Uncovering Adverse Eye Movement Desensitization and Reprocessing Events: A Descriptive Study Among Approved Consultants

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Abstract

Uncovering Adverse Eye Movement Desensitization and Reprocessing Events:

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Background: There is scant research into adverse Eye Movement Desensitization and Reprocessing (EMDR) events or how Shapiro's EMDR protocol is being applied by practitioners.

Aim: The objectives of this study were to: describe adverse events following EMDR that were reported to EMDR International Association (EMDRIA) Approved Consultants by EMDRIA approved EMDR therapy trained practitioners; to report which adverse EMDR event the consultants' thought was the most destabilizing; and to determine whether consultants believe there was insufficient application of Shapiro's EMDR protocol.

Method: This descriptive study used a 12-item survey.

Results: A total of 55 surveys were collected and 34 surveys met criteria for analysis.

While participants reported most EMDR consultations were unrelated to adverse EMDR events, 82% (n=27) described at least one adverse EMDR event reported to them in the past 18 months. The main adverse EMDR events identified were: *increased emotional dysregulation* (n=14); *"flooding"* (n=13); *distressing or intrusive memories* (n=10); emotional numbing (n=9); *spontaneous trance or "zoning out"* (n=8); and *unplanned/unanticipated abreactions* (n=7). 21% (n=7) identified no adverse EMDR events reported to them during consultation.

79% (n=23) reported that up to 81% of the adverse EMDR events reported to them were due, at least in part, to consultees' inadequate use of Shapiro's EMDR protocol Phase 1, and 76% (n=22) reported the adverse event was, in part, related to inadequate application of Phase 2.

Conclusions: This study identified that adverse EMDR events do occur and suggests they may be associated with insufficient application of Shapiro's EMDR protocol Phase 1 and 2. Adverse EMDR effects must be closely scrutinized using both qualitative and quantitative methods and thoroughly reported from both client and practitioner perspectives. Studies also need to examine the impact of deviations in treatment fidelity from Shapiro's 8 phase EMDR protocol on outcomes and client experiences.

Uncovering Adverse Eye Movement Desensitization and Reprocessing Events: A Descriptive Study Among Approved Consultants

In 1995, Francine Shapiro published the first comprehensive text on Eye Movement Desensitization and Reprocessing (EMDR) as a therapy to treat trauma-related mental health problems (Shapiro,1995). Shapiro (2018) recognized that eye movements seemed to decrease negative emotions associated with distressing memories. Shapiro also observed a desensitizing effect of her Eye Movement Desensitization (EMD) intervention with war-traumatized people who reported fewer post-traumatic stress symptoms as a result. In the evolved standard form, EMDR employs a structured 8-phase protocol to work across three temporal prongs: past, present, future. The protocol includes 8 phases: 1) history taking, 2) preparation, 3) assessment of a target memory, 4) desensitization, 5) installation of the positive cognition, 6) body scan, 7) closure, and 8) reevaluation. The active 'ingredient' of EMDR is bilateral dual-attention stimulation (BL-DAS) in the form of induced eye movements, taps, or auditory tones (Shapiro, 2018).

EMDR uses the Adaptive Information Processing (AIP) theoretical framework, which suggests that distressing memories are inadequately processed in the brain (Shapiro, 2018). EMDR seeks to rapidly desensitize and metabolize traumatic memories from the past, using a client's innate information processing to resolve identified issues. Shapiro believed distressing memories, left unprocessed, formed the root of many mental health concerns, and using EMDR could target and change the memory. However, despite EMDR's success in addressing many mental health concerns, questions remain about adverse EMDR events and related safety concerns (Leeds et al., 2022; Shapiro, 2018).

The purpose of this study was to identify adverse EMDR events reported to EMDR International Association (EMDRIA) Approved Consultants during consultations with practitioners who had completed EMDRIA approved EMDR therapy training. EMDRIA consultants were chosen as a sample population because EMDR practitioners seek their assistance for EMDR clinical challenges, so they are likely familiar with adverse EMDR events. Therefore, Approved Consultants have an important perspective on the extent and type of adverse EMDR events that occur, how EMDR is being employed, and whether practitioners whose clients experience adverse EMDR effects are following Phase 1 and Phase 2 of Shapiro's 8-phase EMDR protocol.

Adverse EMDR events have not been systematically studied or reported, leaving a gap addressed by this study. A first step in understanding this issue was to describe adverse events that have been reported to EMDRIA Approved Consultants. This hypothesis generating paper begins with a description of EMDR and transitions to a review of the literature addressing EMDR efficacy while highlighting a lack of research on adverse EMDR events. Moving forward, study objectives and research questions are revealed before addressing methods employed in conducting the research. Under Methods, the research design, sample, and data collection are explained, followed by results, analysis, and limitations.

Background

In controlled studies, EMDR has been found to effectively resolve symptoms associated with 'classic' posttraumatic stress disorder (PTSD). Classic PTSD is defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, as reliving trauma that developed from a threat to life or experiences of extreme fear and helplessness. Symptoms include flashbacks, nightmares, extreme physiological arousal, difficulty concentrating, diminished cognitive function, affect overwhelm, and guilt (National Library of Medicine, 2024).

In their examination of EMDR as an effective treatment for PTSD, de Jongh et al. (2019) reviewed 30 randomized controlled trials (RCT) using narrative analysis. They concluded that EMDR is an effective treatment for PTSD and should be considered a preferred primary intervention because scientific evidence supported its effectiveness. Maxfield (2019) similarly reported on 44 RCTs looking at EMDR as treatment for PTSD, early traumatic stress, and traumatized children, as well as 28 RCTs evaluating EMDR for use with other mental health disorders. Maxfield concluded that EMDR is well documented as an effective treatment to decrease or eliminate PTSD and trauma symptoms. Both Maxfield and de Jongh et al. concluded that previous studies demonstrated the efficacy of EMDR, but their reviews did not specifically address EMDR safety and adverse events.

