know anxiety and depression. Depression can be a big one because you don't might not want to you know you don't know what the mood's gonna take you when you wake up. If you. If you're gonna even wanna go and attend this appointment and everything. So access online made it so much easier. I mean, that was one of the first questions asked yourself, isn't it? Will I have to go anywhere for? Because if I had to you, I would have probably ducked out of it, you know?' (Annie, Page 12)*

Theme 4: Healing Through the Journey of EMDR: preferences, challenges, grounding, and transformation

The first theme underscores the participants' initial scepticism about initiating EMDR therapy. This theme accounts for the participants' journey through their online EMDR therapy and how they embraced the uncertainty despite their initial scepticism. It captures their experiences with the various EMDR processes they

underwent during the journey. Most participants described their preferred form of BLS Butterfly Hugs (BH). They also expressed confusion about some processes with intangible effects, while others, particularly stabilising strategies, had a more tangible impact. It also encapsulates the therapeutic transformation they achieved as their online EMDR therapy journey progressed despite their doubts and confusion. This shows the power of healing beyond a clear understanding of the processes. The theme is divided into four sub-themes, which are presented below:

4.1 The preferred form of BLS: Butterfly hugs or eye movement

This subtheme describes the type of BLS used in therapy and their preferences. Participants used a mixture of BLS, such as tapping on their thighs, eye movement (EM), and butterfly hugs (BH). Most participants preferred butterfly hugs over other BLS methods. They described BH as easier and more grounded, giving them some control over their focus and attention. While one preferred EM over BH, others who used it expressed no preference.

Annie's description indicates that her therapist introduced eye movement by using a pen with auditory sounds. However, she continued with the BH. There seems to be an emphasis on the *'eyes closed'* when she expressed her engagement with the butterfly hugs, which helped her focus, indicating her preference for BH over other forms of BLS.

'[…] she would keep holding of a pen, make noise and light it with the click noise and move it. And I would be doing like this (the butterfly hugs) […].' (Annie, page 4)

'Not, not just the tapping and eyes closed and focused, yeah. Umm... I felt focused with it.' (Annie, page 4)

Chloe expresses similar views on the BLS. She seems to have tried using another tapping method on her thighs, similar to the BLS, but was unable to establish a connection. Instead, she found that the BH method was much easier and more comfortable and gave her greater control over her attention. She says she mostly did it with closed eyes, which seemed more effective. Chole's statements underscore her preference for using BH as BLS.

'[…] but I couldn't quite get a connection with. I actually found it better doing like this. I felt more comfortable and used more than just by tapping. Umm. And we did it, but I can't remember now. I think I did close my eyes most of the time, which worked better for me[...]' (Chloe, Page 53)

'[…] And it and a lot easier, ……..., just kind of gets my attention a bit more and made me focus. And I feel like more controlled the tapping that way. So I just preferred.' (Chloe, page 53)

Samina's description indicates that she also used both EM and BH but preferred BH. She describes her experience with BH as grounding and comforting, almost

like self-soothing and holding, thereby justifying her preference for BH over other BLS.

> *'I used both eye moving and this tapping. For me, I preferred the butterfly tapping...Uh, I think for me that felt more grounding. It felt almost like holding I really liked that' (Samina, page 41)*

Reah mentions that although her therapist suggested combining tapping with EM, she struggled; they ended up using only butterfly hugs. Despite having the option to use different BLS, Reah continued to use butterfly hugs, indicating her preference for them.

> *'So we used tapping (showed butterfly hugs) in therapy, but then he did say I didn't remember my therapist mentioning that if I was struggling with the tapping or feel like I needed to add another dimension, I could do the eye movements as well. And so I remember him mentioning that, but we didn't actually use the eye movement in the end. We did it with tapping. That's good.' (Rhea, page 64)*

Christina seems to recall engaging with the EM as '*movement of the fingers'*. Her description indicates that both EM and the BH were used. Her statements do not specify her preference. However, she said sometimes she used the 'other one' referring to the BH, which indicates that the primary use of BLS was EM, which seemed to have worked for her.

'The movement of the fingers from left to right. But yes, sometimes the other one, the tapping your hands across the body and, you know, tapping the shoulders.[…]' (Christina, Page 76)

In contrast to the others, Poppy says she preferred BLS eye movement and avoided butterfly hugs because they involved bodily contact, which she found uncomfortable and wanted to avoid.

'He tried to get me to use tapping, but I did prefer to use the dot. I didn't want to have bodily contact.' (Poppy, page 18) 'I just didn't like it. I just felt uncomfortable' (Poppy, page 19)

4.2 **Navigating through the confusing and challenging process of EMDR**

This subtheme captures participants' experiences with some processes that they found confusing and challenging. Most participants expressed confusion and difficulties regarding the processes, including identifying the belief process and understanding how the overall EMDR process functions; however, they found the process effective. However, it appears that as the therapy progressed, it became easier for them, potentially contributing to their healing process.

Rhea encountered difficulty in identifying her negative beliefs. It seems to be challenging for her to recognise the impact her trauma memories have had on her self-esteem and confidence. However, through her therapist's support, guidance, and repetition, she became better at identifying and making these

connections. This indicates a gradual improvement despite the initial confusion and challenge.

> *'I found that bit quite difficult actually […] That we did identify, it was like, oh, yeah, that's why it's had such an impact on me and my self-esteem and my confidence.[…] I did need a bit of guidance with that because I didn't really link the two together. But once we did it the first few times, I did get a bit better at it.' (Rhea, Page 65)*

When asked about identifying the negative beliefs, Chloe recalls that it was simpler to recognise them because they were prominent. However, she describes encountering difficulties when identifying the positive beliefs about herself that would help her get those negative beliefs. She needed prompting to recognise and articulate these positive beliefs, a sign of progress despite the associated challenges.

> *'It was quite easy to quite a few of them in my head already. That was the main thing is kind of getting them out because I'd already had them in my mind.' (Chloe, page 53) […]*

> *'I found that quite difficult actually, just because I'm not very good at identifying positive beliefs about myself, just because I am so …I would struggle to kind of kind of express those things she would have to kind of prompt me a lot a […].' (Chloe, page 54)*

Samina's statements indicate her confusion about the therapeutic focus. She described it as confusing to engage with the '*special place'* exercise as opposed to focussing on the traumatic memories and experiences that she needs to work on. However, she says when she understood its reason, she grasped the idea, and it worked. When she says that, generally, the actual process works, she underscores that as therapy progressed, she began to understand the rationale for the procedure and felt the overall therapy worked despite this initial challenge.

> *'I'm at first I think I felt a bit confused because we're kind of focusing on building up. I think, like my grandmother's house and the structure of that memory as a I think a grounding place or special place or something. Yeah. So I felt a bit confused because I was like, but actually I wanna be doing focusing on these memories and these experiences. But then once I got into it, understood why that was needed […]. But in general, I think the actual processes. No, I think it works well.' (Samina, Page 44)*

Christina states that identifying target memory was usually okay, but sometimes it was challenging to articulate the specifics of determining the focus of the therapy session. However, the therapist would direct her to engage in mental replaying and visualisation of the trauma. However, despite her incomplete comprehension of the EMDR procedure, she perceived it as an essential component of her positive journey to recovery, underscoring the theme that, despite the initial struggle and confusion, as therapy progressed, she started to make a connection with it.

'If I remember correctly, and so I would select, because it was all about trauma for me. So I'd select a specific part of my life which I believe was trauma for me, So, I would explain it, but there're times I wouldn't able to explain the actual detail of it, she would tell me to think about it, visualize it and play it in my mind, which was really hard.' (Christina, page 77)

'So she would tell me to visualize it and that's when she. ..So, you asked me about how to identify with it. So, I first struggled because I didn't understand why I had to do this following finger thing.' (Christina, Page 77)

Poppy appears confounded due to her complicated experience with the EMDR process. She poses a question that seems to be a concern or curiosity, seeking a more explicit explanation of how the EMDR mechanism helps with trauma. Her interest in the underlying process of the EMDR suggests that she was uncertain and unable to understand how it worked; however, it worked for her to some extent in '*getting rid of some stuff*', even without her knowing explicitly what and why it worked for her. This underscores the progress despite the confusion.

'[…] That when we were going through the process. It came to me, you know that. The thing is, what I didn't understand how he is supposed to see the actual evidence. The difficulty I had was this. How does the actual effect of that dot result in overcoming the trauma, because I was able to get rid of a certain thing, but he said it wasn't through the EDMR, but it wouldn't have been. I wouldn't have been able to get rid of it if I hadn't had that session.' (Poppy, page 29)

4.3 The tangible processes: Grounding facilitates change

This subtheme describes how participants perceived and understood elements of the EMDR processes contributing to the therapeutic change. Most deemed the grounding and stabilising strategies, such as body scanning, beneficial because they facilitated a sense of reorientation.

Rhea's encounter with the body scan illuminates the dynamic relationship between the emotional state and physical manifestations. She states that it led her to feel relief, and she felt physically lighter. Her statement about the 'positive affirmation' indicates that she also found the positive belief installation phase positive. Her experience appears to have brought her a deep sense of relief, mentally and physically freeing her.

> *'Yeah […] so yeah, the body scanning was definitely useful and feeling like that I'd released by the end of the session as well. I felt like that was really useful to kind of see that physical difference, not only the sort of mental difference and the and, like, sort of feeling lighter mentally as well […] And then the positive affirmation or the positive belief. He would do a lot of work for me to affirm that and tap that in to really ingraining that into me, which I feel really helped definitely.' (Rhea, page 66).*

Samina also echoed her experience of refocusing on the present moment and the necessity of reorientation both during and after the processing of trauma to maintain safety and navigate between states of arousal and calm. It looks like the combination of trauma processing and body-focused strategies to deal with bodily

sensations and emotions helped her have a positive experience. She also described finding the special place as nurturing and holding, indicating a sense of feeling grounded and reoriented.

> *'[…] Yeah, definitely. […] it was after we kind of go through that negative memory process every single time, we would always have like a body scan or something around reconnecting my body back into present to bring myself out to like grounding with my feet backwards and forwards or holding my body in different ways. […] she would always do things around and then getting me to reengage with my senses in the here and now […]' (Samina, page 43)*

> '*I found the kind of initial step of building the special place really beneficial and nurturing and holding.' (Samina, page 45)*

Similarly, Chole highlights the frequent implementation of grounding strategies, including counting down and breathing, indicating the necessity of returning to the present and *feeling grounded.*

> *'I can remember she got me to do the count the numbers so the colours so like count for count 3, count 2, count one. That would make me look around and come back to present which definitely helped.[…] to bring you back into the room[…]' (Chloe, page 53)*

Poppy, like others, also expresses appreciation for the grounding strategies implemented at the beginning and closure of the session, specifically the positive visualisation and meditation exercises.

