Social Workers' Perspectives of the Effectiveness of EMDR in Telehealth for PTSD Patients

by

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ABSTRACT

EMDR therapy is rarely used to treat post-traumatic stress disorder (PTSD), due to a lack of access to practitioners trained in providing EMDR treatment. Virtual EMDR sessions for treating PTSD may reduce access issues; however, it was unclear how social work clinicians viewed EMDR therapy when delivered to patients through telehealth. This qualitative descriptive study examined how social work clinicians perceive EMDR therapy delivered via telehealth to patients with PTSD in the United States. Twelve licensed social workers participated in semi-structured interviews. Two overarching themes emerged: strengths of using virtual EMDR therapy and challenges of using virtual EMDR therapy. Five sub-themes emerged as strengths of using virtual EMDR therapy. These subthemes were (1) efficient and comfortable, (2) accepted, (3) same expectations and practices, (4) better quality of life, and (5) wider reach. Three sub-themes emerged as challenges of using virtual EMDR therapy, which were: (1) family and home influences, (2) problems with using technology, and (3) policies and regulations. Potential positive outcomes associated with virtual EMDR therapy for PTSD patients will impact patients at the micro, mezzo, and macro levels of society and are expected to increase strategies to improve outcomes for PTSD patients.

Key Words: EMDR, PTSD Patients, Virtual EMDR Therapy, Social Workers

DEDICATION

I dedicate this dissertation to so many people. First of all, all trauma survivors. I am passionate about helping others who need healing as they find peace. Next, EMDR practitioners, who work tirelessly to aid survivors.

To my wise parents, Elizabeth and Antonio. The lessons you taught me about self-sacrifice, love, and patience have been invaluable to my development as a leader and servant. In addition, I am grateful for the unwavering guidance I have received from my super-husband, David. Thank you for being my rock, making me laugh, and providing me with a peaceful environment to study and write.

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“I am with you always" Matthew 28:18-2.

"Trust in the LORD with all your heart and lean not on your understanding; in all your ways submit to him, and he will make your paths straight." Proverbs 3:5-6

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Introduction

According to the National Institute of Mental Health (NIMH, 2021), approximately 6% of Americans experience post-traumatic stress disorder (PTSD). According to the DSM V-TP, the diagnostic criteria for PTSD include six criteria that must be met to establish a professional diagnosis for PTSD. The first criterion was that the stressor must be understood and recognized (APA, 2013). The second criterion was that the intrusive recollection was persistently recurring while producing intrusive distressing memories of the event. The individual might relive the experience through illusions, hallucinations, or dissociative flashback episodes. The third, fourth, and fifth criteria included avoidance and numbing, hyper-arousal, and duration. Finally, the sixth criterion was to note if the patient had disturbing occurrences that significantly caused distress or functional impairment during one's lifestyle patterns (APA, 2013).

Approximately 23.2 million Americans will suffer from the adverse outcomes of PTSD annually (NIMH, 2021). Individuals with PTSD suffer from intrusive and persistent thoughts regarding respective trauma and display avoidance behaviors to stimuli associated with traumatic experiences (American Psychiatric Association [APA], 2013). These symptoms often result in decreased functionality and quality of life for those impacted (Kuhn & Owen, 2020; Mavranezouli et al., 2020).

Eye movement desensitization and reprocessing therapy (EMDR), developed in 1989, is a therapy method that has increasingly evolved over the past several decades. This therapy is a unique treatment modality for psychological issues (Every-Palmer et al., 2020; Hase, 2021). While there is no definitive definition within the field and clinical

practice of treating mental health conditions, Laliotis et al. (2021) defined EMDR therapy as a treatment method providing integrative and client-centered treatment for patients with conditions that are disruptive to their activities of daily living.

According to the Bureau of Labor Statistics (2022), there is an estimated 708,000 licensed clinical social workers in the United States. However, there are only approximately 6,507 EMDR clinicians in the United States (Eye Movement Desensitization and Reprocessing International Association [EMDRIA], 2022). Even so, there is a need to examine EMDR therapy in its use for PTSD treatment as limited research associated is with this therapy. Social work clinicians and other EMDR therapy clinicians, such as nurses, psychologists, and counselors, routinely work with individuals with PTSD, delivering various treatments to reduce the adverse symptomology of PTSD (Waegemakers Schiff & Lane, 2019). Many treatments exist for PTSD, including medication, talk therapy, and other interventions. However, researchers have found that EMDR therapy is one of the most effective in reducing harmful symptoms and increasing patient functionality and quality of life (Cuijpers et al., 2020; Sunjaya et al., 2020).

