The utilization of eye movement desensitization reprocessing as a therapeutic tool

Brian Scott Waldman

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THE UTILIZATION OF EYE MOVEMENT DESENSITIZATION REPROCESSING AS A THERAPEUTIC TOOL

A Project
Presented to the Faculty of California State University,
San Bernardino

In Partial Fulfillment of the Requirements for the Degree Master of Social Work

by
Brian Scott Waldman
September 2001
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San Bernardino

by

Brian Scott Waldman
September 2001

Approved by:

8/27/01

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ABSTRACT

Eye Movement Desensitization and Reprocessing, EMDR, is a new clinical treatment shown to be effective for victims of trauma. EMDR is a time efficient, comprehensive methodology backed by positive, controlled research, for the treatment of the disturbing experiences that underlie many pathologies. An eight phase treatment approach that includes using eye movements or other left-right stimulation, EMDR helps victims of trauma reprocess disturbing thoughts and memories.

The purpose of this research project was to describe and explore the utilization of EMDR by licensed clinical social workers (N=230) who were registered as members of the National Association of Social Workers (NASW). Out of 230 licensed clinical social workers 211 were not certified EMDR clinicians (91.7%) and 19 were certified EMDR clinicians (8.3%). Of special interest was the particular clinical problems they address for clients in search of treatment which included Post traumatic Stress Disorder, Adjustment Disorder, Generalized Anxiety Disorder, Dysthymia, Phobias, Major Depressive Disorder, and Obsessive Compulsive disorder.

An additional focus of attention was the prevalence of clinical outcome research conducted in relation to the
utilization of EMDR as a therapeutic tool. The data collected demonstrate that the social workers in this sample utilize EMDR for a variety of clinical problems, but seldom do outcome research. Out of 19 respondents 17 reported that they did not conduct clinical outcome research (89.5%), and 2 reported that they did conduct clinical outcome research (10.5%).
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CHAPTER ONE

INTRODUCTION

Problem Statement

The specific problem or issue this study addressed was the prevalence of the use of Eye Movement Desensitization and Reprocessing (EMDR), presenting problems treated, and corresponding clinical outcome research conducted by licensed clinical social workers. As clinicians, we have a responsibility to not only provide the best care possible for our clients, but also, to evaluate our clinical practice and the underlying theoretical approaches we employ by conducting clinical outcome research. This is especially salient as regards the sudden rise in popularity of the therapeutic technique known as EMDR.

EMDR is a complex method that incorporates salient aspects of the major therapeutic modalities. The basic underlying principles are explained in the Accelerated Information Processing model which posits the ability to directly access and process dysfunctional perceptions that were stored at the time of the traumatic event. These state dependent perceptions are considered the primary cause of posttraumatic stress symptomatology. Additionally, rigid and maladaptive schemata are assumed to be caused by earlier
life experiences that are dysfunctionally stored. The primary goal of EMDR is to release clients from the non-adaptive bonds of the past, thereby providing them with the ability to make positive and flexible choices in the present. Current research (see literature Review) on EMDR substantiates its ability to rapidly and effectively process the targeted event and attendant trauma. The eight phases of treatment are considered necessary to resolve the somatically-based pathologies (Shapiro, 1998).

Being concerned about this research issue should be the responsibility of any clinician using EMDR as a therapeutic tool, whether it be in private practice or under the auspices of a mental health agency. This study focused its energy on licensed clinical social workers, as this researcher was especially interested in this population.

It is important to understand this problem further because it will bring to light the suspected paucity of clinical outcome research being conducted by licensed clinical social workers in regards to their utilization of EMDR as a therapeutic tool. There exists today a considerable gap in the research related to the underlying physiological mechanisms of the effectiveness of EMDR as compared to clinical outcome research. This tends to be the case in the social sciences because to understand why
something works is not considered as important as the simple fact that it works. This may be especially true as regards EMDR. This doesn’t mean that the therapeutic technique shouldn’t be used, but, rather, that clinical outcome research needs to keep pace with scientific inquiry into underlying physiological mechanisms.