> *'[…] Pleasant that he said to picture something really positive and really beautiful and think about that and do your breathing exercises….. Meditate on that for about 15 minutes and then leave with that […]' (Poppy, page 35)*

Annie's statement indicates a similar expression of reorientation experience, as she said she was nicely brought back to the earth.

> *'[…] She was finished it off like that, so I was always brought back to the earth nicely.' (Annie, page 6)*

4.4 '*No longer handcuffed*': Emotional freedom and transformation of mindset

This sub-theme encapsulates how the participants experienced the therapeutic changes that resulted from attending online EMDR therapy. Participants reported a positive transformation as they underwent EMDR therapy online for their traumatic experience. Their statements reflect emotional freedom from trauma and a sense of empowerment, fostering self-confidence and self-belief as their mindset changes.

Christina expresses that attending therapy enabled her to no longer experience negative emotions associated with the memories as intensely distressing, thereby signifying her trauma memory not being painful for her anymore. Her metaphorical description of the release from the feeling of being '*handcuffed*' symbolises the transformation from emotional restraint to emotional freedom resulting from the therapy.

> *'You no longer feel forced. You no longer feel that you're, you're. You know, you've got handcuffs on attached to the seat to watch this film. You feel as though you can freely just sit there and watch it and it wouldn't affect you the same way as it did before.' (Christina, page 79)*

Annie mirrored comparable experiences regarding the alleviation of distressing emotions and traumatic responses, including overwhelming emotions such as anger. It seems that therapy has not only mitigated and retreated the effects of the issues she has confronted, such as flashbacks, but also somehow changed her mindset. She seems to reflect on the positive impact of the therapy, indicating a sense of relief and emotional freedom from the trauma.

> *'So we worked on lots of things throughout the sessions, but. And come by the end of them, you know, my mindset had changed a lot in that. I don't get so worked up about stuff now you know, if I do have a flashback of sort. Ohh so think it through but I just it doesn't affect me anymore as badly as what it did at the beginning. Where I would get very upset and very angry sometimes about things that had happened to me, but It's just like*

all that stuff gone back now a bit. You know, I just. Ohh, it's gone.' (Annie, page 10-11).

Samina expresses her surprise at this result while reiterating the beneficial effects of EMDR therapy and describing it as valuable. However, her statement, '*how much of it could have...*', suggests that she doubted how much benefit resulted from the EMDR. She states it helped her recover from a prolonged state of distress and mitigate her stress, burnout, anxiety, confidence, and medical trauma. Her description of the positive changes underscores the positive impact of EMDR, which goes beyond addressing the trauma memories to stress and anxiety.

'I found that, […], so beneficial. I literally I came to my therapist, having and like a massive amount of anxiety every single time it was about to have a meeting […] I really had concerns about like impostor syndrome and things like that, which weren't even really to do with my traumatic memories. But I think they were in my body anyway because of that. I'm like level of anxiety being caused by my pre-existing trauma. […] So yes, incredibly beneficial. I don't think I expected it to be that beneficial. Actually, I do wonder about this a little bit about how much of it could have to do with EMDR. Umm. And then what else? […] medical trauma […] I don't have any issues now with vaccines or get my blood taken […].' (Samina, page 45)

Although Poppy seems ambivalent about how she experienced the impact of the EMDR therapy, her statement about her '*contemplation on continuing'* treatment indicates some positive effects of the therapy from her traumatic experience.

> *'Yeah, it works. There was a couple of things that we've gotten rid of, which was why. I would have contemplated continuing.' (Poppy, page 21)*

Chloe reports a substantial increase in her self-esteem and personal development, even though it initially seemed '*insane*' and has not completely transformed her. A sense of empowerment appears in her claim of owning the contribution to the change in her expression of *'it was me that did it'*. This seems to give her confidence in her ability to confront comparable challenges in the future, which implies a sense of empowerment and emotional relief as she feels more in control over her traumatic thoughts and memories.

> *'Yes, I mean, I don't think it's changed completely […] but it definitely helped put some self-confidence back into myself again, maybe because I was in control of those thoughts and those memories, I was able to change that. She helped me change, but really it was me that did it. […] I definitely have come out the other side feeling a lot more confident in myself, and my self-esteem is built up and just I have more belief in myself that I can actually get through these things when it happens again. […] Yeah.' (Chloe, page 62)*

Rhea expresses comparable views regarding the advantages of EMDR, stating that in addition to aiding in the processing of distressing memories, it has also

equipped her with physical and emotional relief and positive self-beliefs. From her description of the processing of trauma memories, it appears that Rhea had a transformative experience with EMDR therapy; it not only processed her trauma memories but also changed her self-perception and empowered her.

> *'So obviously at the beginning you think about target memory, you'd go back to kind of reliving that or watching it through as if, like a video. And then by the end of it, I'd be telling myself that I'm strong, that I'm capable, that I'm, you know, worthy, you know, all these really positive things" […] it really helped because not only have I processed the memories, but I've also processed the way that I was feeling about myself.'(Rhea, page 66)*

4.3 Analysis Summary

Overall, this chapter presented the four group experiential themes from the IPA and supporting extracts from participants. The first theme revealed that despite their initial doubts, such as the strangeness of the BLS and their unfamiliarity with EMDR therapy, they took a leap of faith and gave it a go. Regardless of their preference, online worked fine for them, and they went through that intense therapy process online, which proved to be a worthwhile compromise.

The second theme highlighted that the quality of the quality of the therapeutic relationship contributed to their overall sense of safety and trust, thus positively impacting the therapeutic process. They found their therapists could hold and contain them in distress, making them feel safe. They also found that an informal chat with their therapists made them more relatable and created a balanced

therapeutic relationship. Therapists' understanding and sensitivity to issues related to their culture and ethnicity helped them establish a deeper sense of connection. Additionally, they felt high attunement with their therapists on the screen.

The third theme showed an overall positive experience for the participants who attended therapy online. Most participants described having therapy in their environment as comfortable and safe, as that reduced their anxiety, increased their sense of control and safety, and allowed them to be open. They also found online therapy convenient, contributing to increased access, attendance, and engagement in therapy.

The final theme highlighted participants' confusion and challenges over various processes or steps of EMDR, such as identifying negative and positive beliefs. However, they generally felt positive by the end of the session. It also highlights that they found the grounding and stabilising exercises nurturing and holding. Despite the confusion, participants articulated the transformative therapeutic breakthrough; the therapy not only helped them with addressing their traumatic memory, but it also provided a sense of empowerment as their mindset changed. This indicates that healing is beyond understanding; one does not need to understand the healing process.

Chapter 5: Discussion

5.1 Introduction

This chapter summarises and evaluates the research findings, referencing the literature reviews and aligning them with the research questions and aims. It then focuses on reflexivity concerning the research limitations. Subsequently, it considers the practice implications for therapists and the broader mental health systems, providing recommendations for future research, particularly focusing on ethnic minority studies in EMDR psychotherapy. Finally, the thesis concludes with a summary.

5.2 Theme 1: '*Wagging a finger on screen'* – The online EMDR therapy is a compromise that pays off

The theme encapsulates the participants' reservations, scepticism, and ambiguities regarding commencing EMDR therapy online. Despite their uncertainty, they engaged in the intense therapy process, which proved to be beneficial.

The uncertainties stem from unfamiliarity with EMDR therapy and its BLS method. Participants' apprehension and scepticism align with prior research (Marich, 2009; Marich, 2010; Marich et al., 2021), which noted similar concerns, including apprehension about potential control by their treatment institution. Previous studies (van den Hout & Engelhard, 2012; Shipley et al., 2022; Every-Palmer et al., 2023) confirm the perceived strangeness of BLS. Participants labelled BLS

as quackery, a gimmick, and confusing (Marsden et al., 2018; Brotherton, 2009; Naccarato, 2008). Brotherton (2009) also highlighted uncertainties about EM's function, which were echoed by participants in this study. The unfamiliarity with EMDR therapy observed in this study aligns with previous research (Every-Palmer et al., 2023; Terrier et al., 2006). In the Terrier et al. (2006) study, among fourteen PTSD therapies, EMDR was found to be the lowest-ranked therapy choice among university students. Increasing the implementation of EMDR in public services, such as NHS England, could improve familiarity and reduce scepticism.

Despite their reservations, participants adopted a *'nothing to lo*se' and *'worth a try'* attitude, viewing EMDR as a last hope after unsuccessful attempts with other therapies, consistent with previous findings (Every-Palmer et al., 2023; Shipley et al., 2022). Additional reasons included the evidence base of EMDR, trust and connection with therapists, therapist skillfulness, information provided by therapists, and their research on EMDR. Similarly, Marich (2012) suggested that psychoeducation on EMDR can increase client comfort but cautioned against excessive information, which may seem coercive and controlling to trauma survivors.

This study found that individuals' unwillingness to discuss trauma influenced their decision to commence EMDR. The reassurance of the therapy's *'no talking'* approach appears to be this study's unique and intriguing finding. As mentioned in Chapter 2, EMDR aims to activate dysfunctionally stored memories and process them while interacting with the BLS with minimal verbal expression, allowing clients to choose whether to talk. The modified EMDR Blind to Therapist

protocol (B2T) supports this *'no-talk'* approach (Blore & Holmshaw, 2009). Clients do not need to share specific memories or traumatic content, focusing instead on emotional and bodily impacts. Shapiro (2001) advised that if a client refuses to focus on memories, therapists should reassure them that processing occurs internally, even without disclosing specific information. B2T is useful for clients struggling to express trauma or facing cultural and language barriers.

Participants found EMDR therapy intense and overwhelming, highlighting the significance of the emotional and physical demands of EMDR and emphasising the need for post-session time to destress and reconnect. Every-Palmer et al. (2023) noted similar experiences. In this study, the physical intensity was seen as a unique feature of EMDR, requiring active client engagement and contributing to perceptions of its effectiveness. However, it has been articulated that the intensity was short burst, with effects faster than other therapies like CBT, leaving participants feeling contained without needing further homework. This supports Spector's (2007) findings that EMDR works through free association after a short burst of trauma exposure, unlike TF-CBT, which requires prolonged in-session and out-of-session work. This study's participants' lived experiences supported the prior debate discussed in the literature review that EMDR is not an exposure therapy. Feeling contained quickly after the short bursts of distress supports the effectiveness of single-session EMDR. Modified EMDR protocols like R-TEP (Shapiro & Laub, 2014), IGTP (Artigas et al., 2009) and G-TEP (Shapiro, 2013) support this model, which is beneficial during therapist shortages (Mbazzi et al., 2021; Kane et al., 2016), trust issues (Nickerson, 2017), or as a cost-effective strategy.

Only online therapy was available during COVID-19. Thus, participants felt they had no choice. Few participants preferred online therapy, while most preferred face-to-face therapy. They reported feeling anxious and uncomfortable initially; however, later, they found it worked for them and recommended it to others. Similarly, in Bursnall et al.'s (2022) study, participants had comparable initial experiences and became comfortable later and passionate about promoting online EMDR. Online experiences will be covered later in theme three.