Despite being an effective treatment for PTSD, virtual EMDR telehealth therapy is not widely used as a treatment protocol because patients struggle to access healthcare facilities with social work clinicians or other professionals capable of performing EMDR telehealth therapy (Cuijpers et al., 2020; Sunjaya et al., 2020; Waterman & Cooper, 2020). In addition, persons affected with PTSD may have challenges with transportation to and from therapy and may also struggle with avoidance of public spaces (Waterman & Cooper, 2020).

The use of telehealth services as a platform for medical and mental health services has become a viable option (Bestsennyy et al., 2021). Specifically, healthcare and mental health have seen a substantial surge in usage, especially during the COVID-19 pandemic (Bestsennyy et al., 2021). In addition, clinicians can guide EMDR telehealth therapy using telecommunication software (Cuijpers et al., 2020; Nickerson, 2016). As a result, researchers of telehealth EMDR services have agreed that performing EMDR telehealth therapy treatments over a virtual platform is feasible (Bongaerts et al., 2021; Morland et al., 2020; Sunjaya et al., 2020). In general, telehealth services have been on the rise in recent years and offer significant benefits in terms of access to healthcare professionals and services (Bestsennyy et al., 2021). However, EMDR telehealth therapy for PTSD is a treatment modality not utilized often in practice, with only 6,507 EMDR clinicians in the United States (EMDRIA, 2022). Therefore, there is a need to research practitioners' perspectives on potential barriers to using EMDR telehealth therapy with patients who suffer from PSTD and other related traumatic diagnoses.

Problem Statement

Despite promising effects of EMDR as a treatment modality for those with PTSD, it is currently underutilized. There are several reasons, with one of the most substantial being the lack of trained EMDR therapy practitioners able to provide virtual EMDR therapy (Sunjaya et al., 2020), the lack of technological competencies for providers, and distractions in a home environment (Parisi, 2020; Paulik et al., 2021; Rosen et al., 2020; Rutledge et al., 2017). Understanding social work clinicians’ perspectives on virtual EMDR therapy may be an important way of helping to move past these challenges and facilitating the wider use of virtual EMDR therapy. Creating structures for social work

EMDR providers to provide telehealth therapy may address some problems related to EMDR therapy access for PTSD treatment, or other mental health issues, in the future. Strengthening the infrastructure for clinicians to offer virtual EMDR therapy may alleviate some of the stress required to offer in-person care, increasing accessibility to vital interventions. Thus, a higher-level system change may occur concerning the delivery of EMDR therapy for patients with PTSD.

In the absence of how social work clinicians perceive virtual EMDR therapy when delivered using telehealth, there remains the risk that social work clinicians and institutional leaders may not make fully informed healthcare recommendations to patients or optimize EMDR telehealth therapy delivery (Cuijpers et al., 2020; Sunjaya et al., 2020). Social workers have the training to align with patients to increase their quality of life, including creating treatment modalities that show efficacy and are accessible to the patients (Every-Palmer et al., 2020; Knight, 2015; Rolbiecki et al., 2017). Adapting existing treatments, like virtual EMDR therapy, to be delivered in patient-preferred settings shows the versatility of social workers and their ethics toward equity.

Telehealth program staff show positive implications for increasing healthcare accessibility (Morland et al., 2020; Sunjaya et al., 2020; Turgoose et al., 2018). A systematic review by Morland et al. (2020) and Turgoose et al. (2018) examined the delivery of EMDR therapy via telehealth to veterans with post-traumatic stress disorder. The results of the study indicate that both clinicians and patients found EMDR therapy useful. However, issues with nonverbal communication, technology failure, and patient hesitation occurred. Thus, Turgoose et al. (2018) and Morland et al. (2020) argued that further exploration of EMDR therapy over telehealth platforms was needed.

Quantitative researchers have demonstrated the efficacy of delivering EMDR therapy to patients over a virtual health platform (Morland et al., 2020; Sunjaya et al., 2020; Turgoose et al., 2018). However, few telehealth staff use EMDR telehealth therapy, and few social work clinicians are adequately trained to provide EMDR therapy services on a virtual platform (Sunjaya et al., 2020). In addition, there is a gap in the literature regarding how social work clinicians perceive EMDR telehealth therapy delivered via telehealth.