Adverse Events

Despite EMDR's success in addressing many mental health concerns, questions remain about potential harm from EMDR, due to lack of data (Hoppen et al., 2022). Whitehouse (2018) and Shipley (2021) conducted systematic reviews of research into patients' experiences with EMDR. Whitehouse

concluded that research about clients' personal EMDR experiences is lacking, and that adverse effects and tolerability need to be explored. Shipley's systematic review revealed uncertainty as to whether adverse EMDR client experiences are unreported because they do not exist or because they are disregarded. Shipley also noted that most information about adverse client experiences comes from material related to academic pathways and unpublished sources. Both Whitehouse and Shipley concluded that while adverse EMDR-related treatment effects are discussed anecdotally among EMDR therapists, trainers, and consultants, there have not been enough formal studies of EMDR adverse effects. The lack of such studies may lead to an assumption within the mental health field that clients' experiences with EMDR are uniformly positive.

A published research protocol for an RCT (Hofman et al., 2022) demonstrates one of the ways potential adverse effects of EMDR are overlooked in scientific literature. Hofman et al. wrote in the administrative information section of their paper:

> According to the guidelines on data monitoring committees, a Data Monitoring Committee (DMC) might not be implemented in studies with non-critical indications or when the intervention under investigation is characterized and known for not harming patients. EMDR therapy is an evidence-based treatment for PTSD and has been found to be safe in patients with a personality disorder. A (DMC) is therefore not instituted. (p. 2)

Therefore, Hofman et al. (2022), asserting that EMDR is safe, did not implement a DMC in their trial.

EMDR and Dissociation

EMDR therapy, used to treat dissociation, particularly dissociative disorders, is both controversial and understudied (Shapiro, 2018). Both Shapiro and the International Society for the Study of Trauma and Dissociation (ISSTD, 2011) guidelines for treating persons with a dissociative disorder have noted the potential harm and possible adverse events that may occur with inappropriate and uninformed application of EMDR therapy. Two specific issues of concern rose to the top: 1) the indiscriminate use of EMDR therapy by practitioners who are inadequately trained in recognizing and assessing dissociation and dissociative disorders, and 2) the indiscriminate use of EMDR therapy by practitioners who "don't know what they don't know" about treating dissociation, effectively ignoring problems, or oversimplifying what can be profoundly complex (Coy, 2024).

Although Shapiro's (2018) original EMDR protocol stressed, at minimum, the necessity of screening for pathological dissociation prior to introducing EMDR therapy (specifically BL-DAS/BLS) as part of a client's treatment, the requirement to teach EMDR therapy trainees about such screening was only formalized by the EMDR International Association in December 2022 (EMDRIA, 2022). Those trained prior to this date may have had superficial, limited, or no training in screening for dissociation. Leeds et al. (2022) indicated that screening for dissociation has been inadequate and advocated for increased education for EMDR trainees about screening. They also called for formal diagnoses of dissociative disorders prior to employing EMDR to avoid doing further harm to already severely traumatized clients. Using EMDR with dissociative clients without proper screening may contribute to adverse EMDR events (Leeds et al., 2022; Shapiro, 2018).

Cuijpers et al. (2020) conducted a systematic review of RCTs, looking at EMDR effects in studies that mostly focused on PTSD yet included other mental health issues. The review raised concern about RCTs in regard to high risk of bias, effects not examined at follow-up, and significant heterogeneity. These observations led Cuijpers et al. to state:

> the quality of studies is too low to draw definite conclusions. Further, it is evident that the long-term effects of EMDR are unclear and that there is certainly not enough evidence to advise its use in patients with mental health problems other than PTSD. (p. 176)

This systematic review supports cautious consideration when employing EMDR with people who are diagnosed as dissociative and careful assessment of all clients for possible dissociative qualities.

Objectives

The main objective of the current exploratory study was to identify and describe adverse EMDR-related events reported to EMDRIA Approved Consultants by mental health practitioners who have completed EMDRIA approved EMDR therapy training and to report on adverse events consultants considered most destabilizing. The secondary objective was to explore whether the consultants believed there was a lack, or insufficient application, of Shapiro's 8 phase EMDR protocol for assessment, screening, and preparation for EMDR that preceded adverse events.

Research Questions

The specific research questions addressed in this study were:

1) What adverse events do mental health practitioners who have completed EMDRIA approved EMDR therapy training report to EMDRIA Approved Consultants? What events do the consultants characterize as the most destabilizing?

2) Do consultants report that mental health practitioners who describe adverse EMDR events followed Shapiro's EMDR 8-phase protocol correctly and completely by adequately screening for contraindications, and in preparation of the client prior to initiating bilateral dual-attention stimulus (BL-DAS/BLS)?

Methods

Research Design

This descriptive study used data from a 12-question survey designed to elicit information from EMDRIA Approved Consultants. The consultants work with practitioners who have completed EMDRIA approved EMDR therapy training which includes use of Phase 1 and Phase 2 of Shapiro's EMDR 8-phase protocol prior to employing BL-DAS/BLS.

Sample

The study protocol was reviewed and approved by the University of Washington's Human Subject Division review committee on January 22, 2024. All survey participants were EMDRIA Approved Consultants who provided guidance to practitioners that had successfully completed EMDRIA approved EMDR therapy training. This population was chosen because EMDRIA Approved Consultants are contacted by multiple practitioners seeking guidance in using EMDR. Informal discussion with EMDRIA Approved Consultants revealed they are likely to hear about adverse EMDR events encountered by practitioners employing EMDR in their clinical practices during consultation. Collecting data from EMDRIA Approved Consultants also protected the privacy of clients and diminished the potential for any re-traumatization that might happen if clients were asked directly about their EMDR experience or underlying trauma. Finally, surveying EMDRIA Approved Consultants, as opposed to the practitioner who administered the EMDR therapy, likely allowed for a more objective perspective on adverse events, and therefore may have reduced bias.

Participation in the survey was voluntary. Inclusion criteria for participation were as follows:

1. The participant attested they were an EMDRIA Approved Consultant[1] who had been qualified as such for at least 18 months, validating a minimum amount of actual consulting experience.
2. The participant attested they had provided consultation during the past 18 months to at least one mental health practitioner who had completed an EMDRIA approved EMDR therapy training.

A combination of purposive and snowball convenience sampling methods was used to recruit the study population. A link to the survey was included in a cover letter used to recruit participants via email, social media, and in postings to two discussion groups hosted by the International Society for the Study of Trauma and Dissociation (ISSTD). In addition, links to the survey were shared with two EMDRIA Approved Consultants who agreed to pass the link on to other qualified professionals and to post it to social media and appropriate discussion groups.