The overall findings of this theme suggest that participants initially expressed reservation and apprehension towards EMDR therapy and did not believe that it would work. Online therapy was the only choice at the time. Multiple factors contributed to them commencing therapy; particularly, their previous therapies did not work. The therapy was physically and emotionally draining, but after going through that '*short burst'* of intensity, they felt contained, and it seemed to work more efficiently within the session. This shows that it was a compromise that paid off better than expected.

5.3 Theme 2: Creating trust, safety and connection: Therapeutic relationships contribute positively to EMDR therapy

This theme illuminates the dynamic of the therapeutic relationship between the participants and their therapists, contributing to their sense of safety and trust in the therapeutic process.

Participants reported that their therapist's ability to contain their overwhelming distress and maintain a composed, motivating approach facilitated comfort and

encouraged disclosure of profound traumatic experiences. This non-hierarchical TR dynamic enhanced safety and confidence, supporting continued engagement in therapy. Similarly, clients perceived solid connections with their therapist (Naccarato, 2008) and regarded therapist trust as vital for addressing complex issues (Schleyer, 1999; Shipley et al., 2022). Positive TR was associated with developing a sense of safety and trust, which were crucial to the overall success of EMDR therapy (Wise & Marich, 2016).

This view contrasts with the study by Edmond et al. (2004), which found no evidence that TR contributed to the positive outcome of EMDR therapy and suggested that TR is inherent in EMDR psychotherapy. However, in their study, participants reported their views on EMDR, as it focused on clients' perceptions of therapeutic effectiveness rather than the TR. Shapiro (2001) and Shapiro and Laliotis (2015) argue that an adaptive memory network includes the therapeutic connection, emphasising EMDR as client-centred. Therapists must prepare clients to facilitate learning, considering their needs when activating information processing systems (Shapiro & Solomon, 2017). The quality of TR influences change in clients with complex PTSD (Pearlman et al., 2005; Fosha, 2000), who suffered severe abuse and relationship breakdowns and attachments and need repairing relationship experiences (Meichenbaum, 2014; Parnell, 2013). Positive interactions within the therapeutic relationship contribute to an individual's adaptive memory network and can be enhanced through EMDR (Shapiro, 2018). Clinicians must be attuned to momentary changes, actively participate, provide brief affirmations, facilitate emotional processing, ensure security, and serve as a resource during the resource installation phase (Hase & Brisch, 2022).

Participants' overall experiences in this study showed a strong sense of attunement with their therapists during online sessions. Seeing the therapist's face on the screen contributed to their sense of safety and connection, supporting the TR even online. This finding aligns with previous research indicating that online therapy can establish effective TR (Backhaus et al., 2012; Fluckiger et al., 2018; Ghosh et al., 1997). Seeing therapists on the screen helped remove the impersonal element, enhancing TR (Ashwick et al., 2019).

Participants appreciated their therapists' skills, noting that their skilful guidance increased their confidence and trust in their therapist's abilities, making them feel safe. Previous literature also highlights that therapists' skills and clients feeling in capable hands are linked to trust, safety, and connection, which contribute to the therapeutic relationship and the success of EMDR (Marich et al., 2021; Whitehouse, 2019) and therapists were perceived as EMDR experts who would be like a coach (Naccarato, 2008). The familiarity of therapists with the EMDR components (Shipley et al., 2022) and their knowledge and ability to use the approach was considered critical for EMDR's success (Edmond et al., 2004).

The findings suggest that therapists' understanding and sensitivity to cultural and ethnicity-related issues, including transgenerational and intergenerational trauma, contribute to establishing an effective therapeutic relationship (TR). This aligns with research by Sue et al. (2007), emphasising the importance of therapists being aware of their diverse clients' cultural backgrounds and worldviews to provide effective therapy to ethnic minority clients. Neglecting this can strain the TR and hinder therapy success (Sue & Sue, 2003; Sue et al., 2007).

Mbazzi et al. (2021) and Nickerson (2022) similarly stressed the importance of cultural sensitivity in EMDR. Using culturally appropriate metaphors to explain trauma and completing phase 2 before phase 1 can help develop a therapeutic relationship (TR) in a structured way, making clients feel safe to engage in EMDR therapy.

This research indicates that when a therapist and client share a similar ethnic background, it fosters a stronger TR, increases trust, and ensures a sense of safety throughout the therapeutic process. Prior research also suggests that therapists with a common ethnic background may build genuine rapport and facilitate recovery by providing greater legitimacy and acceptance (Franklin & Boyd-Franklin, 2000). In contrast, according to Lipscomb and Ashley (2021), participants felt more secure during EMDR sessions when they trusted their therapist. This appears to be influenced not only by racial similarity but also by the therapists' awareness of ethnicity-related issues and their capacity to address those concerns in therapy. Participants in this study who received therapy from White therapists reported similar experiences.

The results of this study support the previous research that has emphasised the significance of TR in EMDR (Marich, 2012; Marich et al., 2021; Whitehouse, 2019). It supports the preceding argument by proposing that TR is an agent for change in EMDR therapy (Marich, 2012; Whitehouse, 2019). To foster client safety, clinicians should establish a rapport of trust, provide clear explanations of the interventions, and engage attentively with the client. These findings challenge the view that the method alone is the agent of change, highlighting the importance of TR.

5.4 '*In my own space'*: The safety, comfort and convenience of online EMDR Therapy

This theme highlighted participants' positive experiences with online EMDR therapy. They articulated feeling safer in their own environments, closer and more open with therapists, more focused and less anxious than in-person sessions, and an enhanced sense of control. Bursnall et al. (2022) found similar benefits, noting that a personal space creates safety and encourages disclosure without feeling inhibited from accessing and processing traumatic experiences, enabling them to take greater control of their recovery. Fisher (2021) emphasised that ensuring clients' sense of safety and control is particularly important for providing EMDR online. It is essential to manage clients' distress, such as dissociation, which can be very challenging to handle in a remote setting. However, this was not reported by the participants in this study. Therapists' skills and TR helped them to feel contained. The findings of this study, where clients reported feeling comfortable and safe, are very encouraging for the future of online EMDR provision. Therapists need to be observant and assess and manage potential risks and challenges during online sessions, as not all home environments are safe for therapy (Fisher, 2021).

Participants reported that online therapy reduces the complexity and unpredictability that contribute to their anxiety or depression, describing it as a relief from the nightmares of attending in-person sessions. Online therapy was seen as convenient, eliminating challenges like finding a suitable therapist nearby and reducing the time and cost of travel. This convenience decreased stress and anxiety related to commuting, improving attendance and engagement. This

underscores the significance of online therapy in maintaining enhanced commitment and consistency to therapy. Similar benefits, such as increased attendance and reduced travel costs, were noted in previous studies (McGowan et al., 2021; Bursnall et al., 2022; Farrell et al., 2022). Additionally, online therapy allowed access to skilled therapists regardless of location, addressing the shortage of trained trauma-focused therapists in rural and deprived areas. Thus, online therapy enhances geographical flexibility and access to quality therapy.

Participants' experiences in this study suggest that online EMDR therapy is not only effective but can also enhance therapy experiences by providing comfort and reducing barriers to access. A previous study by Bursnall et al. (2022) found vEMDR acceptable for clients and therapists, recommending further research to compare its efficacy with face-to-face EMDR, which was beyond the remit of this study. This study's findings shed some light on the benefits of online EMDR from clients' perspectives, showing that high attunement and a safe space for trauma processing are achievable, indicating that the therapeutic relationship transcends the screen. These insights are particularly relevant for trauma-focused therapy like EMDR, where the therapeutic relationship and consistent engagement are critical. The findings of this study provide valuable considerations for increasing online EMDR therapy practices.

5.5 Theme 4: Healing Through the Journey of EMDR: preferences, challenges, grounding, and transformation

This theme outlines participants' therapeutic journey with vEMDR, their perceptions of the EMDR process, and its therapeutic effects. Most participants described their vEMDR experience as a transformative healing journey.

Participants reported that although they tried other BLS methods like EM and tapping, BH was the most preferred BLS method, finding it comforting and grounding. This aligns with previous findings (Bursnall et al., 2022; Perri et al., 2021). One participant favoured EM due to discomfort with body contact during BH. This finding is consistent with previous evidence that BH was used successfully in the delivery of EMDR (Artigas et al., 1998; Artigas et al., 2013; Jarero et al., 2008). The use of different types of BLS as cultural adaptation was recommended previously (Nickerson, 2022; Mbazzi et al., 2021). Mbazzi et al.'s (2021) study findings provided examples of adaptations of BLS, such as using tapping first rather than EM, as some cultures might view EM as witchcraft or ritual movements, particularly in the Middle East and Muslim world, and using culturally appropriate metaphors (Abdul-Hamid & Hughes, 2015).

Furthermore, participants described BH as easier and providing control over their focus and attention, especially when done with their eyes closed. This contributes to the debate about the necessity of EM in EMDR. Some suggest EM is not essential for processing (Davidson & Parker, 2001), while others argue it adds value (Lee & Cuijpers, 2013). The findings from this study indicate that EM is not the core BLS required for effective EMDR processing.

Participants faced confusion and challenges with specific EMDR components, particularly identifying negative cognitions (NC) and positive cognitions (PC) and selecting target memories. Although the therapy session structure wasn't seen as challenging, confusion with these processes was common. Previous studies also noted difficulties with identifying relevant traumatic memories, connecting with the distress levels during processing in a way that reflects actual triggering situations, and issues with target memories, describing emotions, and validity of cognitions (VOC) (Marsden et al., 2018; Nickerson, 2022; Mbazzi et al., 2021).

The EMDR-adapted protocols do not precisely follow all the steps of standard protocols, such as R-TEP, G-TEP, IGTP, and B2T. Cultural adaptations when attending to the NC and PC and explaining EMDR therapy to clients were emphasised previously (Farrell et al., 2013; Nickerson, 2022; Mbazzi et al., 2021). Nickerson (2022) stressed meeting clients where they are rather than pushing for a balanced emphasis on thoughts, emotions, and sensations. Expressing these cognitions may hinder trauma memory activation if seen as overly disclosing for some clients (Farrell et al., 2020; Nickerson, 2022). Despite high intellectual ability and no visible language barriers, participants in this study found certain components confusing. This suggests that those with limited literacy or language barriers may struggle more with accessing beliefs/cognitions or other EMDR components. Individuals struggling to verbalise their cognitions due to language barriers or social stigma might reinforce negative self-perceptions (Nickerson, 2022). However, therapists should encourage the utilisation of clients' cognitions if they can and are willing to express them verbally (Farrell et al., 2020) and cognitively challenge clients' prejudiced and stigmatised internalised and

externalised negative beliefs related to cultural and racial trauma, which may remain unchallenged otherwise (Nickerson, 2022).