Studies conducted on EMDR telehealth often used pre- and post-testing or quasi-experiments. However, did not address patients' input or lived experiences (Bongaerts et al., 2021; Whealin et al., 2017) nor focus on social work clinicians perceptions of its use. Instead, these researchers focused on whether the patients experienced benefits. Some addressed EMDR challenges when delivered via telehealth, including restricted access to trained clinicians, relevant technology, or information regarding EMDR therapy from patients' perspectives without addressing social work clinicians (Paulik et al., 2021). Social work clinicians' perspectives deserve a voice in developing ways to make virtual EMDR therapy more widely available through telehealth and address their concerns. Exploring the perceptions of social work clinicians will offer insight into how we can begin addressing the existing gaps to develop a more comprehensive approach to training and service, to improve accessibility and affordability. In addition, strengthening the infrastructure for social work clinicians to offer EMDR telehealth therapy may alleviate some of the stress required to offer in-person care, increasing accessibility to vital interventions. This higher-order system change may benefit patients and start to change

the field of EMDR therapy, particularly for highly sought providers that represent diverse populations.

Statement of Purpose

PTSD can profoundly impact a patient's everyday life (Powers et al., 2019). Accessibility to effective treatment for PTSD, such as EMDR, may improve the quality of people's lives. Unfortunately, literature on the perception of virtual EMDR therapy delivered via telehealth is lacking. By addressing this gap, social work clinicians may be better equipped to offer virtual EMDR therapy, alleviate some of the stress of in-person care, and provide vital services to more people. This qualitative descriptive study examined how social work clinicians perceive telehealth EMDR therapy when delivered to patients with PTSD. The research results will ideally lead to a better understanding of virtual EMDR therapy using a telehealth modality, having a wider offering of EMDR telehealth therapy, and aiding more patients with PTSD, specifically, how the use and accessibility of EMDR therapy via telehealth is perceived by social work clinicians.

Research Questions

The research questions included the following:

Overarching RQ: How do social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States?

SQ1: What organizational, environmental, or self-factors do social work clinicians perceive as necessary or conducive for the effective use of EMDR telehealth therapy when delivered to patients with PTSD using telehealth?

SQ2: What organizational, environmental, or self-factors do social work clinicians perceive as barriers to the effective use of virtual EMDR therapy when delivered to patients with PTSD using telehealth?

SQ3: How do social work clinicians perceive that virtual EMDR therapy, when delivered to patients with PTSD using telehealth, could best be expanded?

Overview of Research Design

Qualitative descriptive research examined "How do social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States?" This subjective research method focuses on obtaining in-depth information about individuals' perceptions with direct experience with the research phenomenon (Hammarberg et al., 2016). It can also help researchers understand a central phenomenon outside of specific variables impacting the issue of concern (Hammarberg et al., 2016) and explore relevant perspectives within the population of interest (Merriam & Tisdell, 2015).

The participants in this study was social work clinicians who provided EMDR therapy services using telehealth to a patient within two years. A convenience sampling was used to recruit participants through the location of social work clinicians providing EMDR therapy through telehealth. This approach assisted in targeting experienced social work clinicians with relative experience in using EMDR therapy using telehealth. In essence, the identified target population ensured that the study could realistically describe successful telehealth EMDR therapy, not merely the speculation of those who were aware of it.

Rationale and Significance

The prevalence of PTSD on a global scale is harder to quantify, given the diverse conditions worldwide. However, the American Academy of Social Work and Social Welfare (Uehara et al., 2014) identified harnessing digital technology for social good as one of the global social work's grand challenges. Delivering a proven and effective PTSD treatment through telehealth represents a way to help address that challenge. In addition, the accessibility aspect of delivering EMDR therapy through telehealth has important implications for the ability of social workers to offer EMDR therapy at global and local levels. The widespread use of EMDR therapy by social workers may be valuable to those in remote areas with exceedingly difficult transportation barriers. If the results of this study inspire greater adoption of telehealth EMDR therapy, there is the potential to play a role in addressing global challenges.

