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An Interpretative Phenomenological Analysis (IPA) of EMDR clinicians experiences of bullying

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Abstract

To date, there have been two EMDR related studies that have explored clinicians' experiences of integrating EMDR, post training, back into the participants' clinical environment. One of the aspects that materialised from both these studies highlighted that some newly trained EMDR clinicians were experiencing behaviour indicative of bullying post EMDR training. Work place bullying is a situation in which one or several individuals persistently, and over a period of time; subjectively perceives being the recipient of negative actions from superiors or co-workers. This research project set out to explore this phenomenon in more detail utilising Interpretative Phenomenological Analysis (IPA). Twenty-two EMDR clinicians were recruited to take part. Six themes emerged from the data analysis: Hostility & Scepticism, Professional Practice & Integrity of EMDR, Credibility of EMDR as an Empirically Supported Psychotherapy, Activation and Breaking Point, Clinical Supervision & Consultation, Health & Well-being and Positive Growth. Consistent with IPA, each of the themes are highlighted using detailed narratives from the research participant's experiences. The rationale for this to best capture the participant's lived experience. Results highlighted the implications for individuals, organisations and the wider EMDR community in support of a policy of 'Zero Tolerance' in relation to bullying of any kind.

Introduction and Background Literature

Eye Movement Desensitisation & Reprocessing [EMDR] therapy is an evidence-based, psychotherapy for Post-Traumatic Stress Disorder and other mental health conditions, that is empirically supported by over twenty-four randomised control trials. Since Shapiro's origination of EMDR back in the early 1990's approximately 150,000 international mental health clinicians have been trained (Carrera, 2013). Its increased recognition and acceptance is founded upon several meta-analyses and international guidelines recommending EMDR therapy specifically as a psychological trauma intervention (ISTSS, 2008; WHO, 2013). Trauma Focused Cognitive Behavioural Psychotherapy [TF-CBT] and EMDR are considered to be the treatments of choice in relation to psychological trauma (Bisson & Andrew, 2007; Bisson et al 2007b; National Institute of Health & Clinical Excellence [NICE] 2005; WHO, 2013). As Farrell & Keenan (2013) purport that there is emerging practice-based evidence

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(PBE) relating to the application of EMDR therapy with mental health conditions other than PTSD including phobias, pain management, depression, low self-esteem, anxiety disorders and addictions (Bae, Kim, & Park, 2008; Brown, McGoldrick, & Buchanan, 1997; de Jongh 2012; de Roos, Veenstra, de Jongh, den Hollander-Gisman, van der Wee, 2009; Keenan & Farrell, 2000; Maxfield, 2007; Mevissen & de Jongh, 2010; Ricci, Clayton, & Shapiro, 2006). As Shapiro (2012) accentuates, that EMDR therapy addresses those life experiences that set the foundation for a wide range of clinical complaints involving negative emotions, physical sensations, thoughts, beliefs, behaviours and relationship difficulties.

To date, two studies have explored how clinicians, post EMDR therapy training, have gone on to integrate their new EMDR skills into their existing clinical practice (Dunne & Farrell, 2010; Farrell & Keenan, 2013). Although both studies were extensive, an intriguing phenomenon arose from both studies. Newly trained EMDR clinicians encountered problems after returning to their own working environment and integrating EMDR therapy into clinical practice. Of particular pertinence to this study were reports of 'bullying' types of behaviour in discouraging EMDR therapy to then be practiced post EMDR training.

This phenomenon of alleged bullying prompted further investigation to consider the size of the issue, its characteristics, the implication for the teaching and learning of EMDR, and its impact on the policy, practice and governance of EMDR therapy.

Literature searches for research and comment on workplace bullying reveal insufficient attention relating to the topic although there is increasing focus around bullying within educational establishments (Fekkes, Pijpers, & Verloove-Vanhorick, 2005; Schäfer, Korn, Smith, Hunter, Mora, Merchán, Singer, & Meulen, 2004). Empirical evidence suggests that workplace bullying is an important social problem that has detrimental implications for those exposed, as well as for organisations and society at large (Einarsen, Hoel, Zapf & Cooper, 2011a; Tepper & Henle, 2011). According to Hutchinson et al (2006a, 2006b, 2006c, 2009 & 2012) bullying is a gradual, cumulative, often hidden practice that can be an intensely harmful experience for victims. Bullying itself can involve a wide array of often quite subtle, and at times covert, forms of negative behaviour, the accumulation of which can result in significant distress (Schneider, O'Donnell, Stueve, & Coulter, 2012). Accumulative exposure can result in severe psychological trauma, low self-esteem, depression, anxiety and in some cases PTSD (Hutchinson et al, 2010). Kivimäki, Elovainio & Vahtera (2000), highlight that the unrelenting nature of bullying can not only cause psychological distress but also physical illness. Furthermore, Yamada (1999) suggests that bullying does not just impact and harm an individual but has a profoundly negative impact upon an organisation's productivity and service delivery.

Nielsen, Hetland, Matthiesen, & Einarsen, (2012) define work place bullying as a situation in which one or several individuals persistently, and over a period of time, subjectively perceive being the recipient of negative actions from superiors or co-workers where the target of the bullying finds it difficult to defend themselves against these actions. A current understanding

of workplace bullying emits from organisational psychology and is interpreted as a form of escalated interpersonal conflict. This often arises when individuals, often as a consequence of potential emotional instability operate within a working environment that is conducive to bullying activity. These three facets are outlined in figure 1.

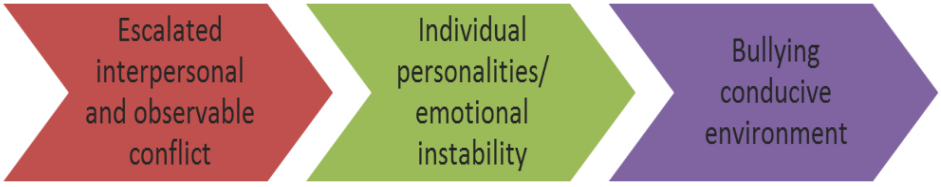

Figure 1: Traditional Model of Power & Bullying

These traditional models purport that conflict creates a situation where the personal power of one person over another is sought and increased through bullying behaviours. However as Hutchinson et al (2012a, 2012b) acknowledges such an over-simplistic understanding of bullying seems increasingly out of step as it fails to consider more detailed conceptions of power, in particular the nature and consequences of organisational power. It is the organisational aspect of bullying in relation to EMDR that prompted this research and was the rational for the study.