Culturally appropriate adaptations are recommended for challenges with identifying cognitions, like using 'bad' or 'cursed' and 'good' or 'blessed' thoughts for NC and PC (Mbazzi et al., 2021), and 'we' statements instead of 'I' due to the interconnected nature of their trauma experiences (Mbazzi et al., 2021; Nickerson, 2022). Other adjustments, such as identifying racial trauma memories for effective trauma processing and being flexible with the approach, were highlighted in previous literature (Mbazzi et al., 2021; Nickerson, 2022).

Although participants in this study found the process confusing and challenging, following their therapist's guidance, most reported getting used to it, which, in the end, worked for them. These findings suggest that the EMDR protocol can be adapted and does not necessarily have to follow all the steps in the standard protocol. This idea aligns with the B2T protocol, which does not include identifying NC, PC, and VOC in phase 3 (Farrell et al., 2020). This adapted protocol can be used in diverse cultural and racial settings to overcome language and stigma, trust issues due to trauma exposure risks, and other societal and cultural barriers to trauma therapy, as previously noted by Nickerson (2022).

Despite confusion about some EMDR processes, participants appreciated grounding and stabilising techniques like body scans and special place exercises. These strategies provided reorientation and physical relief before and after trauma processing, keeping distress within tolerance. Prioritising stabilisation and resourcing exercises before reprocessing or switching back and forth while taking

clients' history was emphasised previously (Mbazzi et al., 2021; Hartung, 2017; Nickerson, 2022). One participant found the PC installation phase brought emotional and bodily relief after receiving positive affirmation, consistent with Farrell et al.'s (2020) B2T protocol structure and Shapiro's (2001) suggestion that PC is part of the AIP, emerging naturally once the trauma memory is processed.

Shapiro (2018) emphasised the importance of ensuring safety, adequate preparation, and orientation in EMDR therapy, a sentiment echoed by participants in several studies (Marich, 2009; Marich, 2012; Marich et al., 2021; Marsden et al., 2018). This study's results provide insight into the appropriate level of preparation, a topic of ongoing debate in trauma-focused therapy (Van Toorenburg et al., 2020). Shapiro (2018) argues that preparation should not be confused with processing and supports proactive strategies, especially in complex cases. However, De Jongh et al. (2016) disputed the need for stabilisation in complex cases, suggesting that trauma-focused therapy is necessary for achieving emotion regulation. This study from individuals' lived experience suggests that stabilisation during EMDR sessions helps manage distress levels and improve the sense of trust and safety in TR, consistent with Mbazzi et al. (2021). These findings suggest that the level of preparation should be tailored to an individual's needs.

Participants reported significant personal transformation during their EMDR therapy journey, evolving from scepticism and confusion to understanding and appreciation. They experienced substantial therapeutic changes, including emotional freedom from trauma, greater control over thoughts and memories, and reduced anxiety and burnout. The process not only helped with their trauma

resolution but also changed their mindset. They observed increased self-esteem and confidence for future challenges and an instilled sense of control and empowerment, suggesting the transformation that occurred as they progressed through their therapy journey. This indicates the long-term effects of EMDR therapy; however, it was beyond this study's inquiry capacity. Previous studies have shown that EMDR therapy participants experienced increased resolution of traumatic experiences, greater detachment from traumatic memories, new insights, improved self-confidence (Marich, 2009; Marich et al., 2021; Cotter et al., 2017), and reduced symptoms (Edmond et al., 2004; Schwarz et al., 2020; Marich, 2009; Every-Palmer et al., 2023). Marich (2010) described EMDR as a tremendously healing experience, highlighting its positive impact.

Previous studies (Marich, 2009; Brown & Shapiro, 2006) have documented similar transformative impacts on individuals with borderline personality disorder, and the present study's findings support these results. Participants reported self-improvement, enhanced self-esteem, increased control, and a strengthened sense of empowerment. These findings suggest that resolving traumatic experiences can address complex and interconnected issues, leading to long-lasting changes in cognition and behaviour by reducing trauma's role in maintaining psychopathology (Whitehouse, 2019). Recent studies (Every-Palmer et al., 2023; Shipley et al., 2022) also reported profound transformations, categorising these experiences into three: symptom reduction, transformation, and gaining a new perspective.

Consistent with prior research, most participants in this study reported positive outcomes from their EMDR therapy despite challenges. However, one participant

exhibited a degree of ambivalence about the therapy's effects. Bisson et al. (2007) and Cusack et al. (2016) questioned whether such ambivalence is underreported due to bias towards EMDR. To address this, it is essential to acknowledge this ambivalence, even though no negative experiences were reported in this study.

The findings of this study align with recent research on online EMDR therapy, such as Perri et al. (2021), Bursnall et al. (2022), and McGowan et al. (2021). This study investigated ethnic minority participants' experiences with vEMDR therapy, revealing that EMDR therapy works effectively online and offers additional benefits. It enhances therapy experiences, increases engagement and accessibility, and leads to positive therapeutic outcomes. The TR is central to EMDR therapy, and therapists can create a sense of trust, safety, and containment online. Therapists' understanding and sensitivity to cultural and ethnicity-related issues and traumas contributed to the TR, and sharing a similar ethnic background deepened the connection with therapists. Additionally, therapists' EMDR knowledge, skills, and guidance contributed to a successful TR.

BH is the preferred BLS form, suggesting EM is not central to facilitating the processing. While identifying some steps was challenging and confusing, and the processing was overwhelmingly intense, their overall experience suggests it was effective for them. The stabilisation and resourcing were found beneficial for maintaining the distress level within tolerance.

A flexible adaptation to the standard protocol, such as the B2T protocol, can be successfully implemented for ethnically and culturally diverse clients. The

findings suggest that EMDR may be particularly suitable for clients who struggle to talk about their trauma. Additionally, its effects are quicker and more noticeable within a session, indicating that a single-session approach to EMDR can be effectively adopted. Beyond freedom from trauma, EMDR also provided therapeutic benefits such as reduced anxiety, burnout, and improved confidence, indicating a broader therapeutic transformation.

The findings underscore the importance of adopting a culturally sensitive approach to EMDR therapy, including culturally appropriate BLS, trauma targets, NC, PC, and resourcing strategies. However, the third theme indicates no specific cultural adaptations are necessary for delivering online therapy, possibly due to participants' higher socio-cultural backgrounds. Conversely, clients from disadvantaged groups with lower intellectual and literacy levels may require additional support for engaging with EMDR therapy online.

Based on the overall findings, while it is realistic to conclude that online EMDR may not be effective for everyone, it is crucial to consider clients' perspectives when deciding or reviewing the therapy approach or delivery mode.

5.6 Reflexivity and Limitations

Yardley's (2017) four criteria for evaluating research validity were rigorously applied to ensure the study's quality and were discussed in detail in the methodology chapter. In IPA research, reflexivity is crucial as it examines the researcher's position and potential influence on the study's execution, addressing how to manage them to ensure the integrity of qualitative research (Willig, 2013;

Finlay, 2008; Smith et al., 2009; Kasket, 2012). This will now be discussed alongside the study's limitations.

Methodological reflexivity

First, we will discuss the sample. Given the idiographic nature of IPA, which aims to capture the complexity and depth of individual experiences rather than generalise results (Smith et al., 2009), a sample size of six was considered appropriate. However, all participants in this study were female, meaning their experiences with trauma and therapeutic interactions may not represent those of other genders. The study did not include diverse gender identities, such as male and non-binary individuals, who could provide unique perspectives influenced by different societal roles, cultural expectations, and identity-specific challenges. These factors can significantly affect how they perceive trauma and experience EMDR therapy. Future research should use purposive sampling to include the experiences of male and non-binary individuals.

The participants in this study had higher educational and intellectual levels. They were primarily second or third-generation immigrants from ethnic minority groups whose parents or grandparents had permanently moved to the UK. Additionally, five participants received private therapy, while one used the NHS. This could positively impact their therapeutic experience, as factors like motivation to engage, shorter waiting times, and greater autonomy over therapist and therapy process choices might influence outcomes. It's important to consider the potential impact of the participants' socio-economic status, including their financial, cultural, occupational, and educational backgrounds, on the study's findings. The

study's results might have altered if the participants were first-generation immigrants facing language or socioeconomic challenges.

Despite the limitations, the homogeneity of the samples allows for a focused exploration of this group's specific experiences, providing depth rather than breadth. This focus is crucial for understanding that group's nuanced experiences and therapeutic needs, offering insights into the real-life application of online EMDR for ethnic minority clients and supporting the research's primary aim. Future research could further explore these dynamics. Additionally, NHS clients might present different experiences due to resource constraints, funding pressures, and longer waiting times, which could impact their therapeutic experiences. Therefore, research focusing on exploring these aspects with an NHS sample would be intriguing.

Additionally, the study's classification of participants as 'minority ethnic' might be a limitation, as this broad category includes diverse communities with distinct historical and sociocultural backgrounds. Focusing on a single ethnic group with similar origins might yield different outcomes. However, recruiting participants from a specific background poses challenges due to the limited number of individuals accessing therapy. Future research could investigate samples from specific ethnic minority groups to address this limitation.

While the study did not assume homogeneity of the participants' experiences, it did aim for a homogeneous sample by selecting individuals who had experienced trauma and completed vEMDR therapy before participating. However, this approach to homogeneity can be criticised due to the different lengths of therapy

sessions, ranging from six to sixteen sessions, which may have influenced participants' perceptions of therapy. Additionally, differences in previous therapy backgrounds, experiences, and complexity of presentations might have impacted their experiences and, consequently, the study's findings.

Another limitation of the study is that participants were recruited through their therapist's recommendations, which may have led therapists to distribute the study advertisement to or encourage participation from clients with positive outcomes. The study's findings also indicate a strong therapeutic relationship between participants and their therapists. Furthermore, all participants expressed that their motivation for participating was either to contribute to ethnic minority research or to share their vEMDR experiences. This motivation likely contributed to the overwhelmingly positive responses. However, a different group of participants might have yielded different results.

Personal reflexivity

IPA recognises that researchers inevitably bring a certain degree of subjectivity to their work, as their personal experiences, values, and agendas can significantly impact the research, especially throughout the hermeneutic cycle. The study is limited by acknowledging that complete bracketing is unattainable (Langdridge, 2007). As an ethnic minority researcher familiar with EMDR, my background initially inspired me to conduct this study and aided my understanding of participants' experiences. However, it may have occasionally limited my curiosity due to assumptions I made based on my own experiences. I sought to minimise these biases by setting aside my assumptions and engaging in purposive

reflective practices, including maintaining reflective journals and discussing insights with supervisors and peers. As outlined in the methodology chapter, I adhered to Yardley's (2017) recommendations to maintain research quality and integrity.

The literature review conducted before the study primarily guided the research aims. While reviewing the literature, I focused on addressing the identified research gap. However, I found myself biased toward specific papers due to my assumptions about online EMDR therapy and issues faced by ethnic minorities. I maintained a journal and took detailed notes on the papers to manage these biases and expectations. Additionally, I engaged in discussions with peers and supervisors to gain diverse perspectives.