The final level of magnitude is the local level. The results of this study will have significant implications to consider within the United States, specifically in rural communities, such as Pennsylvania, where access to healthcare services is limited. A shortage of EMDR-trained social work practitioners remains an issue in rural communities, as they often lack access to healthcare specialties (Cuijpers et al., 2020; Redford, 2019; Sunjaya et al., 2020). With the populations of these areas spread far, people may remain too far to access a trained social worker. Health care and Mental Health services in rural areas, such as rural hospitals and mental health specialty services, fare poorly and often close (Frakt, 2019). This issue existed even before the COVID-19 pandemic placed heavy burdens on rural healthcare infrastructure. This study could benefit rural communities, much like in Pennsylvania, by adopting telehealth EMDR

therapy. Such adoption may allow patients access to specialized therapy via telehealth and less reliance on brick-and-mortar healthcare services at a distance which is challenging to those who are socially inept.

Treating PTSD in these communities may improve the quality of life of those living with it and support further integration into the enjoyable and meaningful aspects of living in a society. The findings of this study will benefit social work clinicians and shed light on the efficacy of EMDR. Addressing this imbalance between a significant and harmful mental illness and a known treatment provides social work clinicians with an important tool to increase their scope of practice. In addition, social workers' desire to ease the emotional pain of clinically diagnosable conditions by learning to administer EMDR therapy effectively through telehealth offers them a concrete new way of doing so. Ideally, such practitioners will find the results useful to go forward with training in the telehealth application of EMDR therapy, improving the reach and volume of telehealth services available to help those struggling with PTSD.

This study is significant as it will begin to address a noted gap in literature. As highlighted above, the focus of existing studies of EMDR therapy through telehealth has been quantitative (Bongaerts et al., 2021; Whealin et al., 2017). In addition, these studies have focused on the patient perspective (Paulik et al., 2021), creating a notable gap in understanding social worker clinicians' perspectives and expressions of meaning. Such a gap is important to address not for completeness but because social workers' perspectives are important to determine whether providers will offer telehealth EMDR therapy services. A better understanding of this key area missing from the present research is academically interesting and relevant for social work theory and practice.

Research Context

This research study has significance in multiple contexts. These include across the three levels of social work in social work education; social work practice; social work theory; and across the micro, mezzo, and macro levels. This section addresses those myriad contexts and their significance to social work.

Significance to Social Work Practice

The significance of the study is prevalent at the micro, mezzo, and macro distinction. In essence, the educational and theoretical significances of this study represent ways of fostering overall better social work practice.

Microlevel. Within social work, microsystems include the individual, family, and group systems (Berkes et al., 2008; International Federation of Social Workers, 2018). At the individual level, the present study's results are important for patients with PTSD, especially in rural areas. Research has already demonstrated that telehealth staff can effectively treat PTSD with outcome quality comparable to traditional or in-person EMDR treatments (Bongaerts et al., 2021). Therefore, the therapy's benefit to individuals with PTSD is established. The missing aspect is turning these results into common practice. Bringing these benefits to individuals who currently lack them aligns with the values-based nature of the social work profession, where social workers seek new and better ways to help patients (Nguyen, 2022).

The current qualitative exploration may offer a roadmap to better usage of telehealth EMDR therapy, which may have huge benefits for individuals because PTSD is, in many cases, a crippling condition for those suffering from it (Powers et al., 2019). PTSD symptoms can make daily life difficult to unbearable, and PTSD is associated with

a significantly greater risk for other mental health issues (Contractor et al., 2022). In severe cases, those with PTSD may be at high risk for suicide (Nichter et al., 2019). In addition to the need to help patients, the National Association of Social Workers (NASW, 2016) noted that supporting and preserving patients' dignity is paramount. Therefore, best practices related to PTSD treatment at the individual level are key.

Mesosystems. Mesosystems comprise the interaction of two or more microsystems (Berkes et al., 2008; International Federation of Social Workers, 2018). For example, some effects discussed in the prior section regarding the effects of PTSD on other microsystems can be understood as mesosystems between the individual context and the family/group context. In this regard, the qualitative method's contextual aspects (Merriam & Tisdell, 2015) helped identify the specific meso-contexts with which the results might be especially applicable.

A particularly relevant meso-context is the rural context. Rural healthcare systems remain overburdened (Frakt, 2019), especially as rural areas have been some of the hardest hit by the COVID-19 pandemic, as the rapid onset of COVID-19 taxed already strained resources (Paul et al., 2020). The present study's results may help alleviate one component of the overburdening by shifting PTSD treatment toward telehealth. The contextual aspects of the qualitative method also helped the study identify the extent to which the participants' patients were rural. Another mesosystem implication could be between the family and group context. If the present study led to improved PTSD treatment, this finding could improve the family lives of individuals with PTSD, as treating impacted family members could increase their overall quality of life within the household. Finally, this finding aligned with the National Association of Social Workers

([NASW]; 2022) belief that social workers should put the needs of patients first, a belief supported by significant policy and legislation.