Fifty-five participants began the survey process by consenting to participate. Of these, 39 completed the survey to the end and pushed the "submit" button. Question 6, which asked about specific adverse EMDR effects, was the primary focus of the survey, so only participants who answered question 6 were included in the final analysis. Five participants did not answer question 6, resulting in a final total of 34 participants.

Data Collection

The 12-item survey (Appendix A) was developed by the researcher and reviewed by expert consultants in both content (EMDR therapy) and methodology (survey studies) for use in this study. The survey included eight multiple choice and four open-ended questions.

The survey was designed to identify what types of adverse EMDR effects are reported to consultants and to explore the consultee's use of Phase 1 and Phase 2 of Shapiro's 8-phase EMDR protocol. Phase 1 involves history taking with assessment and screening for contraindications. Phase 2 involves preparation for managing and containing emotional disturbances at the close of sessions and

[1] EMDRIA Approved Consultant criteria include: Mental health professional licensure or certification; completion of an EMDRIA training program; notarized documentation of a minimum of 300 EMDR sessions with at least 75 clients; 20 hours of "consultation-of-consultation" by an EMDR consultant in EMDR; a letter of recommendation from a consultant and two letters from colleagues or peers; 12 hours of EMDRIA credits; and completion of an EMDR International Association policies agreement (EMDRIA, 2024).

distress that surfaces between sessions. Questions about these phases were designed to gather information related to adequate assessment and preparation prior to starting BL/DAS. To reduce recall bias, participants were asked to report only on consultations held with consultees during the previous 18 months.

Questions 1-3 collected information about education level, years worked as a therapist, and how long the participant had been an EMDRIA consultant. Questions 4 and 5 asked how many consultations were done over the past 18 months and how often those consultations were related to an adverse EMDR event.

Question 6, which asked about adverse events experienced after EMDR treatment, was a ranked choice question. Participants were asked to pick the top five adverse events that consultees have reported to them. This question also included the following option: “None of my consultees described adverse EMDR events with their clients during the last 18 months.”

Open-ended question 7 asked about adverse outcomes not included in ranked choice question 6, and question 8 inquired about the most destabilizing adverse EMDR events or complaints. Question 9 referred to Shapiro’s EMDR Phase 1 and question 11 referred to Phase 2. Both questions inquired about adverse EMDR experiences being related, at least in part, to lack or inadequate use of Shapiro’s EMDR protocol. Open-ended question 10 asked what contraindications, if any, played a role in adverse EMDR experiences. Question 12 ended the survey inviting participants to share additional comments regarding EMDR treatment and/or risk of adverse events.

The survey was created using the Qualtrics platform (Qualtrics, Provo, UT). Pre-tests of the survey indicated it would take about 15 minutes for participants to complete. The survey was open for 38 days. The survey and results from the survey were stored on the University’s password protected Qualtrics platform. Study participants were anonymous as no personal identifiers were collected. Only de-identified aggregate data were downloaded to a personal computer.

Data Analysis

Data was downloaded from Qualtrics into an Excel spreadsheet and analyzed using descriptive statistics. Frequencies reflect all survey items with closed-ended response options. For the four open-

ended questions, the researcher reviewed responses multiple times and categorized responses according to themes relevant to the study's research questions with results triple checked for accuracy.

Of the 34 surveys analyzed, some participants did not answer all the questions. Questions 1 - 5 each had one non-response, and questions 9 and 11 each had five non-responses. Ranked question number 6 gathered information about adverse EMDR events but several options were not selected, including: suicide attempts; headaches; loss of functioning/experience (5 sense perception, paralysis, not feeling pain); psychogenic, non-epileptic seizures (PNES); amnesia; and client disorientation (to person, place, time, and/or situation).

Results

Most of the participants (61%, n=20) held a master's degree (Table 1). Nearly 70% (n=23) of respondents reported practicing as a mental health practitioner for more than 15 years. Years of practice as an EMDR consultant were fairly evenly distributed across categories, with 30% (n=10) having fewer than 5 years' experience and 21% (n=7) having more than 15 years.

Over the past 18 months, 58% (n=19) of participants reported providing more than 15 consultations, and 12% (n=4) reported fewer than five. While participants revealed that the majority of these consultations were related to something other than adverse EMDR events, 82% (n=27) reported at least one consultation related to an adverse EMDR event. The total number of responses to this question was 33 (Table 1).

Ranked choice question 6 collected data from all 34 participants on the most destabilizing and frequent adverse EMDR events identified or reported to consultants which included: *increased emotional dysregulation* (n=14); *"flooding"* (n=13); *distressing or intrusive memories* (n=10); *emotional numbing* (n=9); *spontaneous trance or "zoning out"* (n=8); and *unplanned/unanticipated abreactions* (n=7). Seventy-nine percent (n=27) of survey respondents identified at least one adverse EMDR event had been reported to them in the last 18 months, while 21% (n=7) identified no adverse EMDR events reported to them during consultations in the past 18 months (Table 2, see Appendix B for complete list of adverse EMDR events).

In answering the open-ended questions, four participants offered perspectives related to choosing the "no adverse EMDR events" response as follows: "I have had a number of consultees report that

improvement isn't happening (i.e. - they aren't connecting to adaptive information), but their clients are not experiencing adverse effects"; "This actually can happen with any client, regardless of if you are using EMDR therapy or not, if a clinician jumps into working on trauma before a client is stabilized enough"; "During the course of trauma work it is understandable and expected that a client may have upsetting or uncomfortable responses to EMDR Therapy (or any trauma processing)"; and "I think that these adverse effects cannot always be attributed to EMDR treatment. Any psychological treatment can destabilize and cause the symptoms that you are noting." Out of 20 responses to the open-ended question asking about adverse EMDR effects, in addition to what was already listed in ranked choice question 6, 14 (70%) participants did not identify any additional adverse events (Table 3).