Problem Focus

It is an undisputed point that controlled studies are imperative to examine the effectiveness of EMDR, or any other method of psychotherapy, but a different type of research, extensive clinical reporting, may also be of great importance. Controlled treatment outcome studies have inherent limitations in that the number and type of cases inspected must be finite and the use of the treatment must be carefully administered. In essence, there is much that could be missed about the effects of a therapeutic method in true clinical settings, about the extent of its applicability, and, of tantamount importance, about the dangers or limitations to its use.

The results of this study have explored the area of suspected weakness in clinical outcome research which needs to be addressed. To think that this study might change social work practice in regards to utilization of EMDR and
corresponding clinical outcome research is a lofty goal. This is not the impetus for this research, although, there could be a small, positive, ripple effect within the field of social work due to its inquiry. The motivation for this research was to come to a place of understanding where we are as a profession as regards EMDR and clinical outcome research. Once we understand where we are, we have a place from which to start to utilize the information garnered through research and make changes where necessary, if we so choose. This will benefit the social work profession by making it more accountable for the application of particular therapeutic techniques such as EMDR, and also, most importantly, will help the clinician utilize the most applicable, safe, and effective therapy for each individual seeking help.

Research Question(s)

- What is the prevalence of the utilization of EMDR as a therapeutic tool by licensed clinical social workers?
- What is the prevalence of the utilization of EMDR as a therapeutic tool in relation to specific presenting problems?
• What is the prevalence of clinical outcome research conducted by licensed clinical social workers in relation to the utilization of EMDR as a therapeutic tool?
CHAPTER TWO
LITERATURE REVIEW

As regards the existing knowledge that could have guided this study, there was basically, none, that has been found at this point, specifically concerning the population under study, i.e., licensed clinical social workers. As such this study was exploratory in nature. The information gathered from this study could be utilized within many different agencies and guide direct clinical practice. Also, it could point to further research studies which could be conducted based on the information generated.

EMDR was introduced in 1989 with a controlled treatment outcome assessment study (Shapiro, 1989a, 1989b). This study served the important role of generating further investigation. The study cited was one of the first of its kind in the area of PTSD. (Shapiro, 1995).

A pilot study (Boudewyns, 1993) found significant positive results from EMDR for self-reported distress levels and therapist assessment. Results were considered positive enough to warrant further extensive study, which has been funded by the VA.

A controlled study of the EMDR treatment of 25 Vietnam combat veterans suffering from PTSD (Jensen, 1994), as
compared to a non-treatment control group, found small but statistically significant differences after two sessions for in-session distress levels, as measured on the SUD Scale. This research was conducted by two psychology interns who had not completed formal EMDR training which may have attributed to the lack of positive findings on other assessment scales.

A controlled study of 45 Hurricane Andrew (Florida) survivors (Levin, 1994) found significant differences in scores on the SUD and Impact of Event scales, pointing to a superiority of EMDR treatment to supportive crisis-counseling and non-treatment controls at 1-month and 3-month follow-ups.

In a study of 17 chronic outpatient veterans (Pitman, 1993), subjects were divided into two EMDR groups. One group used eye movements and a control group used a combination of forced eye fixation, hand taps, and hand waving. Six sessions were given for a single memory in each condition. Both groups showed significant decreases in self-reported distress, intrusion, and avoidance symptoms.

A controlled component study of 23 PTSD subjects compared EMDR with eye movements initiated by tracking a clinician’s finger, EMDR with eye movements produced by
tracking a light bar, and EMDR using fixed visual attention. All three methods produced positive changes.

The initial controlled study (Shapiro, 1989a) of 22 rape, molestation, and combat victims compared EMDR and a modified flooding procedure. Treatment effects were positive for the treatment and delayed treatment conditions on SUDs and behavioral measures. These results were corroborated at 1- and 3-month follow-up sessions.