Macrosystems. The macrosystem level comprises the overall, holistic context within which patients exist (Berkes et al., 2008; International Federation of Social Workers, 2018). In this current study, that context was the United States. Within the U.S. context, PTSD is a problem inadequately addressed. Approximately 6% to 9% of people in the United States will experience PTSD in their lifetimes (National Institute of Mental Health, 2021). Additionally, 3% to 5% of the population suffers from PTSD on average each year (National Institute of Mental Health, 2021). These numbers indicate an unmet need nationally.

This current study explored the ability to implement EMDR therapy more widely through telehealth. Hence, the results have potential macro-impact if the strategies identified can be applied widely. Another potential definition of macrosystem may be the state level in the United States. Especially for rural states, the local conditions and culture are defined more at the state level than the national level (e.g., Covid CDC Team, 2020; Straus, 1994).

Within the macrosystem of Pennsylvania, the potential benefits of this current study of social work are even greater. These states often have poor healthcare accessibility (Cuijpers et al., 2020; Sunjaya et al., 2020). In addressing this aspect, the study's qualitative contextualization and description provided valuable insight into whether the identified strategies and approaches would provide a feasible way to improve EMDR therapy access in rural states.

Significance to Social Work Education

The NASW (2016) identified that current and future social workers should be educated regarding the applicability of the technology in social work practice. This need has been accentuated by the COVID-19 pandemic, which has pushed telehealth into the mainstream. In response to the pandemic, many states have eased licensing requirements, in-or-out-of-state requirements, and other obstacles to the widespread use of telehealth (State Federation of Medical Boards, 2022). The results of the present study fit into the current social work landscape in offering recommendations to new and existing social workers. The study results explored the current practice of telehealth EMDR therapy and how current practitioners came to provide that service. Studying these results can be a straightforward and highly valuable educational tool.

Significance to Social Work Theory

Theoretically, the study is significant because it expands the technology-organization environment (TOE) theory. This theory suggests that technology adoption and usage derive from the interaction of technological, environmental, and organizational factors surrounding the effective implementation of telehealth technology for EMDR therapy (Tornatzky & Fleischer, 1990). As discussed previously, qualitative research was an ideal approach to explore new theoretical ground and thereby develop a new theory or extend the existing theory to new areas (Merriam & Tisdell, 2015). The present study tested the theory by determining if such keys could be found. At the same time, the study extended the TOE theory by applying it to a novel yet-to-be-studied problem in social work. The TOE theory was not a social work theory. Therefore, the present study

explored how well that framework fits in a social work context using a qualitative method's exploratory nature.

In today's social work context, the TOE framework is relevant since social work increasingly involves the use of technology (Reamer, 2019). For example, the TOE theory can be more strongly recommended to future researchers addressing telehealth technology adoption problems or problems regarding the adoption of technology in social work. In this regard, the results may have implications for telehealth EMDR therapy and the applicability of TOE theory for understanding the use of technology in social work more generally.

Role of the Researcher

It was personal experience as a counselor offering EMDR services while using English as a second language (ESL) that sparked the researcher's interest in this research topic. As a user of telehealth platforms, the researcher appreciated the remote mode of providing mental health care to those who did not have access to it. There are so few ESL EMDR-certified counselors who work with multilingual and ESL individuals that research suggests more widespread adoption of the telehealth platform. It is believed that telehealth could enhance support and services for the ESL and multilingual population.

Definition of Key Terminology

Eye Movement Desensitization and Reprocessing Therapy (EMDR Therapy)

The EMDR therapy process includes instructing patients to focus on traumatic memories while completing eye movement patterns (Cuijpers et al., 2020; Hase, 2021). EMDR is one of the most effective in reducing harmful symptoms of PTSD and

increasing patient functionality and quality of life (Cuijpers et al., 2020; Sunjaya et al., 2020).

Post-Traumatic Stress Disorder (PTSD)

According to the DSM V-TP, PTSD is a mental health disorder. Symptomology includes intrusive recollection, persistently recurring thoughts while producing intrusive distressing memories of the event, illusions, hallucinations, or dissociative flashback episodes, avoidance, and numbing, hyper-arousal, causing distress or functional impairment during one's lifestyle patterns (APA, 2013).