Twenty-seven participants answered the open-ended question asking them to describe the most destabilizing adverse EMDR symptoms or complaints they have been consulted about. These responses were grouped under the following themes: *emotion dysregulation* (n=18), *physiological responses* (n=8)[2], *dissociation* (n=7), *memories* (n=7), *crisis* (n=5), *discontinued therapy* (n=4), and *nightmares* (n=2) (Table 4). Emotion dysregulation was described by participants as: *decreased containment capacity, flooding, intense fear, internal reactivity and irritability, complete dysregulation, intense abreaction,* and *shutting down emotions.* One participant described emotion dysregulation as: "Usually dissociation and memories of past traumas. Big affect or complete shutdown." The theme of *physiological symptoms* included the following descriptors: *"spacing out," "numbing," "increased physical symptoms,"* and *"dysregulation of nervous system."* One participant offered a perspective about adverse physiological effects related to EMDR and stated, "Patients can't successfully resolve processing due to intolerance of positive and/or negative affect and/or soma." Under the theme of undiagnosed dissociation contributing to adverse EMDR events, participants reported: "It's mainly been people doing EMDR with undiagnosed dissociation and apparent stability who end up with too much too fast" and "Clinicians are not trained in identifying and working with dissociative symptomology."

[2] Participant answers to open ended questions about adverse EMDR events included the description of "spacey" which was coded as a physiological event since the description related to observation of a client's physical presentation. However, "spacey" often refers to a dissociative presentation which might be coded differently by another researcher.

Of the 29 participants who answered the question regarding adequate application of Shapiro's protocol, 79% (n=23) reported that up to 81% of the adverse EMDR events reported to them were due, at least in part, to their consultees' inadequate use of Shapiro's Phase 1 screening for possible contraindications before introducing BL-DAS/BLS. Twenty-one percent (n=6) of participants reported no inadequate use of Phase 1 identified in their consultations about adverse EMDR events (Table 5). Responses offered in open-ended questions highlighted concern about inadequate practitioner training or knowledge of how to identify and assess for dissociation. A participant commented: "I think it was mainly the lack of recognition of the dissociative conditions that led to trouble." Other participant responses describing lack or inadequate use of Phase 1 include: "[The therapist] did not question difficulty in sharing history or gaps in memory", "Attempts to apply aspects of EMDR prematurely (i.e. in the initial session)", and "The most noteworthy is when clinicians do not do a proper assessment before proceeding to BLS."

Regarding Phase 2, which is the preparation before processing, 76% (n=22) reported an adverse EMDR event related, at least in part, to inadequate client preparation. Twenty-four percent (n=7) of the participants who answered this question reported no adverse EMDR events related to inadequate use of Phase 2 (Table 5). A participant reported, "Phase 2 is so important – more important than reprocessing itself. Clients cannot do the work safely if they are not adequately prepared and informed of what to expect." Another participant shared, "Therapists do not understand the procedural steps of Phase 2. They have a limited understanding of what to do when clients cannot obtain or struggle with positive affect."

When asked, in an open-ended question, about contraindications that may have contributed to an adverse EMDR experience,14 of the 22 respondents identified that dissociation was inadequately assessed or diagnosed and this, in part, led to an adverse EMDR event. A participant mentioned: "Dissociative symptoms or a dissociative disorder that was either not identified or not taken seriously as a potential complicating factor in treatment." Another contraindication included *trauma history* (n=7), and one participant reported to an open-ended question: "Fear of dealing with emotions and facing what they have not shared or faced yet." In addition, *therapist skill or role in EMDR protocol* (n=7) was identified as a contraindication. A participant noted: "An awful lot of the adverse experiences occur because a therapist is not experienced with either psychotherapy, trauma, or EMDR." C*lient related factor* (n=7) was also reported as a contraindication, which one participant explained as: "Dissociative symptomatology,

present day life instability, lack of readiness for the reprocessing phases." Noting that contraindications are often hidden, a participant reported: "Clients and practitioners' belief that 'you just need to work through your trauma in order to get better' – this belief has blinded many to contraindications that may be present." Three respondents said they had not had a consultation that revealed unrecognized or undiagnosed contraindications that contributed to an adverse EMDR event (Table 6).

Discussion

The primary goal of this exploratory, descriptive study was to find out what adverse EMDR events are being reported to consultants. Research has focused on EMDR efficacy and has not examined harmful outcomes of this therapy (Hoppen et al., 2022). The secondary aim of the study was to gather information related to practitioner fidelity to Shapiro's EMDR Phase 1 and 2 protocols. The study was particularly interested in whether consultants thought that not following the protocols contributed to reported adverse events.

While the number of adverse EMDR events reported in consultations was low in this study, 82% (n=27) of participants reported at least 1 adverse EMDR event had been discussed in consultations with practitioners during the past 18 months. Hoppen et al. (2022) stated that adverse effects from mental health interventions have historically been ignored. Typically, data supporting efficacy of EMDR has been the focus of research, while harms were not explored (Hoppen et al., 2022).

Identification of adverse EMDR events in this study highlights the disagreement between other studies concerning efficacy and potential harm. For example, Udo et al. (2022) reported EMDR to be "incontrovertible" (p.5) in efficacy for PTSD treatment. However, Cuijpers et al. (2020) encouraged caution and noted that: "Future research should focus on high-quality, sufficiently powered, randomized trials with long-term effects. Without such studies, the effects of EMDR will remain as uncertain as they are now" (p. 176).

This present study also gathered information about the most destabilizing adverse EMDR events, with emotion dysregulation as the highest-ranking adverse event reported, as well as the most frequently identified destabilizing symptom in a ranked choice question. This finding begins to address a gap in research identifying adverse EMDR events. Whitehouse (2018) and Shipley (2021) supported investigation of this gap, having suggested that additional exploration of adverse EMDR events needs to

be completed, especially from a client's point of view. Because of Hoffman et al's. (2022) assumption that EMDR is safe, and therefore not implementing a Data Monitoring Committee (DMC) in their RCT, this attitude in the research field could reinforce a false sense of security regarding EMDR's safety in other clinical settings. Results found in this present study suggest that an assumption of EMDR safety, based on efficacy, often ignores adverse EMDR events.