In Chapter 3, I discussed reflexivity in data collection and analysis. After the first interview, I reflected on my approach, noting that I sometimes prompted, directed, or interrupted participants, which might have influenced their responses and data flow. Despite my efforts to minimise this impact, it may remain a limitation. In the earlier reflexive section, I also addressed the dual role of therapist and researcher and how I managed this.

Additionally, IPA research relies heavily on language for interpretation, allowing researchers to use participants' experiences to gain insight into phenomenological material (Smith et al., 2009). I addressed the use of language and managed issues like EMDR terminology in Chapter 3. All participants were fluent in English and communicated their experiences effectively. Apart from minor interruptions, such as participants' dogs or internet issues, the interviews

proceeded smoothly. To manage these, I asked participants to repeat unclear parts to ensure clarity and refocus their attention. Although five out of six interviews were video-recorded, I took notes on my thoughts and non-verbal cues to reflect on what occurred during the interviews. I recognised that these factors might have limited my interpretation of the data.

Theme three conveys a sense of certainty that online therapy delivery always has an advantage and contributes to a positive therapeutic experience. As an EMDR therapist with experience in delivering online therapy, my interpretations of the data may have inadvertently favoured a more positive outcome. However, I have engaged in reflexivity and included neutral or less favourable data for online therapy to minimise the impact of potential bias.

By presenting distress primarily through a trauma lens, the study may have inadvertently shaped participants' narratives to align with the trauma paradigm, which could raise a potential for confirmation bias. Similarly, when they attended therapy, their therapists might have spoken about trauma as if it were given to them as a predefined concept. These factors might have prevented participants from reflecting on how they understood their distress from alternative explanations, which could be influenced by their sociocultural backgrounds and prior experiences. Future studies should consider allowing participants to express their distress through various lenses, such as socioeconomic factors, cultural expectations, or personal beliefs, to capture richer and more nuanced data.

I attempted to address potential power imbalances between the participant and researcher (Smith et al., 2009) by creating an environment conducive to open

questioning, ensuring data storage transparency, and clearly explaining the interview objectives. These power issues and how I managed them were discussed in Chapter 3. Furthermore, I reiterated my role as a researcher, not as a therapist or trainee CoP, and endeavoured to assume the perspective of an inexperienced researcher to clarify, examine, and analyse rather than make assumptions based on my dual position as a practitioner and researcher. In instances when participants viewed me as an EMDR expert, I focused on being reflective, acknowledged my desire to act as their therapist, and adhered strictly to the interview schedule to maintain my research focus.

When I first explored this topic, I naively expected IPA to be straightforward due to its smaller sample size. However, I found the research process, particularly data analysis, extremely challenging. Although IPA aims for rich interpretations, my analyses tended to be descriptive. I repeatedly tried to be more interpretative, incorporating feedback from supervisors and discussions with peers. I found it extremely challenging because, due to my cultural and linguistic background, I am inherently more descriptive than interpretative, where things are said as they are. Acknowledging that interpretation is a skill that I could learn and develop, I worked hard to improve. As I approach the research's final stage, I've reflected on these challenges and the learning process. Despite the difficulties, I've gained valuable skills and insights with my supervisor's guidance and feel hopeful about improving in future research.

Conducting this research has positively influenced my practice, particularly in understanding participants' perceptions of their therapeutic relationships. I have become more at ease with clients, engaging in brief, informal conversations about

their lives and occasionally offering limited self-disclosure. This approach has noticeably improved the therapeutic relationship and client engagement in therapy, enhancing the experiences of both online EMDR and other therapeutic modalities.

5.8 Implication of EMDR Psychotherapy and Counselling Psychology Practice and Beyond

Practice implications for EMDR therapists and CoPs

The findings of this study hold significant clinical implications for EMDR therapists and Counselling Psychologists, which are discussed below:

Counselling psychologists are broadly responsible for challenging current psychological practices and the underlying theories and assumptions that influence them to reduce social inequities and promote inclusiveness for increased social justice (Tribe & Bell, 2017; BPS, 2019). This study highlights the need for culturally competent EMDR therapy that addresses the unique needs of ethnically diverse populations. By advocating for more inclusive therapeutic practices, the study emphasises enhancing the accessibility and effectiveness of EMDR for these diverse populations. EMDR therapists and CoPs must develop culturally tailored interventions that capture their cultural nuances and engage in systemic advocacy. This involves incorporating cultural sensitivity into therapeutic interventions, ensuring that therapy remains relevant and respectful of each client's cultural background. Fostering a more inclusive therapeutic environment promotes equitable therapy provision, empowers marginalised

communities, and supports broader social justice goals. Moreover, the study underscores the importance for EMDR therapists to conceptualise trauma and provide interventions in ways that are sensitive to racial and cultural context, which includes recognising generational, intergenerational, and transgenerational trauma and ensuring that therapeutic practices address these complex layers of trauma effectively.

The study findings highlight the necessity for a flexible approach to the EMDR protocol, adjusting interventions to accommodate clients' situational, cultural, and linguistic needs. This flexibility reinforces the pluralistic perspective by incorporating culturally sensitive bilateral stimulation (BLS), appropriate language use, and adapted protocols. Additionally, EMDR therapists should involve clients actively in the therapeutic process, provide information in an accessible format (e.g., their language), value their input, and tailor interventions according to their preferences. This approach fosters empowerment and engagement, aligning with CoP's commitment to client empowerment (BPS, 2017). By adopting a flexible, adaptable, and client-centred approach, therapists can ensure that therapy is responsive to diverse challenges, ultimately enhancing therapeutic engagement and outcomes.

The novel findings of this study demonstrate that online EMDR therapy is effective and offers additional benefits like comfort, safety, and accessibility. This approach expands opportunities for EMDR therapists and CoPs to provide therapy in remote areas or globally, where trauma therapists are scarce, thereby alleviating the demand. However, therapists may need to acquire specific skills to deliver trauma therapy effectively and safely online.

This study demonstrated that EMDR methods were effective due to clients establishing strong therapeutic relationships with their therapists, marked by safety, trust, and containment. EMDR practitioners should prioritise creating such relationships, as they are critical for effective trauma therapy. By focusing on building trust and providing safety, therapists can better support clients in processing and healing from trauma.

Implications for the wider mental health system:

The research findings also have broad implications for the wider mental health system, particularly for organisations like NHS England and training providers.

NHS England prioritises the need for evidence-based, cost-effective, and efficient therapy, which has become even more urgent considering the global pandemic. The findings suggest that online EMDR is effective and offers practical benefits. Therefore, further developments and expansions of EMDR therapy are suggested to address the needs. NHS England should consider this in shaping their policy and treatment guidelines for various mental health problems. Mental health services should adopt online EMDR therapy as a standard practice, using technology to enhance access to care and reach clients in remote or underserved areas.

Furthermore, there is an overwhelming global demand for trained trauma therapists. Incorporating EMDR, an evidence-based therapy model with new advances in research, into Counselling Psychology training can help meet this demand. By expanding training in this area, the mental health system can better

serve communities in need. The study also emphasises the necessity for therapists to cultivate a more nuanced understanding of culture and ethnicity when conceptualising clients' distress and providing therapeutic interventions. Mental Health Services should prioritise additional training for EMDR therapists to develop and enhance their cultural competence, aiming to reduce inequality in mental health care provision.

CoPs should integrate leadership as a core aspect of their professional identity to advance the field's science and practice (Shullman, 2017). Those in leadership positions should actively champion the redesign of trauma service provisions, ensuring that online EMDR is effectively integrated and adapted to meet the needs of diverse clients, including ethnic minorities. By championing these changes, CoPs can help create a more inclusive and accessible mental health system.

5.9 Further prospects for research area and dissemination

Counselling psychology might identify a significant gap in research, and when the gap is addressed, it improves professional practice (Kasket, 2012). With this view, further research and dissemination prospects are discussed now.

Positive outcomes from the study support the use of online EMDR therapy with clients who belong to an ethnic minority group. More research is needed to ensure that these findings are acceptable. In terms of future research, a comparative IPA study could explore a longer post-therapy period to examine the longer-term effects of online EMDR therapy. As highlighted in the limitation, a

purposive sample consisting of specific gender identities, such as male or non-binary participants from minority ethnic origins, would ensure that the voices of individuals from diverse gender identities are heard. Studies of a similar nature, including NHS samples and cultural and language challenges, might be carried out. The results showed that a common understanding of culture and ethnicity might facilitate a deeper relationship. Thus, it would be intriguing to research this with participants who share therapists' cultural origins.

The findings also showed the therapeutic benefits go beyond addressing the trauma. Therefore, it would be interesting to investigate participants' experiences with specific difficulties such as depression, anxiety, and low self-esteem, as well as PTSD and complex PTSD. The results also imply that for EMDR therapy to be successful, both the therapeutic relationship and the technique are required. It is possible to do experiential research on the adapted B2T protocol using a comparable population, especially those with disadvantaged backgrounds with cultural and linguistic barriers. While the qualitative study focused mostly on the client's experiences in the US, some in the UK, and one in Africa, more experiential studies conducted outside the US and the UK would highlight the clients' experiences in various cultural contexts.

Regarding dissemination, the EMDR UK research committee has contacted me to present this in the ethnic minority EMDR working group, publish an article for the quarterly magazine, and present a poster at the conference. In the future, I also hope to publish the research in the EMDR UK journal. I also intend to disseminate the study within the clinical setting, with a peer supervision group,

and present it to the NHS Trust, where I work within their larger specialist health psychology team.

5.10 Conclusion

This study provides insight into the process of online EMDR therapy experienced by ethnic minority clients for trauma. This type of account offers a more comprehensive understanding of how clients understand their experience of the therapy process, including which components they find understandable, the areas where they feel at ease, their experiences during therapy, and the changes they observe both during and after therapy. This understanding adds depth to the current experimental evidence base.

The study findings show that EMDR and its online delivery were new to the participants, who initially expressed scepticism and uncertainty. However, it turned out to be a transformative experience, highlighting the effectiveness of the EMDR delivered online. The findings suggest that online EMDR works effectively for ethnic minority clients.

The therapeutic relationship is central to EMDR therapy's effectiveness, shifting the primary focus from EMDR methods to the therapeutic relationship. A strong therapeutic relationship was observed online, with non-specific therapeutic factors such as safety, trust, and connectedness being key to client engagement and the success of therapy. Therapists' understanding and sensitivity to cultural

and ethnic issues contributed to a good TR, and shared backgrounds with their therapists created deeper connectedness. The findings highlight that eye movements do not have to be the core BLS for change; other forms of BLS can be used based on participants' preferences.