While there is no coherent, universally accepted definition of workplace bullying, the importance of the power imbalance between people is a key element within most definitions. Table 1 outlines Zapf et al's (1996) seven categories in differentiating bullying behaviours.

Table 1: Typical Bullying Types of Behaviours (Zapf et al, 1996)
• Work related bullying • Social isolation • Attacking the private sphere • Verbal aggression • Spreading of rumours • Physical intimidation • Attacking personal values and attitudes

According to Leymann (1996) an individual act of hostility in itself may not be considered bullying. Rather, it is the accumulation effect of patterns of behaviour rather than a specific act that has the potential for causing the most damage and distress to an individual. This cumulative impact can become destabilising, distressing and potentially traumatic for a recipient.

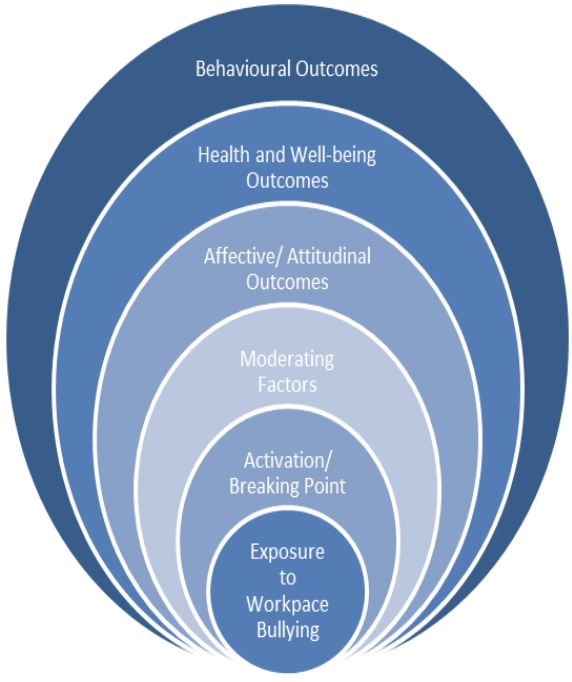

Figure 2: Consequence of bullying for individuals (adapted from Nielson & Einarsen, 2012)

Figure 2 outlines the possible relationship between bullying and consequences for individuals. There is an interaction between the severity and nature of the bullying and the individual characteristics and coping skills of the bullying recipient. This accumulative exposure to workplace bullying reaches a breaking point for a person. This activation occurs when there is a discrepancy between expectation and what actually happens (Ursin & Erikson, 2004) when moderating factors are instigated. These moderating factors include individual personality traits and coping patterns, affective and attitudinal outcomes including issues such as job satisfaction, work ethic, professional commitment and even a strategy of intent to leave the workplace. Health and well-being outcomes include mental and physical health problems, somatisation, adjustment disorder, psychological distress, PTSD, depression, fatigue, burnout, substance misuse, etc. The consequences for individuals therefore include diminution in their performance, increased absenteeism, and a significant impact upon career trajectory and professional development (Schäfer, Korn, Smith, Hunter, Merchán, Singer, & Meulen, 2004). However the organisational culture within which bullying takes place is also important to consider. Hutchinson et al (2010) suggests that bullying is more prevalent in institutions where certain organisational characteristics create a favourable climate for bullying to occur. Such characteristics include the existence of bullying networks and alliances within organisations, a culture that not only tolerates but actually rewards bullying behaviour, the misuse of legitimate authority, processes and procedures, and institutional normalisation of bullying behaviour within the organisation. During times of organisational downsizing there is an increased risk to employee safety and well-being which in turn increases the prevalence of violence and bullying at work. At one end of the

continuum this may manifest as micro-managing or undermining individuals and withholding important information (Einarsen, Hoel, Zapf, & Cooper, 2011).

The WHO (2013) Guideline for the management of conditions specifically related to stress determines:

> *"Trauma-focused CBT and EMDR therapy are recommended for children, adolescents and adults with PTSD ". Like CBT with a trauma focus, EMDR therapy aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve:*
>
> *(a) Detailed descriptions of the event*
> *(b) Direct challenging of beliefs*
> *(c) Extended exposure*
> *(d) Homework" (p.1)*

A question relates to the relationship between CBT and EMDR in considering if this plays any part in understanding EMDR clinicians' experiencing of bullying behaviour. Historically Shapiro was a behavioural psychologist who considers that, if her background had instead been of a psychodynamic persuasion, then EMDR therapy would have been more broadly accepted within the academic community. This is an interesting perspective but why should this be a factor?

In seeking to understand the phenomenon of bullying within the context of this research the relationship between EMDR and Cognitive Behavioural Therapy requires further exploration. Before its current understanding of EMDR therapy the intervention was known instead as Eye Movement Desensitisation (EMD). Its focus was that of 'Desensitisation' a technique considered consistent with CBT and imaginal exposure intervention. EMD became EMDR when Shapiro considered that the intervention was more than just desensitisation, trauma memories were actually being reprocessed. A theoretical rationale was developed known as Adaptive Information Processing (AIP) a model used to understand pathology and predict outcome of the EMDR therapy intervention. Despite EMDR therapy's strong empirical evidence base the approach still draws much criticism and scepticism from within the international CBT community.