This study identified that the majority of participants thought inadequate attention to Phase 1 and 2 of Shapiro's EMDR protocol partially contributed to reported adverse EMDR events. Leeds et al. (2022) stated that EMDR therapy requires rigorous assessment and intentional screening. Focusing on assessment and screening, Pietkiewicz et al. (2021) added that practitioners need specific training to become skilled in assessing dissociative disorders and identifying nuanced dissociative characteristics in client presentation. Qualitative data from this present study similarly suggests that in some cases there is a lack of skilled practitioner assessment and understanding of dissociation. This finding indicates that a lack of training may contribute to adverse EMDR effects in some cases.

Participants in this study identified dissociation as the leading contraindication implicated in adverse EMDR experiences. The ISSTD (2011), Leeds et al. (2022), and Shapiro (2018) all highlighted the risk of harm when employing EMDR with a client who has an unrecognized dissociative disorder; the present study's findings support this concern. Pietkiewicz et al. (2021) stated that pathological dissociation is a "disorder of hiddenness" (pg. 8), and suggest clinicians need to understand the subtleties that accompany dissociation, subtleties that make it difficult to assess and diagnose. Additionally, Wilson et al. (2018) concluded that EMDR is most effective when employed by experienced practitioners. Targeted and comprehensive training on assessment and screening and appropriate safeguards for dissociation are critical to reduce possible adverse EMDR events (ISSTD, 2011; Leeds et al., 2022; Shapiro, 2018).

Several survey respondents indicated that adverse events following EMDR therapy led to discontinuation of therapy. Hoppen et al. (2022) concluded that participants who drop out of randomized controlled trials that evaluate psychological interventions for PTSD may be having adverse reactions to the intervention. They go on to say that most clinical trials of this nature do not usually collect data on why participants drop out, or whether they are experiencing worsening symptoms, yet this is important

information for researchers and clinicians. Identification and understanding of adverse effects from treatments like EMDR is important in increasing retention rates in clinical trials, but also for preventing patient harm during therapy (Hoppen et al., 2022). Future research examining why EMDR participation was discontinued and looking at the long-term effects of early termination of EMDR treatment could reveal more information about adverse EMDR effects.

The findings of this present study support suggestions from other researchers stating that EMDR is a whole-person therapy, and future research needs to explore the client's subjective experience during and after therapy (Laliotis et al., 2021; Shipley et al., 2021; Whitehouse, 2018). Qualitative or mixed methods research designs are ideally suited to capture this type of data. Marich et al. (2020) claimed that qualitative research can explore EMDR effects from a "bottom up" (p.119) perspective, giving credence to individual experiences. This present study presented additional information about adverse EMDR events through a qualitative lens that expanded the perspective on quantitative results. Valuable information was gathered from open-ended questions answered by EMDRIA consultants reporting on consultations with practitioners. One participant stated, "Over the years, I have, unfortunately, seen most, if not all, of the adverse symptoms you listed." Marich et al. (2020) added that most EMDR research reveals clinical efficacy gathered from quantitative data, while missing "how and why" consequences from EMDR that can be revealed with qualitative inquiry (p. 118). The mixed methods used in this study brought practitioner perspectives and client experiences forward, which provided additional information about adverse EMDR events. These results can then support further research from either a qualitative or quantitative point of view.

Limitations and Suggestions for Future Research

This exploratory, descriptive study did not provide evidence about the prevalence of adverse events resulting from EMDR therapy or the extent to which adverse events result from inadequate screening and assessment. However, this study offers significant evidence to guide future research endeavors aimed at investigating the prevalence of adverse EMDR side effects.

In the current study, data was gathered from consultants who responded to an invitation to participate in a study of adverse EMDR events. It is possible that participants self-selected based on their concerns about how EMDR is being implemented and the occurrence of iatrogenic effects, therefore,

future research should attempt to gather data that is more representative of the widespread application of EMDR. A related limitation was that the study may have missed uncovering negative events that clinicians deemed less serious and did not report to an EMDRIA Approved Consultant. Therefore, by gathering only information reported to consultants, this study may not have captured the full range of adverse EMDR events. The current study may, however, provide insight limited to the occurrence of more serious EMDR events as opposed to minor adverse events. Nevertheless, consultees who are truly concerned about their client are more likely to come forward to seek guidance from an EMDRIA-Approved Consultant, so this study may provide insight into the occurrence of more serious EMDR events as opposed to minor adverse events.

The study findings related to the use of Phase 1 and 2 of Shapiro's EMDR 8-Phase protocol suggest the need for future research that gathers data specific to dissociation as a clinical presentation: including the frequency with which it occurs among EMDR patients, the form in which it presents, and the sensitivity and specificity of screening protocols.

The number of responses to questions about Shapiro's EMDR protocol were lower than responses to other questions. The decrease in responses might indicate that some participants did not have consultees who reported clients' adverse EMDR experiences and were not able to answer this question. In hindsight, a "not applicable" option should have been provided.

In the survey, the question about adverse EMDR events asked for participants to identify the most frequent, acute/destabilizing symptoms or complaints resulting from EMDR therapy. Offering more defining terms, for example, sustained impact and/or persistent effect, might have elicited different responses.

Conducting qualitative research to understand EMDR from client and clinician perspectives might reveal hidden aspects of the experience not previously uncovered in quantitative research. The next step would include exploring opportunities for qualitative data collection.

As with any survey, the data was also limited by the ability of participants to recall details of specific consultations during the previous 18 months. Future research could vary the time frame for clinician recall of details.

Conclusions and Implications for Practice

This study identified that adverse EMDR events do occur and begins to address the gap found in research related to documenting EDMR efficacy with limited reporting about adverse EMDR effects. In addition, this study suggests adverse EMDR events may be related, in part, to inadequate training and/or insufficient application by EMDR practitioners of Shapiro's EMDR protocol Phase 1 for assessment and Phase 2 for client preparation. While the efficacy of EMDR has been routinely studied in RCTs and peer-reviewed articles, a conclusion of this study is that adverse EMDR events need to be more closely scrutinized using both qualitative and quantitative methods and thoroughly reported from both client and practitioner perspectives. Studies also need to examine the impact of deviations in treatment fidelity from Shapiro's 8 phase EMDR protocol on outcomes and client experiences.