In a controlled comparative study (Vaughan, 1994), 36 subjects with PTSD were randomly assigned to treatments of (1) imaginal exposure, (2) applied muscle relaxation, and (3) EMDR. All treatments led to significant decreases in PTSD symptoms for subjects in the treatment groups as compared to those on a waiting list, with a greater reduction in the EMDR group, particularly with respect to intrusive symptoms.

In a controlled study (Wilson, D., 1995), 18 subjects suffering from PTSD were randomly assigned to eye movement, hand tap, and exposure-only groups. Significant differences were found using physiological measures and the SUD Scale. The results revealed with the eye movement condition only, a one-session desensitization of subject distress and an automatically elicited relaxation response, which arose
during the eye movement sets and which appears to support a conditioning model.

Wilson, S. (1995) randomly assigned 80 trauma subjects (37 diagnosed with PTSD) to treatment or delayed-treatment EMDR conditions and to one of five trained clinicians. Results worth noting were found at 30 and 90 days and 12 months posttreatment on 6 different scales and effects were similar whether or not the subject was diagnosed with PTSD.

The investigation of any new method should include both clinical observations and experimental findings. The previous empirical research in the area of EMDR consists primarily of research related to Post Traumatic Stress Disorder (PTSD). Controlled clinical outcome research in many areas of mental health is unfortunately scarce and traditionally lags far behind clinical practice. Clearly, there is a strong need for more clinical outcome research on trauma populations. This is the underlying assumption driving this research endeavor as it relates to the specific population of licensed clinical social workers and the use of EMDR as a therapeutic tool.

A guiding principle of this study was the fact that the need to upgrade the level of clinical research is extremely important for the practicing clinician. Knowing the extent to which clinical outcome research is conducted in relation
to EMDR is a starting point upon which to build further knowledge. No single study causes a method such as EMDR to be accepted or discarded, but it is the personal responsibility of the clinician within the social work profession to be guided by the scientific principles of research. If the purpose of research is to objectify subjective experience, then it becomes apparent that there must be some external validation of the clinician’s subjective utilization of the therapeutic tool, in this case, EMDR.

The question of how well clinical outcome research studies are conducted, much less the extent to which they are being conducted, is hardly an academic issue only. It is an issue that relates directly to the practicing clinician, especially in the age of managed care, where research results drive decision making. If licensed clinical social workers are to be directed toward or away from using any specific treatment methods in the care of their clients, this guidance needs to stem from the testing of methods which are consistent with clinical practice.

Much more scientific inquiry needs to be done, and such issues as treatment fidelity, the use of appropriate standardized measuring instruments and treatment comparisons, and the identification of suitable populations
must be made most salient so as to test therapeutic tools such as EMDR adequately. EMDR’s therapeutic potential is vast, and so is each licensed clinical social worker’s responsibility to use it wisely and well. Clients place their lives and their psyches in the care of licensed clinical social workers and other licensed professionals. It is imperative that only one’s highest integrity, one’s most educated level of skill, and one’s most heartfelt compassion should guide the clinician’s response to the client’s need.
CHAPTER THREE

METHOD

Participants

The sample from which the data were obtained was the listing of licensed clinical social workers in the National Association of Social Workers (NASW) clinical registry. The NASW clinical registry contained the names and addresses for approximately 7,000 licensed clinical social workers. The data source were the responses from a self administered mail survey sent to 663 licensed clinical social workers whose names were obtained from this listing, and represented approximately 10% of the total population.

The selection criteria for this study determined where the sample was obtained from because social workers must be licensed in order to be trained in EMDR therapy. At a practical level, this study utilized an easily accessible population from which it obtained its sample, having been sufficient in quality and quantity to fulfill the requirements of the proposed study.
Procedures

The data were gathered through a self administered mail survey, consisting of 19 questions which were quantitative in nature. The data were gathered by this researcher and a small team of volunteers that assisted in addressing envelopes and affixing postage. The total number of questionnaires sent out was 663. Each mail survey contained an informed consent (see Appendix A) form and a statement of confidentiality, a self addressed stamped envelope, a debriefing statement (see Appendix B), and a survey (see Appendix C). Respondents were asked to place a check mark on a line acknowledging the purpose and nature of the study and informed consent. The licensed clinical social workers were asked to return the informed consent along with the survey.