A major controversy relates to the use of bilateral stimulation (BLS) within EMDR therapy as to whether it is an important component of the treatment. Despite several meta-analyses supporting the significance of BLS within EMDR (Lee, Taylor, & Drummond, 2006; Schubert, Lee, & Drummond, 2011; Jeffries, & Davis, 2012; Lee & Cuijpers, 2012) there is still a tendency for this aspect to be seen as superfluous. Instead more significant aspects are suggested including activation of functional memory networks, dosed exposure, cognitive restructuring, subjective evaluation, demand characteristics and the impact of the therapeutic relationship in itself. According to the American Psychological Association (APA) Division 56, EMDR is currently considered a 'controversial' therapy despite the abundance of evidence to indicate the contrary. Their exploration of the literature is just as comprehensive

as the WHO (2013) yet their guidance pro-actively supports trauma-focused CBT (TF-CBT) and Prolonged Exposure Therapy (PET) rather than EMDR therapy. A further example is offered by O'Donohue & Fisher (2012) who state:

> *"Cognitive Behavioural Therapy (CBT) is an important therapeutic paradigm as it has been shown repeatedly to be an efficacious and effective intervention for a variety of psychological problems ..... it might be argued, in an important technical sense, that it is the only valid therapeutic paradigm ..... the only, or at least the foremost, paradigm in psychotherapy .... it is not a 'one problem therapy' as some interventions are for example EMDR".*

EMDR therapists would simply not agree with O'Donohue and Fisher's (iBid) sentiments and yet it is a frequently presented viewpoint of EMDR therapy. Despite its strong, empirical evidence base, EMDR therapy is consistently subjected to ridicule, academic diminution and misunderstanding (Cahill, Carrigan, & Frueh, 1999; McNally, 1999). The empirical literature on PTSD treatments carried out by the US Department of Veterans' Affairs/Department of Defence (2004) expert panel concluded:

- ''Overall, argument can reasonably be made that there are sufficient controlled studies that have sufficient methodological integrity to judge EMDR as an effective treatment for PTSD'' (p. 5).
- ''Exposure therapy may not be appropriate for use with clients whose primary symptoms include guilt, anger, or shame'' (p. 4).
- ''EMDR may be more easily tolerated for patients who have difficulties engaging in prolonged exposure therapy'' (p. 2).
- ''The possibility of obtaining significant clinical improvements in PTSD in a few sessions presents this (EMDR) treatment method as an attractive modality worthy of consideration'' (p. 1).
- 'EMDR processing is internal to the patient, who does not have to reveal the traumatic event'' (p. 1).
- ''EMDR has been found to be as effective as other treatments in some studies and less effective than other treatments in some other studies'' (p. 9, summary).

However no psychological therapy or treatment intervention is beyond criticism. Any effective therapy should be robust and empirical enough to withstand the inevitability of critical review. The increasing evidence base in support of EMDR therapy, along with its global implementation often in response to various humanitarian crises, suggests that the therapy will always have its critics. The point being that criticism is not unique to EMDR. CBT is the strongest empirically supported psychotherapy currently available and is an approach that despite its abundant evidence regarding efficacy is subjected to critical consideration on a continued basis (Castro-Blanco, 2005; House & Loewenthal, 2008; Owen-Pugh, 2009; Wheelahan, 2009).

Even though clinical guidelines are designed to assist mental health clinicians, these guidelines are interpreted and implemented in various ways. For example within the United

Kingdom some psychology services will allow the use of EMDR for PTSD only and base this entirely upon NICE guidelines, whereas other psychology departments take a broader and more flexible approach to EMDR allowing its use with other mental health conditions beyond just PTSD. This inconsistency limits many clients ability to access EMDR therapy. For EMDR clinicians, knowing the potential for EMDR therapy being greater than PTSD, this creates an understandable degree of tension and frustration. A consideration therefore is should a client be made to fit the therapy, or the therapy adapted to meet the needs of a particular client? The National Institute of Health and Clinical Excellence (2005, 2011) guideline for PTSD stipulates that clients should be offered either trauma-focused psychological treatment (trauma-focused CBT or EMDR). The recommendation is that clients should be offered choice between the two interventions. But does this translate to practice? These macro perspectives regarding EMDR in relation to policy, clinical governance and service delivery potentially has some impact in how the teaching and learning of EMDR is translated to practice. An exploration is to consider what impact bullying may have, if any, with regard to this. In any research activity it is essential to clearly define the key terms that are core to the project. For the purpose of this research project bullying is defined as any severe or pervasive physical or verbal act or conduct, including communications made either in writing or by means of an electronic act.

Methodology

Interpretive phenomenological analysis (IPA) aims to explore in detail how participants make sense of their personal and social world and has social cognition as its central analytic focus (Smith & Osborn, 2007). It provides a framework for the research process and a structured system for data analysis. The approach is phenomenological in that it attempts to explore an individual's personal perception of an object or event rather than produce an objective statement of the object or the event itself. IPA assumes a 'chain of connection' between peoples use of language and their thinking and emotional state. However, it also recognises that it is impossible to gain an insider's perspective completely or directly. Access depends upon and is complicated by the interpretations of the researcher. The method recognises that people struggle to express what they are thinking and feeling and the researcher often has to interpret people's mental and emotional state from what they say. The onus in this method is to make those interpretations explicit and open to challenge and modification. Therefore within IPA the research exercise is a dynamic process, meaning the researcher taking an active role is a vital part of the process. IPA involves a two stage process of interpretation known as a double hermeneutic: the participant trying to make sense of their world whilst the researcher is also trying to make sense of the participant making sense of their own world. Inherent within the process is a combination of an empathic hermeneutic and a questioning hermeneutic.

The aim of this research project was as follows:
Through the use of interpretive phenomenological analysis explore EMDR clinicians' experiences of alleged bullying post EMDR training.

The study adhered to two research objectives:

1. Undertake a narrative appraisal of participants' experiences of alleged bullying post EMDR therapy training
2. Exploration of research participants' subjective meaning and appraisal post alleged bullying

The discourse of 'alleged' is imperative in that throughout the study, no attempts were made to either prove or disprove the participants' experiences. The participants' experiences were their experiences.