References

Coy, M. (2024, March 21-25). *Deepening into unthought knowns: Integrating ego state therapy and EMDR to treat dissociation* [Pre-conference workshop]. *2024 International Society for the Study of Trauma and Dissociation (ISSTD).* Frisco, TX, United States. https://annualconference.isst-d.org/program/pre-conference-workshops

Cuijpers, P., Veen, S. C. van, Sijbrandij, M., Yoder, W., & Cristea, I. A. (2020). Eye movement desensitization and reprocessing for mental health problems: A systematic review and meta-analysis. *Cognitive Behaviour Therapy*, *49*(3), 165–180. https://doi.org/10.1080/16506073.2019.1703801

de Jongh, A., Amann, B. L., Hofmann, A., Farrell, D., & Lee, C. W. (2019). The status of EMDR therapy in the treatment of posttraumatic stress disorder 30 years after its introduction. *Journal of EMDR Practice and Research*, *13*(4), 261–269. https://doi.org/10.1891/1933-3196.13.4.261

EMDR International Association (EMDRIA). (2022, December). *EMDR basic training curriculum requirements*. https://www.emdria.org/wp-content/uploads/2022/12/EMDR-Basic-Training-Curriculum-Requirements-Dec-2022.pdf

EMDR International Association (EMDRIA). (2024). *EMDR consultant criteria.* https://www.emdria.org/emdr-training/emdr-consultant/

Hofman, S., Hafkemeijer, L., de Jongh, A., Starrenburg, A., & Slotema, K. (2022). Trauma-focused EMDR for personality disorders among outpatients (TEMPO): Study protocol for a multi-centre, single-blind, randomized controlled trial. *Trials*, *23*(196), 1-15. https://doi.org/10.1186/s13063-022-06082-6

Hoppen, T. H., Lindemann, A. S., & Morina, N. (2022). Safety of psychological interventions for adult post-traumatic stress disorder: Meta-analysis on the incidence and relative risk of deterioration, adverse events and serious adverse events. *British Journal of Psychiatry*, *221*(5), 658–667. https://doi.org/10.1192/bjp.2022.111

International Society for the Study of Trauma and Dissociation. (2011). Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma & Dissociation, 12*(2), 115-187. https://doi.org/10.1080/15299732.2011.537247

Leeds, A. M., Madere, J. A., & Coy, D. M. (2022). Beyond the DES-II: Screening for dissociative disorders in EMDR therapy. *Journal of EMDR Practice and Research, 16*(1), 25–38. https://doi.org/10.1891/EMDR-D-21-2021-00019

Laliotis, D., Luber, M., Oren, U., Shapiro, E., Ichii, M., Hase, M., La Rosa, L., Alter-Reid, K., & Tortes St. Jammes, J. (2021). What is EMDR therapy? Past, present, and future directions. *Journal of EMDR Practice and Research*, *15*(4), 186–201. https://doi.org/10.1891/EMDR-D-21-00029

Marich, J., Dekker, D., Riley, M., & O'Brien, A. (2020). Qualitative research in EMDR therapy: Exploring the individual experience of the how and why. *Journal of EMDR Practice and Research*, *14*(3), 118–134. https://doi.org/10.1891/EMDR-D-20-00001

Maxfield, L. (2019). A clinician's guide to the efficacy of EMDR therapy. *Journal of EMDR Practice and Research*, *13*(4), 239–246. https://doi.org/10.1891/1933-3196.13.4.239

National Library of Medicine. (2024). *Exhibit 1.3-4 DSM-5 Diagnostic Criteria for PTSD*. National Institute of Health. https://www.ncbi.nlm.nih.gov/books/NBK207191/box/part1_ch3.box16/

Pietkiewicz, I. J., Bańbura-Nowak, A., Tomalski, R., & Boon, S. (2021). Revisiting false-positive and imitated dissociative identity disorder. *Frontiers in Psychology*, *12*, 637929–637929. https://doi.org/10.3389/fpsyg.2021.637929

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures.* Guilford Press.

Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures (3rd ed).* The Guilford Press.

Shipley, G., Wilde, S., & Hudson, M. (2021). What do clients say about their experiences of eye movement desensitisation and reprocessing therapy? A systematic review of the literature. *European Journal of Trauma & Dissociation 6*(2), Article 100226. https://doi.org/10.1016/j.ejtd.2021.100226

Udo, I., Javinsky, T.-R., & Awani, T. (2022). Eye movement desensitisation and reprocessing: Part 1 – theory, procedure and use in PTSD. *BJPsych Advances*, 1–10. https://doi.org/10.1192/bja.2022.32

Whitehouse, J. (2021). What do clients say about their experiences of EMDR in the research literature? A systematic review and thematic synthesis of qualitative research papers. *European Journal of Trauma & Dissociation, 5*(3), Article 100104. https://doi.org/10.1016/j.ejtd.2019.03.002

Wilson, G., Farrell, D., Barron, I., Hutchins, J., Whybrow, D., & Kiernan, M. D. (2018). The use of eye-movement desensitization reprocessing (EMDR) therapy in treating post-traumatic stress disorder-A systematic narrative review. *Frontiers in Psychology*, *9*, 923–923. https://doi.org/10.3389/fpsyg.2018.00923

Appendix A

Survey for EMDRIA Approved Consultants regarding adverse EMDR events

This survey was developed to learn more about adverse events associated with Eye Movement Desensitization and Reprocessing (EMDR) therapy. As an EMDRIA Approved Consultant, you are being asked to describe your experience as a consultant to mental health clinicians who have completed EMDRIA approved EMDR training.

Participation in this survey is voluntary. The eligibility criteria for completing this survey are:

1. You must be an EMDRIA Approved Consultant who has been qualified as such for at least 18 months.
2. You must have provided consultation in the past eighteen (18) months to AT LEAST ONE consultee who is a mental health clinician that has completed an EMDRIA-approved EMDR training.

We are interested in your experiences and opinions, and there are no negative consequences for any answers, for skipped questions, or for declined participation. No unique identifying information or protected information will be collected, and your responses will be anonymous. All information you provide will be maintained by the researcher in a secure manner on the University of Washington's online server.

This survey consists of 12 questions and will take about 15 minutes to complete. While completing this survey, you may choose not to answer specific questions, and/or you may exit the survey at any time.