The confidentiality of the individual was maintained throughout the data gathering and date entry process. Any information that was obtained in connection with this study and that could be identified with the participant, remained confidential. Anonymity was secured by not having any subject identifiable information on the survey instrument.
Instruments

A survey/questionnaire (see Appendix C) developed by this researcher was used to gather the necessary data. The instrument consisted of nineteen questions. However, only if respondents answered affirmatively to number 5 did they continue on with the survey and complete all nineteen questions. The first five questions were demographically oriented and included gender, age, ethnicity, years as a licensed clinical social worker, and whether or not the respondent was certified in EMDR.

The next six questions, numbers 6 - 11, were also demographic in nature, and consisted of the following, years as a certified EMDR clinician, capacity employed, clients treated with EMDR, total number of clients in caseload, and number of clients currently receiving EMDR therapy. Question number 12 specifically probed for information related to one of the research questions of this study, asking respondents what type of presenting problems they have treated with EMDR therapy. The next six questions, numbers 13 - 18, utilized a Likert-type scale, where subjects rated questions which consisted of the following, use of EMDR therapy over the past three months, personal experience in client role during training, importance of supervised practice, comfort level using EMDR therapy, how
often EMDR therapy has led to physical and/or psychological reactions, and the effectiveness of EMDR therapy. Question number 19 was specific to one of the research questions also, asking whether or not they conduct clinical outcome research for individual clients receiving EMDR therapy.
CHAPTER FOUR

RESULTS

Descriptive Statistics

The number of responses for this study was 230 (38.7%) out of a total 663 mailed surveys (69 were returned to sender). Out of 230 licensed clinical social workers 211 were not certified EMDR clinicians (91.7%) and 19 were certified EMDR clinicians (8.3%). The sample consisted of 176 females (76.5%) with an average age of 57.3 and 54 males (23.5%) with an average age of 58.6. The demographic nature of those respondents who used EMDR compared to those respondents who did not use EMDR was obviously not significantly different, and needed no inferential statistical analysis. The average age of all respondents was 57.9, and the range of ages was from 35 to 80 years old. The average age of respondents that were EMDR certified was 58.5, and the average age of respondents that were not EMDR certified was 57.5. Out of 230 licensed clinical social workers 2 were Asian/Pacific (0.9%), 3 were Native American (1.3%), 4 were Latino (1.7%), 4 were African American (1.7%), and 217 were Caucasian (94.3%). The respondents had an average of 22.1 years as a licensed clinical social worker. The average number of years as a licensed clinical
worker. The average number of years as a licensed clinical social worker of respondents that were EMDR certified was 22.5, and the average number of years as a licensed clinical social worker of respondents that were not EMDR certified was 22.1.

The following results were generated from data gathered from the licensed clinical social workers who were certified EMDR clinicians (n=19). The average respondent had been certified for 3.1 years, and spent 81.1 percent of their time in direct practice. Out of 19 respondents 17 reported their capacity of being employed in private practice (89.5%), 1 reported being employed in a state/mental health agency (.4%), and 1 reported being employed as a university affiliate (.4%). Respondents reported having treated an average of 57.2 clients with EMDR therapy, and the range was from 2 to 400 clients. The average number of total clients in the respondent’s caseload was 39.4, and the range was from 15 to 150 clients. Respondents reported an average of 4.9 clients in their caseload that were currently receiving EMDR therapy, and the range was from 0 to 20 clients.

The licensed clinical social workers in this sample reported having treated individuals with EMDR therapy for the following types of presenting problems (see Table 1).
Table 1.