The study involved **two** distinct stages with the first utilising an electronic survey questionnaire via Survey Monkey. The questions asked included: when they completed their EMDR therapy training, current EMDR therapy experience, gender, professional job title, gender of alleged perpetrator of bullying, whether the alleged bullying was reported and investigated, pertinent factors, relationship with the alleged bully(s), and the type and experiences of alleged bullying, levels of absenteeism, organisation systems and investigatory procedures, overall subjective narrative about their experiences.

Many of the questions asked were 'open' to enable research participants to expand upon their narrative experiences. At the end of the electronic survey questionnaire research participants were invited to participate in stage two which explored the phenomenon in more detail through the use of a semi structured interview.

Questions included:

1. For you as a clinician what is your attraction with EMDR?
2. Could you tell me more about your experience of being bullied post EMDR therapy training?
3. What was it about this experience that made it so significant for you?
4. What would you say is your 'here & now' perspective on this experience?
6. In your opinion how do you think the EMDR community can address this issue, if at all?
7. How has it been for you to be part of this research study?

With the semi-structured interviews, the investigator had an interview schedule however; importantly the interviews were guided by the schedule rather than dictated by it. According to Smith & Osbourne (2007) four principles were in adherence when undertaking these interviews:

1. An attempt to establish rapport with the research participant
2. The ordering of the questions were of less importance
3. The interviewer was free to probe interesting areas that might arise from the interviews
4. The interviewer followed the research participant's interests or concerns.

A key component of IPA is that analysis should be developed around substantial verbatim excerpts from the data. To ensure greater transparency and reflexivity, and in addition

purposeful triangulation, analysis was carried out by all of the research team members and formed the basis of open discussion and dialogue. To reduce bias IPA employs several methods of cross-validation, including co-operative inquiry and researcher, method, and analysis triangulation. Cooperative inquiry allows participants to agree with or challenge a researcher's interpretation. Researcher triangulation involves having different researchers approach the same issue and then compare their analyses.

Interview transcripts were read, and re-read several times by each member of the research team, to ensure that a general sense was obtained of the whole nature of the participant's accounts. During this stage notes were made of potential themes and the process was further informed by the researcher's experience of the interview itself. This involved both the insider phenomenological perspective with the outsider interpretative position. During re-reading emergent themes were identified and tentatively organised. Attention focused on the themes to define them in more detail and establish their inter-relationships. The focus was on the psychological content of the phenomenon under investigation and the data was then condensed (Osbourne & Smith, 1998). The shared themes were organized to make consistent and meaningful statements which contributed to an account of the meaning and essence of the participants' experience grounded in their own words. In order to give a stronger identity to each of the themes, the capture of the research participant's narrative ensured a rich context of their lived experience.

The advantages of using semi-structured interviews were that it facilitated rapport, aided empathic attunement, allowed greater flexibility and has a greater potential for producing richer data from the participant's narrative. These interviews were carried out by telephone and were audio recorded and then transcribed before being subjected to interpretative phenomenological analysis. Analysis involves the following stages:

1. Identification of initial themes
2. Clustering of themes
3. Emergent themes
4. Research participants were recruited from EMDR UK & Ireland, EMDR Europe, EMDR International Association (North America), EMDR Asia and EMDR Ibero-America (South America)

Analysis

Twenty-two participants took part in the study. The participants themselves considered that their experiences were indicative of 'bullying' as per the study's definition. The research team did not attempt to question or challenge the participant's experiences. Within the group of participants twenty described their experiences as being historical experiences with the remaining two declaring that the bully was current. Three research participants described that their experiences of being bullied had lasted over seven years in duration. Other participant's experiences ranged from one episode to several months through to a

couple of years. Only nine participants ever reported their experiences the other thirteen did not pursue any further action or investigation. Six participants declared that the extent of the bullying was so powerful that they ended up going off on sick leave'. Table 2 highlights some of the data that emerged from the research participants.

Research Question Areas from Stages 1 & 2	***Theme Results***	***N=22***
In what year did you complete your EMDR Training?	Pre 2005 Post 2005	8 (36%) 14 (64%)
Current EMDR experience?	EMDR Accredited Consultant EMDR Accredited Practitioner EMDR Clinician	2 (9%) 6 (27%) 14 (64%)
Please indicate your gender/	Male Female	5 (23%) 17 (77%)
Please highlight your professional job title?	Psychiatrist Psychologist Psychotherapist/ Counsellor Social Worker Occupational Therapist	7 (32%) 6 (27%) 5 (23%) 3 (14%) 1 (4%)
Gender of alleged perpetrator?	Male Female Both	32% 26% 42%
Did you ever report the bullying?	Yes No	37% 63%
Pertinent factors in relation to the bullying **(Rank Order)**	Professional background Professional Competence Relationship status Age Cultural background/ ethnicity Gender Sexuality	1 2 3 4 5 6 7
	Manager/ Team leader Colleague Other	11 (50%) 9 (41%) 2 (9%)
Type of bullying	Overt Covert Both	5.3% 36.8% 57.9%

Table 2: Research Question Areas, Themes and Results

Following an analysis of each of the narratives from the twenty-two participants six themes were identified:

- Hostility & Unhealthy Scepticism

- Professional Practice & Integrity of EMDR
- Credibility of EMDR as an Empirically Supported Psychotherapy
- Activation and Breaking Point
- Clinical Supervision & Consultation
- Health & Well-being and Positive Growth

Theme 1 - Hostility & Unhealthy Scepticism

One of the strongest themes that emerged from the research, related to the ways in which EMDR was viewed with various degrees of hostility and scepticism from both hierarchal personnel in the form of managers and team leaders but also from fellow colleagues. An example of this relates to participant 3's experience:

> "I interviewed for a possible internship placement in an organisation that worked with military veterans. In my application I indicated that I was trained in EMDR. This came up during the interview when the manager of the organisation informed me that "EMDR does not work" and cited a 1995 study of women sexual assault victims as sole evidence. Following our interview I found out that one of my colleagues was actually taken on for the internship. A couple of weeks later I was called into this same manager's office and was told that there was "no place for my particular skills". Because of my interest and passion in EMDR I was labelled as 'difficult to work with", a label that despite no evidence to support, I was unable to shake off for many, many years." (Participant 3)