This survey was developed in partial fulfillment of a master's degree in nursing. If you have any questions about this study, please contact the Principal Investigator Joan Keltgen-Lo at jklo@uw.edu.

If you choose to participate, and if you are CURRENTLY an EMDRIA Approved Consulting therapist who has been asked for advice from AT LEAST ONE EMDRIA EMDR trained therapist regarding the use of EMDR in their clinical practice in the past 18 months, please click "Agree" below to indicate you have read the information on this page.

- Agree (go to survey)
- Disagree

1) What is the highest level of education have you completed?

- Masters
- PhD

- MD/DO
- ARNP
- DNP
- Other (Please specify)

2) How many years have you worked as a mental health practitioner offering one-to-one therapy?

- Less than 5 years
- 5 to 10 years
- 11 to 15 years
- more than 15 years

3) How long have you been an EMDRIA Approved Consultant?

- Less than 5 years
- 5 to 10 years
- 11 to 15 years
- more than 15 years

4) Over the past 18 months, approximately how many EMDR trained practitioners have you provided consultation to regarding EMDR? Please include in your count all individual therapists in 1:1 or group consultation (count each person in a group format).

- Less than 5
- 5 to 10
- 11 to 15
- More than 15

5) Approximately what percentage of EMDR therapists who seek consultation with you do so because their client experienced an adverse EMDR event?

- 0
- 1 - 20%
- 21 - 40%
- 41 to 60%
- 61 - 80%
- Greater than 80%

6) During the last 18 months, please choose up to FIVE of the most frequent, acute/destabilizing symptoms or complaints resulting from EMDR therapy that have been reported to you by consultees. (please check up to 5 that apply)

- Increased emotion dysregulation
- "Flooding"
- Emotional numbing
- Anger episodes

- Sustained fear or terror
- Spontaneous trance or 'zoning out'
- Intrusive thoughts or voices
- Internal struggle
- Amnesia
- Client disorientation (to person, place, time, and/or situation)
- Dissociative switching (to another self' state)
- Depersonalization and/or derealization
- Unplanned/unanticipated aberrations
- Distressing or intrusive memories
- Flashbacks
- Nightmares
- Sleep problems
- Difficulty functioning in daily life
- Brain fog or decreased cognitive functioning
- Exacerbation of existing/presenting symptoms
- New or previously unidentified symptoms
- Non-fatal self-harming behavior
- Suicidal thoughts or impulses
- Suicide attempt
- Headaches (new or increased in frequency/intensity)
- Intrusive, body-based symptoms (without an identifiable trauma-based source)
- Loss of functioning/experience (5-sense perception, paralysis, not feeling pain, etc.)
- Psychogenic, non-epileptic seizures (PNES)
- Non-specific distressing physical symptoms
- None of my consultees described adverse EMDR events with their clients during the last 18 months

7) Were there any other EMDR related adverse outcomes that your consultees described to you that were not included in the previous list? If yes, please list below.

8) Please describe the most destabilizing adverse EMDR symptom(s) or complaint(s) reported to you.

Questions 9, 10, and 11 refer to Phase 1 and Phase 2 from Shapiro's EMDR 8-phase protocol.

9) Phase 1 of Shapiro's protocol includes history taking with assessment and screening for contraindications. Among the consultees with clients who had adverse EMDR experiences, about what percentage of these adverse experiences were likely due, at least in part, to lack of, or inadequate use of, Phase 1 screening/assessment for potential contraindications prior to introducing BL-DAS/BLS into treatment?

- <1%
- 1 - 20%
- 21 - 40%
- 41 - 60%
- 61 - 80%
- Greater than 81%

10) What contraindications, if any, may have played a role in the client's adverse EMDR event? (Please list all below)

11) Phase 2 of Shapiro's protocol includes preparation for managing/containing emotional disturbances at the close of sessions as well as distress that surfaces between sessions. Among the consultees with clients who had adverse EMDR experiences, about what percentage of these adverse experiences were likely due, at least in part, to inadequate or no preparation prior to beginning trauma processing (BL-DAS/BLS)?

- <1%
- 1 - 20%
- 21 - 40%
- 41 - 60%
- 61 - 80%
- Greater than 81%

12) Is there anything else you think is important for us to know or understand about EMDR treatment and/or the risk of adverse events?

Thank you for your time in completing this survey. If you would like to receive a summary of the results, please contact Joan Keltgen-Lo at jklo@uw.edu.

Note. Online survey questions answered by participants.

Appendix B

Most frequent destabilizing symptoms or complaints resulting from an adverse EMDR event reported by consultees in the past 18 months.

Adverse events	Quantity
Increased emotion dysregulation	14
"Flooding"	13
Distressing or intrusive memories	10
Emotional numbing	9
Spontaneous trance or 'zoning out'	8
Unplanned/unanticipated abreactions	7
None of my consultees described adverse EMDR events with their clients during the last 18 months	7
Depersonalization and/or derealization	6
New or previously unidentified symptoms	6
Internal struggle	5
Exacerbation of existing/presenting symptoms	5
Nonspecific distressing physical symptoms	5
Dissociative switching (to another self-state)	4
Suicidal thoughts or impulses	4
Sustained fear or terror	3
Nightmares	3
Difficulty functioning in daily life	3
Sleep problems	2
Brain fog or decreased cognitive functioning	2
Non-fatal self-harming behavior	2
Anger episodes	1
Intrusive thoughts or voices	1
Flashbacks	1
Intrusive, body-based symptoms (without an identified trauma-based source)	1
Amnesia	0
Client disorientation (to person, place, time, and/or situation)	0
Suicide attempt	0
Headaches (new or increased in frequency/intensity)	0
Loss of functioning/experience (5-sense perception, paralysis, not feeling pain, etc.)	0
Psychogenic, non-epileptic seizures (PNES)	0