Participants found grounding and stabilising strategies helpful, highlighting the need for a preparation phase and body scanning to ensure clients feel safe and grounded. The processing phase (desensitisation phase) was intense and overwhelming, which was a distinctive EMDR experience. Although some processes were confusing and challenging, particularly identifying beliefs associated with the trauma, participants appreciated the preparation. By the end of the process, they felt different as it worked for them, demonstrating the power of healing beyond understanding.

The study highlights the need for cultural understanding and sensitivity, which may involve adaptations to the EMDR components (e.g., BLS, NC, and PC) and protocols to engage and deliver EMDR to clients with diverse ethnic backgrounds. Besides, the quick reduction of distress associated with traumatic memories suggests a single-session protocol like the B2T protocol can be adapted for clients with language or complex cultural issues where verbal articulation is difficult. The standard EMDR protocol is flexible and can be adapted to individual client's needs, aligning with the humanistic principles of counselling psychology.

The results show the benefits of vEMDR therapy, revealing that attending therapy in their own space is comfortable and safe. Online therapy reduces anxiety and mood-related unpredictability, increases attendance, and saves time, money, and

stress related to finding therapy. It increases access to suitable therapists regardless of location, showing the potential for vEMDR therapy, especially in rural areas where trauma-focused therapists are limited.

The overall effects of the therapy were positive, helping participants achieve a core transformation of their mindset beyond trauma resolution. The findings suggest that online EMDR therapy works for ethnic minority clients. Given the global burden of trauma exacerbated by the COVID-19 pandemic and the shortage of trauma therapists, the success of online EMDR therapy, with its added benefits, suggests it could be implemented more widely to meet the demand.

Considering the limitations inherent in the study's methodology, I provided recommendations and implications for EMDR therapists and counselling psychology, the wider systems, future research, and dissemination. This study offers an opportunity to add to the EMDR literature for online delivery and the ethnic minority experience as one of the first contributors to the online EMDR study with ethnic minority research, contributing to the field of EMDR psychotherapy and CoP psychology.

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University of East London

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS (Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form

(please read carefully)

1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/

	▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	**Shireen Sultana**
2.2	**Your supervisor's name:**	**Dr Lucy Poxon**
2.3	**Name(s) of additional UEL supervisors:**	**Dr Rachel Tribe**
		3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Professional Doctorate in Counselling Psychology**
2.5	**UEL assignment submission date:**	**19/04/2022**
		Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.		
3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Exploring ethnic minority Clients' experience of online Eye Movement Desensitisation and Reprocessing therapy: An Interpretative Phenomenological clients' perspective.
3.2	**Summary of study background and aims (using lay language):**	The proposed study would examine clients' experiences with online EMDR therapy. The National Institute of Clinical Excellence (NICE, 2005, 2018) guidelines for trauma recommend EMDR as an evidence-based therapy alongside trauma-focused Cognitive Behavioural Therapy. EMDR has historically been delivered in person. However, due to restrictions and social distancing measures imposed by the COVID-19 epidemic, it was required to offer EMDR online to clients. Since online EMDR is a recent evolution, the research is still inadequate. However, researchers' interest in online EMDR is growing. The proposed study will examine how clients experienced online EMDR and therapeutic relationships. Understanding clients' experience of online EMDR can help the professionals, and NHS England, develop and shape effective therapy provision for the clients. This study is interested in exploring clients' subjective and intersubjective lived experiences of online EMDR, which falls within the humanistic value of the Counselling Psychology discipline (Cooper, 2009). Besides, identifying their views and perceptions on online EMDR therapy will mean they can have a voice in that process, which fits with counselling psychologists' responsibility to empower clients (BPS, 2021).
3.3	**Research question(s):**	The primary research question is: How do clients experience EMDR online? The lines of the queries will be explored through two sub-questions: How do they make sense of the various components of EMDR? How do they experience other therapeutic factors, such as the therapeutic relationship?
3.4	**Research design:**	The study will use qualitative methodology using Interpretative Phenomenological Analysis (IPA). IPA is associated with the detailed exploration of the participants' lived experiences and attempts to understand personal accounts or perceptions of an event or object instead of confirming an objective truth (Smith, 2009), which is particularly relevant to this research as it aims to explore individual's lived experience of online EMDR (Smith et al., 2009).
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	Participants will be 18 years old and over, from an ethnic minority background. They do not need to meet specific diagnostic criteria, but they will have experienced trauma

		symptomatology. Participants will have received a course of EMDR therapy via video conferencing and have completed therapy at least six months prior to the interview.	
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	A purposive sampling of 4-8 participants will be recruited. Participants will be recruited via snowballing method through EMDR therapists, primarily via EMDR UK (the professional registered body of EMDR therapists). Recruitment will be advertised in The EMDR Therapy Quarterly magazine and promoted on Jiscmail, a platform for EMDR UK registered therapists. Participants' permission will be obtained prior to contacting.	
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	An interview schedule will be used during the interview and the interview will be recorded on Microsoft Teams. Interview questions are listed below (Appendix – E).	
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Once I receive permission to contact the participants, I will contact the participants for a screening call to check if they meet the inclusion criteria for the study. The consent form will be sent to them to complete and return via email. The data collection will involve semi-structured interviews and will ask participants about their experience with online EMDR (See appendix E- for the schedule). Interviews will last for approximately 60 -90 minutes, be conducted via Microsoft Teams and be recorded and transcribed verbatim. At the interview, participants will be offered a debrief and will be provided contact details of services where they can access further help should they wish (Appendix D).	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☒	**NO** ☐
	If yes, please detail why it is necessary.	Participants will be informed that participating in the study contributes to knowledge production, and therefore, no remuneration will be made. However, an incentive by means of a voucher will be offered to them.	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	25.00 pounds Amazon gift voucher (self funded by student)	
3.11	**Data analysis:**	Pseudonyms will be used throughout the process. For the data analysis process, I will follow the guidelines proposed	

		by Smith et al. (2009). The procedure begins with multiple readings of each individual transcript in turn. Two-column methods will be used to capture comments explaining the meaning of the data alongside line-by-line analysis. After that, I will analyse the initial comments through an interpretative lens into emerging themes to a higher level of reflective titles. I will then group the interconnected emergence themes in clusters with a summary table for each case, in which examples of extracted data will be presented. At the next stage, each transcript will be compared to identify superordinate themes which will reflect participants' experiences across the sample (Willig, 2017). A master table will be then presented with the superordinate and subordinate themes. Finally, a detailed commentary will be produced, including the analysis of the identified themes, with close reference to the data.

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.	Please detail how data will be anonymised	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	Any identifying details will remain anonymous as a pseudonym will refer to them. The transcripts and the audio recordings will be referred to by their pseudonyms instead of the client's name to maintain anonymity. If the participants refer to family names, specific service providers and psychologists – these will be anonymised throughout the transcripts.	
4.3	**How will you ensure participant details will be kept confidential?**	Participants will be reassured that any information they provide will remain confidential. The electronic transcripts will be stored on a password-protected laptop, and documents will be password protected. The recordings will be stored on UEL One drive under the pseudonym. Participants will be made aware that the recordings will be listened to by myself and my	

		supervisor, and the recordings will be destroyed upon completion of the study. The contact details of the participants, and the consent forms will be stored in a password-protected document on a password-protected laptop. The information will be destroyed once the study is completed.	
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	Data will be stored anonymously and securely on the laptop with password protection. The password-protected transcripts and recordings will be shared securely with the supervisor via UEL One Drive.	
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	The researcher and the research supervisors. An anonymised example of transcript data will be available on the PhD Manager for the examiners.	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	Anonymised interview transcripts will be retained	
4.7	**What is the long-term retention plan for this data?**	As evidence for future research publication for 5 years (BPS, 2021)	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	Participants will be made aware of the potential emotional responses that the interview may evoke. All the participants are required to have attended therapy.	

		However, the sensitivity of the research and the nature of their study experiences may evoke intense emotions or distress. I will be mindful of participants becoming distressed or upset. I will check in continuously to confirm consent to carry on with the research. They will be offered a debriefing session following the interview and will be provided with the details of the relevant psychological services (such as crisis numbers, and their local Talking Therapies) should they wish to access these services (Appendix D).	
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	There are no physical risks anticipated. Participants' experiences may evoke some psychological distress and anxiety. I will have regular debriefing sessions with my supervisor who will be aware of my interviews. I can also take this to my personal therapy to manage my own psychological distress if required.	
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒	
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐ **N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐
	If yes, where?	**Online**	
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒
	If yes, where?	Please state the country and other relevant details	
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics	**YES** ☐	

	folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.	

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or		

	(2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☒	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☒	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	**001707324097**	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the	**YES** ☐	

	institution/organisation). Please confirm that you have attached written permission as an appendix.	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.	

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Shireen Sultana**
8.3	**Student's number:**	**U0508553**
8.4	**Date:**	**19/04/2022**
Supervisor's declaration of support is given upon their electronic submission of the application		

Student checklist for appendices – ***for student use only***

Documents attached to ethics application	**YES**	**N/A**
Study advertisement	☒	☐
Participant Information Sheet (PIS)	☒	☐
Consent Form	☒	☐
Participant Debrief Sheet	☒	☐
Risk Assessment Form	☒	☐

Country-Specific Risk Assessment Form	☐	☒
Permission(s) from an external organisation(s)	☐	☒
Pre-existing questionnaires that will be administered	☐	☒
Researcher developed questionnaires/questions that will be administered	☐	☒
Pre-existing tests that will be administered	☐	☒
Researcher developed tests that will be administered	☐	☒
Interview guide for qualitative studies	☒	☐
Any other visual material(s) that will be administered	☐	☒
All suggested text in RED has been removed from the appendices	☒	☐
All guidance boxes have been removed from the appendices	☒	☐

Appendix B: Ethics approval decision

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue | Student:** Please complete/read sections in **orange**

Details	
Reviewer:	**Martin Willis**
Supervisor:	**Lucy Poxon**
Student:	**Shireen Sultana**
Course:	**Prof Doc Counselling**
Title of proposed study:	Exploring ethnic minority Clients' experience of online Eye Movement Desensitisation and Reprocessing therapy: An Interpretative Phenomenological clients' perspective

Checklist (Optional)			
	YES	**NO**	**N/A**
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐

If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.

NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments

Please clearly detail the amendments the student is required to make

Please state at 4.3 how you will keep contact details confidential (i.e., email addresses required for Teams meeting invitation) and what will be done with these details after the study is completed.

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

Has an adequate risk assessment been offered in the application form?	**YES** ☐	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	

If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:

HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☒
LOW	Approve and if necessary, include any recommendations in the below box.	☐
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**M**artin Willis
Date:	**03/05/2022**
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee	
RESEARCHER PLEASE NOTE For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place. For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.	