This participant clearly considered that her EMDR experience actually led to her discrimination from being able to successfully secure an internship. A similar viewpoint was presented by participant 18:

> "Because of my interest in EMDR and wanting to integrate it into the existing service provision, I have been ostracised from colleagues, made to feel that I don't belong and in fact have been told so on repeated occasions. I have had Clinical Supervisors being quite verbally nasty. I have had colleagues not speak to me, all because of EMDR." (Participant 18)

In this example the hostility is much more overt and explicit. This participant found this whole experience profoundly distressing and questioned why so many other aspects of their clinical practice were not subjected to the same degree of hostility as EMDR was? Participant 5 goes even further by suggesting that their being trained in EMDR was akin to being an "unbiased EMDR cult devotee":

> "The bullying began with scare tactics, i.e. being told that we might train in EMDR but would not be allowed to use it since no supervisors were interested in being trained. Bullying continued when supervisors who eventually were trained, failed to

> be spectacularly effective with the one or two clients they tried it with. Then I began to experience a weird level of questioning of my experiences as if I might be making up the successes of my clients! I am now treated like I am a hopelessly unbiased EMDR cult devotee. The bullying in my opinion continues since all therapists who need consultation or want additional training have to pay for this out of their own pocket. One supervisor tried to convince me that I was not allowed to get outside consultation since this violates county confidentiality policy. We have supervisors who are inexperienced in using EMDR in complex cases. These supervisors don't use EMDR themselves, either because they do not carry a caseload or because they have such low confidence in their ability to supervise an EMDR clinician that they discourage its use in most cases" (Participant 5).

> "The managers were saying nobody's going to do EMDR, we don't do that here, we're CBT kind of focused" (Participant 2).

Participant 7 is explicit in his assertion that the bullying was connected with EMDR:

> "Yes, yes…It is confusing because we don't know what's on other peoples' minds and there are always other issues involved but basically I think the core of those three events was my insistence of doing eye movement therapy. Subsequently, I've had trouble with …I've had problems with other members of the Psychology department. One of my colleagues has ended up shouting at me on two occasions. My immediate manager ...took a more pessimistic view of EMDR and insisted on conditions surrounding its use, which I didn't particularly think were necessary" (Participant 7).

Theme 2: Professional Practice & Integrity of EMDR

The impact bullying had upon the professional practice and integrity post training in EMDR emerged as a key theme:

> "I do think that EMDR itself as a message came in for a lot of scrutiny …but even as a message there were a lot of people very sceptical about it, despite the reviews it was getting…and critique being passed on if you're using it (EMDR), then you are obviously not a serious clinician. From a personal point of view, if I would have brought it up as a treatment option, some people would have been quite supportive of it and other people blatantly ignored me" (Participant 4).

> "A client requested EMDR as she had researched EMDR on the internet and is aware I am EMDR trained. The Psychologist working with the same client refused as she did not think she would benefit from EMDR…The Psychologist said she knew everything about EMDR; but did not do the training…somebody came to their team and told them about EMDR" (Participant 1).

> "They would exert their character...say things as though they had been EMDR trained, they would sort of promote their own version of the protocol...to say that the original EMDR protocol was rubbish in some way ...and they were off, doing their own thing....inadvertently they were doing something which I felt was compromising" (Participant 2).

Theme 3: Credibility of EMDR as an Empirically Supported Psychotherapy

A further theme, which emerged strongly, related to how fellow professional colleagues viewed the existing literature in relation to EMDR and how decisions were being made by professionals neither trained nor experienced in EMDR. This is exemplified by participant 8:

> "When I disclosed being trained in EMDR, colleagues indicated that it wasn't really a 'proper therapy' as it was no more than a 'one trick pony'. At team meetings, my psychodynamic colleagues were always taken extremely seriously. On the contrary, any attempts I made to highlight the increasing evidence base of EMDR were never taken seriously at all. My manager told me in the strictest terms that if I was to use EMDR then I could only use EMDR for PTSD and nothing else and that I would soon see that using TF-CBT was much better for this client group. When I asked him to justify this decision, he stated that it was from the benefit of his own considerable experience in the field" (Participant 8).

Participant 11 provides a further example in outlining how they were being judged academically by assessors making decisions of extreme importance to their professional development and identity, yet at the same time these assessors clearly had no understanding of EMDR as a psychotherapy approach and its subsequent application:

> "I believe EMDR related to the entire experience of being bullied. I was completing a training program with the British Psychological Society (BPS) to become a Chartered Psychologist and was required to submit a Case Study. This case study demonstrated EMDR as the therapeutic approach working with a client with PTSD. The division of the BPS of which my training is aligned with (Division of Counselling Psychology) failed my submission and the feedback I received was not only inappropriate, but it was clear from their comments they knew nothing about EMDR and consequently made a number of unfounded assumptions about my use of EMDR. Comments were made in relation to a point in a session where the client exceeded their window of tolerance but they claimed that it was because I did not carry out EMDR well enough! We also used the future template featuring an imaginal journey into town on a bus. I didn't feel it necessary to gauge a Subjective Unit of Disturbance (SUD) at the beginning of the 'journey' as my client wasn't distressed, but a little later my client did encounter a 'hot spot' so I elicited a SUD. Feedback from the assessors was as follows: "SUDS not clearly applied; the

> candidate decides once not to use scaling and then changes her mind as an apparent reaction to failure?" And then, in reference to inviting the client to really notice as many sensations as possible for full sensorial experience; to really imagine being there at the bus stop, what it feels like being on the bus, notice smells and sounds etc., the assessors stated that "my own material interfered" and that I "filled in the details from my own memory". They added that EMDR was a process that required "demystifying" and then questioned whether I was "really comfortable with these methods". The Division of Counselling Psychology has made it very clear that if I use EMDR in my next submission I will fail that one too" (Participant 11).