Presenting Problems Treated with Eye Movement Desensitization Reprocessing

<table>
<thead>
<tr>
<th>Problems</th>
<th>Frequencies (n)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Traumatic Stress</td>
<td>16</td>
<td>84.2</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>11</td>
<td>57.9</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>9</td>
<td>47.4</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>7</td>
<td>36.8</td>
</tr>
<tr>
<td>Specific Phobias</td>
<td>6</td>
<td>31.6</td>
</tr>
<tr>
<td>Major Depression</td>
<td>5</td>
<td>26.3</td>
</tr>
<tr>
<td>Obsessive Compulsive</td>
<td>4</td>
<td>21.1</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>3</td>
<td>15.8</td>
</tr>
<tr>
<td>Bipolar I Disorder</td>
<td>2</td>
<td>10.5</td>
</tr>
<tr>
<td>Polysubstance Dependence</td>
<td>2</td>
<td>10.5</td>
</tr>
<tr>
<td>Dissociative Identity</td>
<td>2</td>
<td>10.5</td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>1</td>
<td>5.3</td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td>1</td>
<td>5.3</td>
</tr>
<tr>
<td>Pathological Gambling</td>
<td>1</td>
<td>5.3</td>
</tr>
<tr>
<td>Paranoid Personality</td>
<td>1</td>
<td>5.3</td>
</tr>
<tr>
<td>Schizophrenia Paranoid Type</td>
<td>1</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Out of 19 respondents, 5 reported that their use of EMDR therapy had increased moderately (26.3%), 3 reported significant increases (15.8%), and 6 reported no change (31.6%).

Out of 19 respondents, 6 rated their personal experience in the client role during training as moderately helpful (31.6%), 5 reported it as minimally harmful (26.3%), 5 reported it as minimally helpful (26.3%), and 3 rated their experience as neutral (15.8%).
When respondents rated the importance of supervised practice during training sessions, 6 thought it was extremely important (31.6%), and 7 thought it was very important (36.8%).

When asked to describe their comfort level using EMDR therapy, 12 respondents reported that they were as comfortable as with any procedure (63.2%).

In terms of the effectiveness of EMDR therapy, 8 respondents rated it as moderately effective (42.1%), 7 reported it as very effective (36.8%), and 4 reported it as somewhat effective (21.1%).

Out of 19 respondents 17 reported that they did not conduct clinical outcome research (89.5%), and 2 reported that they did conduct clinical outcome research (10.5%).
The purpose of the study was to describe and explore the utilization of Eye Movement Desensitization and Reprocessing (EMDR), presenting problems treated, and corresponding clinical outcome research conducted by licensed clinical social workers. The percentage of social workers in this study that were certified in EMDR therapy (8.3%) is slightly less than the 11 percent reported by the EMDR institute in a demographic survey of the first 2,000 individuals trained (Shapiro, 1995). The difference may be accounted for by the average age (57.1) of the respondents sampled from the NASW clinical registry, being that EMDR therapy is a relatively new therapeutic technique.

As expected, the most treated presenting problem was Post traumatic Stress Disorder (PTSD). This was expected because the majority of the early application and research of EMDR therapy was centered around treating victims of trauma that suffered from PTSD symptoms. Since that time, as this study has shown, clinicians treat a wide variety of presenting problems, and have found it to be effective and efficient.
Also as expected, licensed clinical social workers are not conducting clinical outcome research. This is disturbing because as clinicians, we have a responsibility to not only provide the best care possible for our clients, but also, to evaluate our clinical practice and the underlying theoretical approaches and specific techniques we utilize. This is especially important as regards the increased utilization of EMDR therapy.

Limitations

The limitations found in the study exist within the relatively small sample of respondents that were certified EMDR clinicians. This made difficult the use of any statistical analysis other than frequencies. To overcome this problem in the future, it would be necessary to sample a population of licensed clinical social workers that were known to be certified in EMDR therapy.