Confirmation of minor amendments (Student to complete)
I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	**Shireen Sultana**
Student number:	**U0508553**
Date:	**03/05/2022**
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

Appendix C – Approval of Criteria Amendments

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents	
A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**Shireen Sultana**
Programme of study:	**Professional Doctorate in Counselling Psychology**
Title of research:	**Exploring ethnic minority Clients' experience of online Eye Movement Desensitisation and Reprocessing therapy: An Interpretative Phenomenological clients' perspective**
Name of supervisor:	**Dr Lucy Poxon**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Removing 6 months post therapy criteria from the participants recruitment criteria	Difficulties with recruitment as clients are not usually in contact with the therapist after 6 months of ending therapy
Increasing the amount of gift voucher to 50.00 from 25.00 pounds	Participants will have to spend a significant amount of their time, for which they may have lost income. This might make it easier for them to engage.
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Shireen Sultana**
Date:	**21/11/2022**

Reviewer's decision

Amendment(s) approved:	**YES** ☒	**NO** ☐

Comments:	**If participants have already been recruited, you cannot change the amount of the Amazon voucher offered – as participants will receive a different amount for taking part in the same study. If no participants have been recruited yet, this change to the Amazon voucher can be made.**
Reviewer: (Typed name to act as signature)	**Trishna Patel**
Date:	**21/11/2022**

Appendix D: Study advertisement

Research – Invitation to Participants
Investigating clients' experience of online EMDR therapy

Therapists can give this information sheet to the clients who have completed EMDR therapy online.

About the research:

EMDR therapy has been proven to be highly effective. There has been an increasing demand for EMDR therapy online since the COVID-19 pandemic, and the researchers' interest is also growing in online EMDR. However, there is only a little evidence on online EMDR, particularly from clients' perspectives. My research aims to explore clients' experience of online EMDR therapy to understand how clients make sense of their experience of online EMDR therapy. It will help us to understand what and why it works or not. Clients' view is central to shaping and designing client-centred services. This research can contribute to that significantly.

The study will involve
I am looking for clients who will be willing to attend an interview with me as the researcher. You will be asked to tell us about your experience with online EMDR therapy and how you made sense of that experience. The interview will be conducted over the Microsoft Teams and will last approximately 60-90 minutes.

Participants' Eligibility

Individuals are:
- 18 and over
- An individual from an ethnic minority background
- Have completed a course of EMDR therapy for trauma symptoms via an online video platform
- At least six months have passed since the therapy has completed
- Can communicate English well

What next:
Please share this with anyone who might be interested in taking part in this study. Individuals Interested in taking part, please contact:

Researcher: Shireen Sultana
Counselling Psychologist In-Training
University of East London
Email: u0508553@uel.ac.uk

Recruitment advert: Version 1, Apr-22
Project title: Understanding clients' experience of online EMDR therapy: an interpretative analysis.

Appendix E: Participant Information Sheet (PIS)

Version: 1, Apr-22

Date:

PARTICIPANT INFORMATION SHEET

Title of research: Exploring ethnic minority Clients' experience of online Eye Movement Desensitisation and Reprocessing therapy: An Interpretative Phenomenological clients' perspective.

Contact person: Shireen Sultana
Email: u0508553@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information, which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before deciding. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Shireen Sultana. I am a Postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Professional Doctorate in Counselling Psychology Course. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into exploring ethnic minority clients' experience of online Eye Movement Desensitisation and Reprocessing therapy (EMDR). The proposed study would examine clients' experiences with online EMDR therapy. EMDR has traditionally been offered face-to-face. However, since the COVID-19 pandemic, therapists across the world started to offer EMDR online via video platform due to restrictions and social distancing measures. Although researchers are showing more interest in this field and some research showing promising results, there is not enough qualitative research representing clients' views on online EMDR has been conducted. Understanding clients' views and perceptions of online EMDR

therapy will help NHS England and the service providers to shape the client-centred therapy provisions.

Why have I been invited to take part?
To address the study aims, I am inviting individuals 18 years old and over from ethnic minority backgrounds to take part in my research. If you have received EMDR therapy for trauma symptomatology via video conferencing and have completed therapy at least six months before attending the interview, you are eligible to participate in the study.
It is entirely up to you whether you take part or not, and participation is voluntary.

What will I be asked to do if I agree to take part?
If you agree to take part, you will be asked about your experience of the online EMDR therapy you received. The interview will be semi-structured and will last for approximately 60-90 minutes. It will take place online on Microsoft Teams. The interview will be recorded and transcribed verbatim.
By participating in this study, you will contribute to EMDR therapy as well as the broader psychotherapy and psychology field. However, following the interview, 25.00 pounds Amazon gift voucher will be given to show my gratitude for your contribution.

Can I change my mind?
Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the study, you can do so by emailing my supervisors or me. If you withdraw, your data will not be used as part of the research, and your recordings and transcripts will be destroyed.
Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?
Although you will have received therapy prior to the interview, it may evoke some psychological distress. Therefore, you will be offered an opportunity to debrief at the end of the interview. You will also be provided with the details of the relevant psychological services should you require to access these services prior to the interview.

How will the information I provide be kept secure and confidential?

Participants will be referred to by pseudonym in the recordings as well as the transcript, protect anonymity and to maintain confidentiality. The recording will be saved on the UEL One Drive and transcript document will be password-protected and will be stored in password-protected laptop. Recordings and the transcript will be read by myself and my supervisor, and the audio recording will be destroyed upon completion of the study. Data will be shared via UEL One Drive. The transcripts will be kept with my supervisor and will be destroyed after 5 years.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes

this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's Online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, the public, etc.) through journal articles, conference presentations, talks, and magazine articles. In all material produced, your identity will remain anonymous, in that it will not be possible to identify you personally. Any identifiable information will be removed, and your name will be replaced with pseudonyms.

You will be given the option to receive a summary of the research findings once the study has been completed, for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by myself and Dr Lucy Poxon for a maximum of 5 years, following which all data will be deleted.

Who has reviewed the research?
My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Shireen Sultana
Email: u0508553@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lucy Poxon School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: l.poxon@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Student checklist for Participant Information Sheet (PIS) – *for student use only*

Information to include in PIS	**TICK**
Study title	☒
Who you are	☒
Purpose of research, including any advantages to taking part	☒
Inclusion/exclusion criteria	☒
What participation will involve: location, duration, tasks, etc.	☒
Right to withdraw participation: withdraw involvement at any point without the need to provide a reason or negative consequences	☒
Right to withdraw data: a time specified to do this within (typically a three-week window)	☒
Participation is voluntary	☒
Potential risks to taking part (pain, discomfort, emotional distress, intrusion)	☒
Attempts to minimise risks	☒
Contact information of supporting agencies/relevant organisations	☒
How data will be kept confidential	☒
When confidentiality might be broken	☒
How data will be managed by UEL	☒
How data will be securely stored (e.g., where, who will have access, etc.)	☒
How long data will be retained for, where and by whom	☒
Dissemination activities	☒
Clearly communicated that participants will not be identifiable in any material produced for dissemination purposes	☒
Your name and UEL email address	☒
Your supervisor's name and UEL email address	☒
The Chair of the SREC's name and UEL email address	☒

Appendix F: Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of research: Exploring ethnic minority Clients' experience of online Eye Movement Desensitisation and Reprocessing therapy: An Interpretative Phenomenological clients' perspective.

Contact person: Shireen Sultana

Email: u0508553@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft.	
I understand that my personal information and data, including audio/video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……
……

Participant's Signature

……
……

Researcher's Name (BLOCK CAPITALS)
SHIREEN SULTANA
……
……

Researcher's Signature

……
……

Date

……..……
……

Appendix G: Participant Debriefing Sheet

PARTICIPANT DEBRIEF SHEET

Exploring ethnic minority Clients' experience of online Eye Movement Desensitisation and Reprocessing therapy: An Interpretative Phenomenological clients' perspective.

Contact person: Shireen Sultana
Email: u0508553@uel.ac.uk

Thank you for participating in my research study on exploring ethnic minority clients' experience of online Eye Movement Desensitisation and Reprocessing therapy (EMDR). The proposed study would examine clients' experiences with online EMDR therapy. EMDR has traditionally been offered face-to-face. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publically available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. Any identifiable information will either be removed or replaced with pseudonyms.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by myself and Dr Lucy Poxon for a maximum of 5 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- Your GP can refer or you can self-refer to your local Talking Therapies Service (IAPT). To find your local services:

  https://www.nhs.uk/service-search/mental-health/find-a-psychological-therapies-service/

- Mind Please call on 0300 123 3393, email info@mind.org.uk
- For an urgent need mental health referral, find your local urgent NHS mental health services:

https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

- For emergency crisis please call 999 or 111.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Shireen Sultana
Email: u0508553@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Lucy Poxon. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: l.poxon@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

Appendix H: Interview schedule

Q1. I would like to ask some questions about EMDR but first if you can please tell me about your experience of receiving EMDR therapy online to begin with?

Q2. How many sessions of EMDR did you have?
(Prompts: When was the last session and what was that for?)

Q3. How did you feel about starting EMDR therapy online?

Q4. What did you know about EMDR therapy before starting therapy? Were you provided information about EMDR?

Q5. Which platform was used for providing therapy?
Prompt: Zoom, Teams, Bialateral base

Q6. Please tell me your experience of attending EMDR therapy online?

Components of EMDR:

Q7. What types of bilateral stimulation was/were used in therapy? What was your experience of them?

(Prompts: various – eye movement, butterfly hugs, tapping, positive, negative, easy, difficult etc)

Q8. How did you find identifying the target memory/image, negative cognitions, positive cognition, VOC?

Q9. What was your experience of the intensity of EMDR therapy (compared to the previous therapy if you have any experience)?

Q10. What is your overall experience of the EMDR therapy procedure (the steps of EMDR) online?

Therapeutic relationships:

Q11. Can you please tell me about your experience with your therapist? How did you experience your relationship with your therapist?
Prompt – positive, negative, helpful, unhelpful.

Q12. How did your experience of your relationship with the therapist contribute to your engagement in EMDR therapy?
Prompt: Would that be different

Q13. EMDR therapy require intense engagement. Did you How did you feel about role of your therapist guidance on this? Do you think about how the therapist's contribution to the change?

(Prompt – trusting therapist, sense of safety etc.)

Q14. If you have had any in-person therapy before, compared to that experience, how did you feel the presence of your therapist online?

(Prompt: any differences)

Q15. Would you like to add anything else about your overall experience of online EMDR therapy?
(Prompts: advantage, disadvantages)

Appendix I: General Risk Assessment Form template

UEL Risk Assessment Form

Name of Assessor:	**Shireen Sultana**	**Date of Assessment:**	**20/4/2022**
Activity title:	**Semi-structured interviews**	**Location of activity:**	**Microsoft Teams**
Signed off by Manager: (Print Name)	**Dr Lucy Poxon**	**Date and time: (if applicable)**	**26.4.22**

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc.).
If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

The qualitative study aims to explore ethnic minority clients' experience of online EMDR therapy. Interpretative Phenomenological Analysis research method will be used and semi-structured interviews will be used for data collection.