This participant disclosed that the only way in which they eventually secured their Chartered Psychology Status was to not mention EMDR in any context. A similar vein is expressed by participant 14 in their experience as a Consultant Psychiatrist in which requesting EMDR clinical supervision from an EMDR Europe Consultant was seen as an indication of professional weakness and questionable competency:

> "As a newly appointed Consultant Psychiatrist I wanted to incorporate EMDR into my workload. When I asked if the trust would support my receiving clinical supervision from an EMDR Europe Consultant the Clinical Director laughed and stated that maybe they were wrong to have appointed me if I felt that I still needed clinical supervision. I would say our relationship never recovered from that point. EMDR was never taken seriously by my other psychiatrist colleagues. At professional meetings my colleagues would describe EMDR as 'rubbish and all a load of nonsense'. Whenever I tried to present a clinical case where I had used EMDR they would roll their eyes and grown. I knew that I certainly didn't have the professional respect of my colleagues. It was a horrible working environment. I knew I had to leave otherwise I would have been subjected to a competency review" (Participant 14).

Participant 2 highlighted that in order to finally be allowed to use EMDR back in their clinical service was only under the following conditions:

> "I had to produce documentation and the complete NICE guideline for PTSD etc., to satisfy my own organisation that what I was doing with EMDR was safe and was underpinned by robust meta-analyses and empirical research" (Participant 2).

Theme 4: Activation and Breaking Point

Participant 21 outlined that for them their experience of bullying reached a tipping point after three distinct episodes that happened in fairly quick succession. They considered their working environment to be 'professionally toxic' to such a degree that they felt their health and well-being was being directly affected:

> "The bullying happened in three ways: Firstly I was verbally attacked in quite graphic and demeaning language, and was accused of being unprofessional by the director of my mental health unit when I completed my EMDR training and suggested to integrate EMDR in the therapy setting; Secondly at a non-EMDR Conference reception I got talking to a Psychology University Professor. When I told him about my interest in EMDR he verbally attacked me and highlighted that EMDR was 'stupid' and 'hocus pocus', 'controversial, and that 'research is showing it is complete rubbish!'; Thirdly at an encounter with colleagues, who do not really know EMDR, yet at the same time claim that EMDR it is just hypnosis, however they also considered that EMDR is just what they do in their practice anyway as it is just common sense, they 'know' what EMDR is, and declared that EMDR therapists are all out to get money by fooling clients" (Participant 21).

> "The shock of being subjected to constant bullying was huge; the taste it left me with, I carried inside me for years. It takes me time to shake off what is not mine" (Participant 13).
> Participant 1 felt that successful results with EMDR led to an increase in bullying.
> My manager sent an email to all saying that only she will decide when clients meet the criteria for EMDR. As she is not trained to do this, she was unable to make the decision on her own. Then she started refusing these clients and the workers responsible discussed it with me. Many of these clients would be suitable candidates for EMDR. My manager has no choice as to re-refer these cases to me. She now makes life very difficult for me –checking on everything I do and even humiliated me… the more success, the more bullying"
> (Participant 1).

The experience was also significant for her in three ways:

> "In the first case, by helping these clients with EMDR, the local authority could save thousands of pounds preventing children from going into care…this is very frustrating for me. In the second case, I think there is some fear that EMDR is threatening to the psychologist's job and in the third case, the manager's controlling behaviour and attitude prevent me doing EMDR (Participant 1).

Theme 5: Clinical Supervision & Consultation

Another aspect that emerged from the narratives related to the relationship between EMDR and clinical supervision/ consultation. This related to both those seeking EMDR Europe accreditation but also those that were not seeking this. Emerging narratives included:

> "My manager informed me that my supervisor would not be EMDR trained, as it's ok she knows about PTSD" (Participant 3).

"I was bullied by supervisors who are jaded and do not believe real solutions exist for clients. I think that EMDR success stories remind these supervisors of how many times they had felt jazzed after EMDR training but then could not produce results. The supervisors who trained with us did not participate with much focus during the training and then did not experience the fantastic results that I did after the training. Other supervisors who were not trained were resentful of the cost of the additional consulting groups and specialty training (for children and for dissociation in complex trauma) (Participant 14).

"When I was working in a complex cases service for clients with personality issues I was told I could practice EMDR if I felt competent enough to do so but I could not have outside specialised supervision. So, although it had been agreed for me to train in EMDR & had been paid for by the service I was not permitted to practice ethically. The decision making process around this was done in a way that felt bullying and left in me an untenable position, this resignation. In my current role I was unable to continue working with a client who turned out to be a very complex PTSD and I was not permitted to complete treatment safely within the service. As I had a training, voluntary slot which was empty, I have continued to see the client within this slot because to not complete treatment felt unethical. I have since withdrawn EMDR as a treatment option within the current service I work because I do not feel that I can practice in a way that feels safe. I am not sure that I would have determined my treatment in this instance as being bullied, except by an un-flexible criteria"(Participant 15).

"It was two supervisors, two administrators and a few therapists who began negative campaigning such as saying that EMDR was risky, unproven, and might be dangerous to the client or was not usable for our clients since many of our clients have some level of dissociation. Although many of the perpetrators of the bullying had been EMDR trained, they were not reporting success in using EMDR with their clients, had not been carrying an active caseload of clients before the training, had only one or two clients to use EMDR with after the training, had allowed months to lapse between the training and their first attempts to use EMDR with their client, had not studied the original materials provided in the initial HAP training and had not sought out additional education using EMDR for complex trauma" (Participant 20).

"In the context of trying to clarify supervision arrangements and, particularly EMDR supervision for working towards both practitioner status and maintaining safe practice with complex clients, I tried to arrange a meeting with the consultant/manger to organise this. I suspect that because of her own experiences of a counsellor in training, who had been having outside supervision and had then had a run in over the treatment plan, she was reluctant to consider having another outside supervisor, although it was made clear that clinical decisions about the

> clients treatment was separate from EMDR supervision which would focus specifically on technique and management of material (something no one else could give me within the service because nobody had seen an EMDR session let alone be able to supervise me appropriately). Instead of arranging an informal meeting to discuss issues I was subject to a meeting with the team leader (a close friend of the consultant), the consultant and the manger (who was not the manager who had agreed to my initial training). I asked my in house supervisor to attend with me. Instead of an informal discussion, it felt like the decisions had been made and the implication was that I was choosing not to treat with EMDR because I did not feel competent. It was also stated that the supervision I was receiving was adequate for my needs. Clearly I disputed this and stated that I was being asked to practice unethically. I was very shocked by the meeting and very upset because I had already begun ground work with clients who I had been treating for some time. I would not have begun any ground work if I had not thought I would be appropriately supported. This meant that I had to stop any plans for EMDR work" (Participant 13).