Another limitation found to exist in the study was the wording of question number 5 in the survey. The respondents were asked if they were licensed EMDR clinicians. Individuals do not become licensed in EMDR therapy, but rather they become certified. But, it is necessary to be a licensed professional, and this created confusion and may have affected the results. Again, this limitation can be
overcome in any subsequent study by sampling a population of licensed clinical social workers known to be certified in EMDR therapy.

Conclusion

Results of the study create a ground from which further exploration can be done. The results show that the utilization of EMDR is prevalent enough to warrant focusing attention on clinical outcome research, especially in light of the variety of presenting problems individuals are being treated for by licensed clinical social workers. The results show that licensed clinical social workers think EMDR therapy is effective, but how do they know? Clinical outcome research is the answer. This will benefit the social work profession by making it more accountable for the application of particular therapeutic techniques such as EMDR, and also, most importantly, will help the clinician utilize the most applicable, safe, and effective therapy for each individual seeking help.
APPENDIX A:

INFORMED CONSENT
APPENDIX A

Informed Consent

Survey participant,

My name is Brian Waldman. I am a graduate student in the Master of Social Work program at California State University, San Bernardino. The purpose of the following survey is to describe and explore the utilization of EMDR as a therapeutic tool by licensed clinical social workers.

The length of time necessary to complete this survey is approximately 15-20 minutes. Your responses will be anonymous as no identifying information such as your name is required. Instead, all completed and returned surveys will be identified by a number only. The information obtained will be reported as to the make-up of the entire sample of licensed clinical social workers asked to participate. It will not reflect any one individual in particular. The results of this study will be used for a research project as partial fulfillment of the requirements for a master degree in social work.

Your potential participation is entirely voluntary, and you have the right to withdraw your participation and data at any time. This researcher can see no foreseeable risks associated with participation in this study.
APPENDIX A (continued)

This research study has been approved by the Department of Social Work Sub-Committee of the California State University, San Bernardino, Institutional Review Board. If you have any questions or concerns regarding this research study, please feel free to contact the MSW Research Coordinator, Dr. McCaslin, Professor of Social Work (909) 880-5507).

My mark below indicates I have been fully informed about this study and freely volunteer to participate.

_________ Date_________
APPENDIX B:
DEBRIEFING STATEMENT
APPENDIX B

Debriefing Statement

The study in which you have just participated will describe and explore licensed clinical social workers' utilization of EMDR as a therapeutic tool in their clinical practices. All licensed clinical social workers participating in this study were found in the NASW clinical registry, and were randomly chosen. Your participation in this survey will inform other professions, as well as your own, about the utilization of EMDR as a therapeutic tool.

If you are interested in the results of this study, you may contact this researcher, Brian Waldman at (909) 981-4788 or E-mail BrianSWaldman@hotmail.com. Complete results will be available after June, 2001. If you have any questions or concerns regarding this research study, please feel free to contact, Dr. McCaslin, Professor of Social Work (909) 880-5507.
APPENDIX C:
SURVEY/QUESTIONNAIRE
APPENDIX C

SURVEY/QUESTIONNAIRE

1. What is your gender? Male_____ Female_____

2. What is your age?_____

3. What is your ethnicity?
   - African American_____
   - Native American_____
   - Caucasian_____
   - Latino_____
   - Asian/Pacific_____
   - Other(specify)_____________

4. How many years have you been a licensed clinical social worker?_____

5. Are you a licensed EMDR clinician? Yes_____ No_____ 
   If you responded Yes to question number 5, please complete the rest of the questionnaire. If you responded No to question number 5, it is not necessary to complete the rest of the questionnaire, but please do return the survey with the above five questions answered, using the self addressed stamped envelope provided. Thank you.