Overview of FIELD TRIP or EVENT:

Semi-structured interviews will be held on the Microsoft Teams. 4 to 8 participants will be interviewed by the researcher individually on different dates and times.

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity							
Hazards identified	**Who is at risk?**	**Existing Controls**	**Likelihood**	**Severity**	**Residual Risk Rating (Likelihood x Severity)**	**Additional control measures required (if any)**	**Final risk rating**

Psychological distress, pain and discomfort to the participants	Participants	Participants will be made aware of the potential emotional responses that the interview may evoke. All the participants are required to have attended therapy. However, the sensitivity of the research and the nature of their study experiences may evoke intense emotions or distress.	1	1	1	I will be mindful of participants becoming distressed or upset. I will check in with continuously to confirm consent to carry on with the research. They will be offered a debriefing session following the interview and will be provided with the details of the relevant psychological services (such as Mind, Crisis details and their local Talking Therapies) should they wish to access these.	1
Psychological distress to the researcher.	Researcher	There is no physical risk is anticipated. However, participants experience may evoke some distress in me.	1	1	1	I will debrief with my supervisor and take it to my personal therapy manage any distress.	1

Review Date

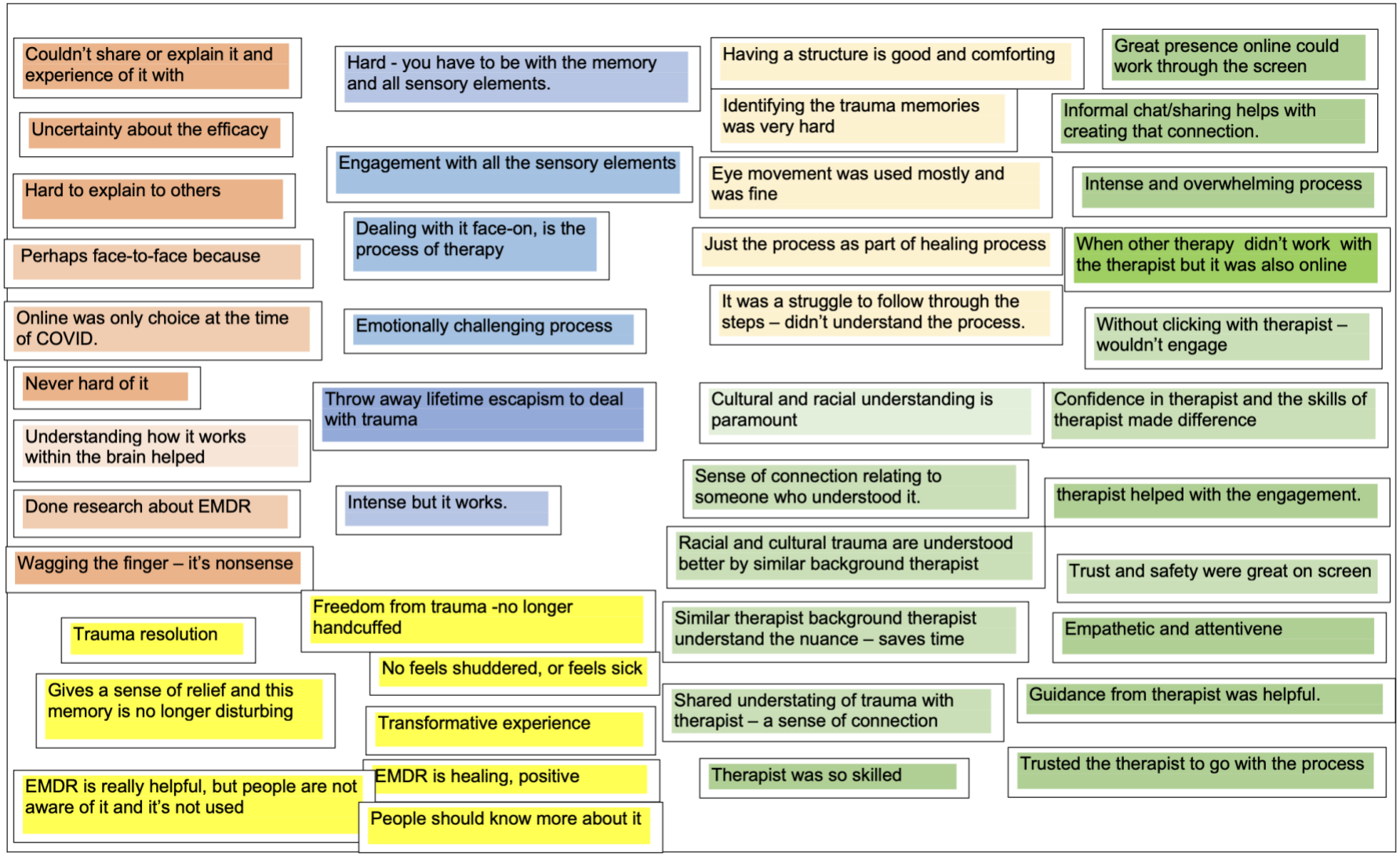
Appendix J: Presentation Key of Participants and Themes

Group Experiential Themes	Sub-themes	Annie	Poppy	Samina	Chloe	Rhea	Christina
'*Wagging a finger on screen'* – The online EMDR therapy is a compromise that pays off	Sceptical at the beginning but, '*anything's worth a go'*	✓	✓	✓	✓	✓	✓
	'Handcuffed to a chair' - intense and overwhelming processing but contained by the end	✓	✓	✓	✓	✓	✓
	Face-to-face was not an option but online was worthwhile	✓	✓	✓	✓	✓	✓
Creating trust, safety and connection: The impact of therapeutic relationships in EMDR therapy	Holding and containment by therapists provide a sense of safety and control	✓	✓	✓	✓	✓	✓
	Sensitivity to culture and ethnicity increased connectedness	✓		✓	✓	✓	✓
	Therapists' attunement was present even through the screen	✓		✓	✓	✓	✓
'*In my own space'*: The safety, comfort and convenience of online EMDR Therapy	A safe and comfortable environment ensures feeling at ease in therapy	✓	✓	✓	✓	✓	
	Spares *'the nightmares*': Convenience and accessibility of online therapy	✓	✓	✓	✓	✓	
Healing Through the Journey of EMDR: preferences, challenges, grounding, and transformation	Preferred methods of bilateral stimulation: The comforting butterfly hugs	✓	✓	✓	✓	✓	✓
	Navigating through the confusing and challenging process of EMDR		✓	✓	✓	✓	✓
	The tangible processes: Grounding facilitates change	✓	✓	✓	✓	✓	
	'*No longer handcuffed*': Emotional freedom and transformation of mindset	✓	✓	✓	✓	✓	✓

Appendix K: Example of analysis process

Experiential statements		Verbatim transcript (Page 79)	Explanatory comments
Intense and overwhelming process Throw away lifetime escapism to deal with trauma Engagement with all the sensory elements Dealing with it face-on, is the process of therapy	P	Hard because, because yeah you've never had to directly. Well, I've never had to directly anyway, Okay, So. So usually anybody, anybody that, with me anyway, I can't speak for anyone else but with me, if you suddenly remember a thought, you, you, you've trained yourself to immediately forget about it, put it to the side. Think about how else to replace that thought so that you don't have to. It's also about smells. It's about different smells and. And smells, small are harder to put because it still it still stays there, the smell. But when they put it in, when you have to think about it constantly, there's a part, there's a part of me that's a little bit angry because I am forced to. Because usually my escapism is the way I escape the situations is the way that I've learned to heal. What I thought trying to heal myself is to run away from it and to think about something else. But then you realise that you just have to just deal with it face on, isn't it really? Well, with this therapy, you do anyway. Deal with it face on. I found it really hard. I found that really, **really hard. That was really hard.** Yeah.	Found the processing '**really** hard' Couldn't use the regular previous escapism – avoidance and coping strategies? The process involved putting away the lifetime coping mechanism and dealing with it – it's that hard. Usually, replacing thoughts would help, but in the process, you have to constantly stay with it, not only the memory, but with all the sensory elements too, e.g. smells. Feel angry that she was forced to engage with it to 'deal with it face on'. **(Descriptive comments)** But seems to have a self-realisation that the lifetime coping strategies which she thought was helping, it's not helping her. Seeing the benefit of processing - that 'forced' engagement of dealing with it. Emphasising the intensity by saying it three times "really hard". **(Conceptual comments)**
	I	Okay It is. I could I'm sensing that you, even now. It's almost coming to you, isn't it? Just kind of the intensity of difficulties? Are you. Are you okay?	
Emotionally challenging process Intense but it works.	P	Yeah. It's only because you just, you just think about. It's funny because I'm not getting emotional because of just the process of it; it's it's hard it's really hard to have to. What it is essentially is it's that you ok let me just try to explain this. *You're given a clip of film, right? Which is an experience of your life. You have to press play, right? And you have to sit down, square on, in front of that screen and look at it. Your coping mechanism is being able, you being able to press pause and just turn the screen off, right. But you are forced to sit there; It's like somebody has literally got you handcuffed to a chair and you're forced to sit there with your eyes open and look at the screen. And you have to constantly look at that screen. You can't take your eyes off the screen. So that's hard. It's really hard. But you realize that as you constantly play this thing in your head over and over again that through the therapy that is given to you, that you're, it's slowly, can't explain it, like it slowly gets better.*	She gets emotional as she explains the process. Playing a '*A clip of film*' explains the overwhelming process of processing – as if feeling like someone '*handcuffed*' her and forced her to watch that file (her traumatic experiences), and constantly, with no pausing or stopping, watch that film without taking the eyes off the screen (no usual coping strategies, e.g. avoidance or distraction) and it's hard, watching this film repeatedly slowly makes it better and easier. This metaphorical explanation describes the intensity of the process, but it got easier and better (effect of the traumatic memories gets better?) **(Linguistics comments)**

(Initial scattering of experiential statements with no particular order)



(Clustering of experiential statements)

Appendix L: Ethics Approval of Change of Title application

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Research Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Shireen Sultana**
Programme of study:	**Professional Doctorate in Counselling Psychology**
Title of research:	**Exploring Ethnic Minority Clients' Experience of Online Eye Movement Desensitisation and Reprocessing Therapy: An Interpretative Phenomenological Clients' Perspective**

Name of supervisor:	**Dr Lucy Poxon**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Exploring Ethnic Minority Clients' Experience of Online Eye Movement Desensitisation and Reprocessing Therapy: An Interpretative Phenomenological Clients' Perspective
New title:	Exploring Ethnic Minority Clients' Experience of Online Eye Movement Desensitisation and Reprocessing Therapy for Trauma: An Interpretative Phenomenological Clients' Perspective
Rationale:	Viva amendment has been suggested to include trauma to represent thesis topic appropriately.

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature

Student: (Typed name to act as signature)	**Shireen Sultana**
Date:	**20/05/2024**

Reviewer's decision

Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The title change was suggested in the viva.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**20/05/2024**	