Theme 6: Health & Well-being and Positive Growth

For participant 6 the impact of the bullying, which had lasted for over 7 years was such that it considerably affected their overall health and well-being:

> "It devastated me personally. The experience was very damaging for my patients and has negatively impacted on my marriage, my children and friendships. My health suffered a lot. I put on a lot of weight, developed arthritis and palpitations. My husband and I were on the verge of splitting up because of the stress which went on for years. However, thanks to support, I am trying to get some constructive things out of the experience and have also used it as the basis of my dissertation, so trying to educate myself." (Participant 6)

Of all the participants, it was this narrative that for this person suggested they were still profoundly caught up in the trauma of being a recipient of bullying:

> "I am not valued. I did lots of extra training courses during the past 4 years: I got compliments from the judges in court and other professionals. For the last 4 years (twice a year) I facilitate a group for young mothers with attachment difficulties and was called in by the Ofsted Inspectors and they praised me after they spoke to some of the members of the group who now function independently from Social Services. Yet it never made any difference at all. The bullying continues" (Participant 7).

For another participant their narrative indicates more healing but at the same time acknowledges the trauma consequences of their experiences:

> "Basically I feel as if it ruined my career. I have lost a lot of professional confidence where organisations are concerned. Paradoxically I think it has made me a better therapist, and I get referred very complex patients now because I have lived such a complex situation myself...and survived (just)" (Participant 16).

This is also highlighted by this participant, who stated:

> "In general, I have an increased awareness of the systemic stigma and oppression working against our efforts to provide high quality services to low income mentally ill clients. Personally I feel very frustrated and upset that I have to watch patients deteriorate on the wards when EMDR could at least in some cases be tried (Participant 13).

Positive growth appeared a learning experience, which was integrated personally and professionally for many of the participants including participant 2:

> "Well the growth element is on a personal level and a professional level, lots of learning and you know, you learn by experience and integrate that experience…as time goes by I've got more positive experiences" (Participant 2).

As highlighted above, there appear to be **six** distinct themes that emerge from the research interview. As table 2 highlights the research participants for this study were extremely divergent. The range in relation to when participants were trained in EMDR was extremely high (22 years). As the study was conducted from the United Kingdom the research team was mindful as to whether the National Institute of Health & Clinical Excellence Guideline on PTSD (2005) had made any difference. However the research yielded no such distinction. For some participants there seemed a significant disconnect between policy guidelines and empirical data and how individual clinicians were actually being managed back in their particular organisation.

Other important aspects related to the gender distinction between recipients and perpetrators with more female (77%) recipients of bullying than males (23%) but in relation to perpetrators there did not seem much distinction (M26%, F26%, both 42%). The fact that the highest numbers of research participants were psychiatrists (32%) was intriguing bearing in mind Farrell & Keenan's (2013) study about the disparity between the numbers of psychologists training in EMDR as opposed to the number of psychiatrist.

As Hutchinson et al (2010, 2012) and Nielson et al (2012) outline the organisational context within which bullying takes place creates a favourable climate that not only tolerates bullying but also rewards it. Of the 22 participants who took part in the study only 37% ever took action against their perpetrator of which none described a positive outcome from this process other than by leaving the organisation itself. Many of the research participants

described how the bullying behaviour that they were subjected to, did escalate, which in turn seemed to generate more distress and discomfort for them. For some participants certain events were related to 'one off' incidents however it was the cumulative effect of this that actually created a significant tipping point. The hostility some participants encountered, as demonstrated in participant 3's experience, was so potentially discriminatory as to determine whether or not they obtained a professional position with the organisation in question. The fact that this clinician just wanted to utilise EMDR, as per numerous clinical guidelines and empirical support, with an appropriate clinical population, and to have been prevented from doing so purely on the basis that the intervention was EMDR, is an extremely uncomfortable narrative to hear. As participant 5 highlighted that being seen as 'passionate' about EMDR was interpreted as being an unbiased cult devotee. It would be intriguing to explore whether mental health clinicians trained in other psychotherapeutic paradigms would be met with the same powerful discourse?

Several participants alluded to the impact CBT has on EMDR. There appeared to be two distinct viewpoints in relation to this, firstly akin to Bannink's (2012) perspective that '... Mindfulness, ACT, and EMDR are considered to be the third wave in CBT; secondly that EMDR is simply a 'one trick pony' as advocated by O'Donohue & Fisher (2012). A further concerning issue arose in theme 2: professional practice and integrity of EMDR in that as participant 4 disclosed that to be seen using EMDR in some way diminished your standing as a professional. As participants 1 & 2 point out that their experience of managers was such they considered being trained in EMDR was superfluous.

There seems to be two further aspects that emerge from the narrative data. Most of the participants considered that their experiences of bullying, specifically in relation to EMDR, was a collective phenomenon that identified the significance of peer relationships as an integral facet through individuals consistently experiencing negative attitudes and behaviours from peers. The second aspect is that persistent exposure to bullying as a collective phenomenon has a significant relationship effect of an individual's perception of self of which, in turn, this perception of self, influences professional relationships.

As mentioned earlier regarding post-appraisal systems only 37% of the participants took any action in relation to their experiences of being subjected to bullying. Of the 63% who did not, most considered that there was 'nothing to be gained' from taking action. This 'non-action' approach has many characteristics including inertia, apathy, trauma, powerlessness, burnout, fatigue or as one participant expressed "it was wiser not to" (Participant 7). A further aspect of the 37% group was that of those who took action, none of the participants described any positive outcome and described their experiences as re-traumatising with many ending up leaving clinical services, leaving the NHS entirely, setting up in private practice, or becoming completely disenfranchised. Others were able to access some 'inner healing', 'resilience' or 'post-traumatic growth'. That the bullying had reached such a level those participants considered that their only option was to change their working environment was a strong narrative to have emerged for the research data.