6. How many years have you been a licensed EMDR clinician?_____

7. What percentage of time(approximate) do you spend in direct practice?_____

8. In what capacity are you employed?
   - Private practice_____
   - Veterans Administration_____
   - State or mental health agency_____
   - University affiliate_____
   - Other(specify)_____________
APPENDIX C (continued)

9. What number (approximate) of clients have you treated with EMDR?____

10. What is the total number of clients in your caseload?____

11. What is the number of clients currently in your caseload receiving EMDR therapy?____

12. What types of presenting problems (mental disorders defined in the DSM-IV) have you treated with EMDR therapy? (please list)

                                       
                                       
                                       
                                       
                                       
                                       
                                       
                                       
13. Has your use of EMDR therapy over the past 3 months (circle one number to rate)

<table>
<thead>
<tr>
<th>decreased</th>
<th>stayed the same</th>
<th>increased</th>
</tr>
</thead>
<tbody>
<tr>
<td>-3</td>
<td>-2</td>
<td>-1</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

14. In order to become a licensed EMDR clinician it was necessary for you to participate in EMDR workshops where you were the recipient of EMDR treatment as a client. How would you rate your personal experience in the client role when you received EMDR treatment in practice sessions at the EMDR workshop? (circle one number to rate)

Very harmful | Neutral | Very helpful
-------------|---------|-------------
-3           | -2      | -1          |
| 0           | 1       | 2           |
| 3           |         |             |
APPENDIX C (continued)

15. How important is it for EMDR training to include supervised practice? (circle one number to rate)

<table>
<thead>
<tr>
<th>Not important</th>
<th>Somewhat important</th>
<th>Extremely important</th>
</tr>
</thead>
<tbody>
<tr>
<td>-3</td>
<td>-2</td>
<td>-1</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. How would you describe your comfort level using EMDR therapy? (circle one number to rate)

<table>
<thead>
<tr>
<th>Very uncomfortable</th>
<th>Somewhat uncomfortable</th>
<th>As comfortable as with any procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>-3</td>
<td>-2</td>
<td>-1</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. Compared to other treatment procedures you have used, how often have EMDR sessions led to...

<table>
<thead>
<tr>
<th>More often</th>
<th>As often</th>
<th>Less often</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal ideation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal ideation and activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extreme agitation or panic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergence of repressed material</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-session dissociation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post session dissociation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye damage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancellation of appointment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premature termination of therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General negative side effects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General beneficial effects</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. In general, how would you rate the effectiveness of EMDR? (circle one to rate)

<table>
<thead>
<tr>
<th>Not effective</th>
<th>Somewhat effective</th>
<th>Very effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>-3</td>
<td>-2</td>
<td>-1</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31
19. Do you conduct clinical outcome research for individual clients receiving EMDR therapy? Yes No. If yes, please briefly describe the means by which clinical outcomes are measured. Also, if you have any comments or additional information you would like to add, please use the backside of this page. Thank you.
APPENDIX D:

DEMOGRAPHIC SURVEY TABLE
APPENDIX D

DEMOGRAPHIC SURVEY TABLE OF THE SAMPLE

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>FREQUENCIES (n)</th>
<th>PERCENTAGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE (Mean=57.13)</td>
<td>230</td>
<td>100</td>
</tr>
<tr>
<td>YEARS LCSW (Mean=22.14)</td>
<td>230</td>
<td>100</td>
</tr>
<tr>
<td>GENDER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>176</td>
<td>76.5</td>
</tr>
<tr>
<td>Male</td>
<td>54</td>
<td>23.5</td>
</tr>
<tr>
<td>ETHNICITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>Native American</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>Caucasian</td>
<td>217</td>
<td>94.3</td>
</tr>
<tr>
<td>Latino</td>
<td>4</td>
<td>1.7</td>
</tr>
<tr>
<td>Asian/Pacific</td>
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<td>0.9</td>
</tr>
<tr>
<td>EMDR CERTIFIED</td>
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<td></td>
</tr>
<tr>
<td>No</td>
<td>211</td>
<td>91.7</td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>8.3</td>
</tr>
</tbody>
</table>
REFERENCES