Note. n=34

Tables

Table 1

Sample education, experience, and nature of consultations

	No (%)
Education	
Masters	20 (61%)
PhD	9 (27%)
Other	4 (12%)
Years of practice as a mental health practitioner offering 1:1 therapy	
Less than 5 years	1 (3%)
5 to 10 years	4 (12%)
11 to 15 years	5 (15%)
more than 15 years	23 (70%)
Years of practice as EMDRIA Approved Consultant	
Less than 5 years	10 (30%)
5 to 10 years	9 (27%)
11 to 15 years	7 (21%)
more than 15 years	7 (21%)
Number of EMDR trained practitioners who consultants have counseled regarding EMDR in past 18 months	
Less than 5	4 (12%)
5 to 10	7 (21%)
11 to 15	3 (9%)
more than 15	19 (58%)
Percentage of EMDR practitioners who sought consultation regarding an adverse EMDR event	
0	6 (18%)
1 - 20%	20 (61%)
21 - 40%	4 (12%)
41 - 60%	2 (6%)
61 - 80%	1 (3%)

Note. n=33

Table 2

Most frequent, acute, destabilizing symptoms or complaints resulting from EMDR therapy reported by consultees in the past 18 months from a ranked choice list

Adverse events	Quantity
Increased emotion dysregulation	14
"Flooding"	13
Distressing or intrusive memories	10
Emotional numbing	9
Spontaneous trance or 'zoning out'	8
Unplanned/unanticipated abreactions	7

Note. n=34. Seven participants reported no consultees described adverse EMDR events with their clients during the last 18 months.

Table 3

Additional adverse EMDR events named by consultants, not identified in previous list

Additional EMDR adverse effects	No (%)
None	14 (70%)
Regret EMDR	2 (10%)
Psychological	2 (10%)
Physiological	1 (5%)
Lack of trust	1 (5%)

Note. n=20

Table 4
Most destabilizing adverse EMDR event identified from open-ended question

Key themes	n	Subthemes	Example, background, quote
Emotion dysregulation	n=18	Complete, emotional dysregulation	"Flooding, dysregulation of nervous system, intense fear, flashbacks, collapses, destabilization of dissociative system."
		Flooding, big affect, emotional crying	"The *safe place* is not enough."
		Decreased containment capacity, intense fear	"Processing targeted a childhood memory that was too overwhelming for the client to process via standard protocol without significant titration, stabilization and grounding skills."
		Emotional shutdown, collapse, no affect	"She presented with almost no affect and was unable to access relevant memories."
		Intense abreaction*	
		Flooding	"Flooding of memory material that was previously not consciously accessible and heightened internal struggle."
Physiological response	n=8	Increased physical symptoms	"Client experienced an increase in intrusive symptoms (nightmares, flashbacks, intrusive pain and other body memories) after an EMDR session."
		Dysregulation of nervous system	"Internal reactivity and irritability."
Dissociation	n=7	Destabilized dissociative system	"Clinicians who are not trained in identifying and working with dissociative symptomology."
		Increased dissociation	"The proper assessment of dissociation is vital. It is the most common issue that creates issues with EMDR."
		Switching	"Patient physically attacked therapist (an angry part attacked) for disturbing the system. Therapist terminated therapy for their safety.
		Undiagnosed dissociation	"It's mainly been people doing EMDR with undiagnosed dissociation."
Memories	n=7	Memories of past traumas, flashbacks	"Intrusive memory material and new symptoms best represent the most destabilizing elements."
Crisis	n=5	Suicidal ideation	"This was a crisis consultation"
		Psychiatric hospitalization	"The client became suicidal and had to attend ER"

		Withdrawal from engaged living	"She had to withdraw from her daily activities and became agoraphobic. She was afraid she was dying."
Discontinued therapy	n=4	Flooding	"Client not wanting to continue with therapy because of the flooding."
		Fear	"Fear of what might come up in processing, not returning to therapy."
		Memory overwhelm	"Client became overwhelmed with a particular memory and shared they don't want to continue the work."
Nightmares	n=2*		

Note. n=27. *No additional context given. Four participants stated no adverse EMDR events had been reported to them.

Table 5

Frequencies for reported percentages of adverse EMDR events due to consultee's inadequate application of Shapiro's EMDR protocol Phase 1 and Phase 2 in the past 18 months

Phase 1	No (%)
<1%	6 (21%)
1 - 20%	10 (34%)
21 - 40%	3 (10%)
41 - 60%	2 (7%)
61 - 80%	5 (17%)
Greater than 81%	3 (10%)

Phase 2	No (%)
<1%	7 (24%)
1 - 20%	8 (28%)
21 - 40%	4 (14%)
41 - 60%	2 (7%)
61 - 80%	7 (24%)
Greater than 81%	1 (3%)

Note. n=29

Table 6

Contraindication(s) contributing to adverse EMDR event

Key themes	n	Example, background, observation
Dissociation not assessed or undiagnosed	n=14	"People were generally good about thinking about preparation and resourcing, but they couldn't resource or prepare for what they could not see. So many people think of dissociation as synonymous with zoning out, and they miss other manifestations."
		"A client with dissociative symptoms which were not picked up on the DES screening tool."
		"The vast majority of issues I see present have to do with an inadequate assessment for dissociative disorders."
Trauma history (known or not known)	n=7	"Not utilizing the lens of traumatology in the use with complex clients and jumping into the reprocessing phases of EMDR Therapy too quickly."
		"Working on trauma, regardless of the modality, can cause adverse reactions if clinicians are not trained in and/or aware of how to work with clients with complex PTSD and dissociative disorders.
		"I believe the difficulty lies in the lack of information / assessment about complex trauma and dissociation along with a clinician's eagerness to help relieve their clients' symptoms quickly and a sincere belief that EMDR standard protocol will offer this relief."
Client related factor	n=7	"Inability to hold dual attention"
		"Poor affect tolerance. Severe and early (relational) trauma."
		"Dissociation, severe childhood adverse experiences, people with parts/DID"
EMDR protocol - therapist related skill/role	n=7	"Lack of clear treatment planning, and not having a solid and safe stablished relationship (yet) with the client."
		"Clinician who allows the client to access too much information without adequate preparation, meaning, accessing and activation of the neurological network without prep."
		"Phase 2 is so important- more important than reprocessing itself. Clients cannot do the work safely if they are not adequately prepared and informed of what to expect."
None	n=3	"I have not answered most of these questions because none of my consultees in the past 18 months have reported adverse events following EMDR. Some consultees have described reluctance to begin processing out of concern that adverse events might occur, or that they (consultee) might not be able to manage these symptoms."

Note. n=22