Another aspect was that one of the consequences of this was that in relation to the twenty-two participants involved in this study no participant outlined how their respective perpetrator(s) were ever sanctioned, disciplined in anyway, or their behaviour effectively addressed by their organisation. No participant had a narrative where an organisation had addressed the issue of bullying effectively despite many acknowledging that robust policies and procedures were in place to address this important issue. The research highlighted disconnect between policy, practice and procedures.

The overall impression from the participants was that as EMDR clinicians, having a professional contract and obligation with their respective organisation, they also had a psychological contract with their clients and their employers. Participant's experiences were that this psychological contract is then fundamentally challenged as a direct consequence of being subjected to bullying. For participants in order to survive this process the psychological contract needed to be re-negotiated. As one participant put it 'the caring profession is often an oxymoron, certainly I would say that the department I worked in was positively toxic' (Participant 19). This was further highlighted by participant 1's experience when they considered that the more 'success' they had with EMDR the 'more the bullying increased'.
'The more success I had using EMDR therapy with my clients, the more the bullying increased. It was like my manager resented every client that I discharged where I used EMDR therapy'.

Another interesting aspect that emerged from the study related to the high number of psychiatrists that had encountered work related bullying in relation to EMDR with Psychologists being the second highest. No mental health nurses trained in EMDR participated in the study. This raises a question surrounding the link between bullying and professional hierarchy? Many of the participants were in fact senior clinicians rather than lower down the professional hierarchy. If professional hierarchy is not a mitigating factor then this shifts emphasis instead to organisations themselves. Most of the participants considered that their working environments not only failed to take action against bullying but instead covertly condoned it.

The research determined that both managers and team leaders, particularly those from 'Improving Access To Psychological Therapies (IAPT) services, considered CBT to be superior to EMDR on the basis of CBT being 'more versatile and effective'. The experiences of the research participants were such was that their respective managers/ team leaders on many occasions had little understanding of what EMDR therapy actually is and how it can be effectively applied.

Since this is a qualitative study, and therefore the findings in no way determine any degree of correlation, no causal direction is proved. However one of the strongest unifying aspects of the research participants' experiences highlighted that that it was EMDR itself, or rather what EMDR represented internally for each of the perpetrators in question, was one of the

key factors that migrated across each of the narratives. EMDR was central to each of the research participant's experiences of bullying.

A consistent running theme for all the research participants related to the lack of good quality EMDR Clinical Supervision/ Consultation. EMDR Clinical Supervision (Farrell, Keenan, Knibbs & Jones, 2013) requires six areas of consideration:

1. Foundations of EMDR as an eight-phase protocol, empirically supported psychotherapeutic approach
2. EMDR research and development (including evidence based practice and practice based evidence)
3. Various approaches in the clinical application of EMDR with diverse mental health and well-being populations
4. EMDR clinical supervision and consultation
5. EMDR and cultural diversity
6. EMDR ethics and practice

These six areas could potentially mitigate the impact of bullying behaviour with regard to EMDR clinical governance in reducing incidence.

Conclusion and Implications for EMDR

Despite the powerful narratives expressed by the research participants this needs to be placed into some form of context. The recruitment strategy for this study was to target the international EMDR community. With this in mind it is important to highlight that the up-take for the study was low. Potentially this suggests that the phenomenon may not be widespread and certainly not endemic. Of the research participants just over 75% were from the UK and Ireland and therefore, as a proportion of approximately 9,000 trained in EMDR, (Farrell & Keenan, 2013) to date in the UK it is extremely low.

As most of the participants were from the UK and Ireland the research team were mindful as to whether the impact of the National Institute of Health & Clinical Excellence (NICE) Guideline on PTSD may have had any difference in relation to EMDR clinician's experiences of bullying. However the research findings found no difference pre and post 2005 from the research participants. As the data highlighted more participants were post NICE PTSD Guideline (2005). It seems that this guideline is viewed both positively and negatively from the perspective of the research participants.

International and National treatment guidelines supporting the efficacy of EMDR is a welcome contribution within the EMDR and Non-EMDR community however there seems to be variance in how these guidelines are interpreted and implemented in to clinical practice. The fact that EMDR seems only mandated for PTSD is also considered both positive and negative and highlights the need for further research to address this aspect further.

Further considerations from participants was the constant need to persistently try and explain EMDR and defend how it works both psychologically and physiologically. Participant's perceptions were that other psychological therapies have to do this less so. An argument is that the EMDR community can only take responsibility for its own destiny, growth and future development by continuing to pursue high quality research to enhance further understanding about EMDR, how best to improve its efficacy and efficiency, and determine a better understanding of its exact mechanism of action.

There is a viewpoint that EMDR will always be subjected to scepticism, both healthy and unhealthy, regardless of empirical support. Even though acknowledgment of the 'empiricism versus politics' debate is important this can never be used as a justification or a means of condoning workplace bullying under any circumstances. All bullying of any form, type and description is abhorrent regardless of whether it relates to EMDR or not. The provision of effective, robust, good quality EMDR clinical supervision/ consultation is extremely important in reducing incidence of bullying.

The implications of 'bullying' on the wider EMDR community is a question that requires further empirical investigation as are the implications regarding the teaching and learning of EMDR.

For many of the participants who took part in this study their experiences of being bullied took place in an environment of institutional silence and in some cases even censorship. In turn this creates such an environment where bullying can therefore flourish. However one message that could be stated explicitly in challenging institutional silence is for EMDR national and international organisations to explicitly declare a specific 'Zero Tolerance' policy to all forms of bullying of any kind. Hostility and unhealthy scepticism will persist towards EMDR. The best response form the EMDR community is to continue to produce empirical, good quality research that supports EMDR as an effective, efficient and robust psychological treatment.

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