Telehealth Services

Telehealth services refers to healthcare services delivered over a virtual modality. Telehealth services include online platforms for delivering medical and mental health services virtually, especially during the COVID-19 pandemic (Bestsennyy et al., 2021).

Theoretical Framework

The TOE framework and empowerment theory underpin the current study. Tornatzky and Fleischer (1990) developed the TOE framework to explain and provide a context for adopting inter-organizational systems. Rappaport (1981) developed empowerment theory as a process from which an individual was taught autonomy and self-determination to become more confident and enable them to overcome feelings of powerlessness. Zimmerman (2000) later expanded Rappaport's (1981) theory, explaining that empowerment could help clients realize identity reformation when used for mental health therapy. The empowerment theory advocates personal development, emphasizing increased self-awareness and taking control of one's life.

Technology-Oriented Environment Framework

The TOE framework details how an organization (or individual) adopts new technologies and if the organization (or individual) has the means to support such technological changes, improvements, or equipment innovation (Sukardi et al., 2021). The TOE framework builds from three interconnected contexts that influence whether an organization or individual can adopt a novel technology in the technological, organizational, and environmental contexts. First, through TOE, technology adoption in organizations follows a specific process, so the workforce of such an organization is more accepting of the technological changes (Tornatzky & Fleischer, 1990). Implementing new or updating old technology in any environment can create discord with employees, thereby putting constraints on production as all individuals may not accept the new or updated technology. The TOE was established as an organizational-level analysis to promote such changes and encourage employees to accept these changes (Awa et al., 2017).

The TOE framework uses combined technological, organizational, and environmental frameworks. Each offers patterns of complex behaviors at the individual level within an organization. Adopting technology often has organizational leaders incorporating such behavioral models as the theory of planned behavior, the technology acceptance model, and the theory of reasoned action. Each model interprets and explains individual behavior patterns associated with technology changes (Awa et al., 2017). The application of TOE supports the technological context relating to the context of the organization or individual having the equipment to implement new operations or technology. Thus, the technological context comprises older and current technologies

relevant to the end goal (Li, 2020). The existing technologies are vital because they set the scope and pace of new technological change (Li, 2020). Modernizations that exist but are not yet in use at the firm also influence innovation by "demarcating the limits of what is possible and showing firms ways in which technology can enable them to evolve and adapt" (Salisu et al., 2021, p. 9).

The organizational context relates to whether the organization has the resources to implement the innovation (Li, 2020; Tornatzky and Fleischer, 1990). Organizational resources can include the company's communication process, size, and the ability to link formal and informal structures (Li, 2020). Although organizational construction may vary, they are all similar in the means and methods for accepting (or adopting) new technology. The organization's foundation must incorporate perceived usefulness for the entire company and determine the ease of use based on size, communication, and management relationship with employees (Li, 2020).

The environmental context relates to how the organization or individual can relate its decisions and processes to stakeholders. Identifying any relationship with or for the adoption process consists of decentralized structures and ties all three constructs together. The links between formal and informal systems, the communication process, or the organization's size affect these relationships. The new technology is more likely to be adopted if all three contexts support the innovation (Li, 2020).

After Tornatzky and Fleischer (1990) published the TOE model, Awa et al. (2017) expanded this framework. Awa et al. applied the TOE framework to the individual, incorporating technology adoption at the individual level. In addition, the new

framework encompassed other theoretical constructs, such as the theory of planned behavior and the theory of reasoned action (Awa et al., 2017).

The combination of these components within the TOE framework established a reason for implementing new technology and ensuring the new technology was suitable for the organizational need. Tornatzky and Fleischer (1990) believed that innovation processes drove adoptions within any organizational structure. Baker (2011) suggested the base structure of an organization had specific responsibilities and roles for all employees, and leaders within the organization should recognize it was not a formalized manner of reporting such relationships but the methods of commitment and cooperation that would allow a successful iteration with technology adoption.

Empowerment Theory

Social workers define empowerment as the "acquisition of personal, interpersonal, or political power to improve the lives of marginalized people" (Zoabi & Gal, 2020, p. 964). The empowerment theory emphasizes the efforts to apply control at three equally interdependent levels of analysis: individual, organizational, and community (Zimmerman, 2000). This theory provides strengths that include constancy with social work values and ethics, addressing discrimination, marginalization, and oppression on a political and clinical scale. It is in line with the person-in-environment perspective.

The empowerment theory comprises three distinct components: interpersonal, interactional, and behavioral. Each component has a specific role in the empowerment process. For example, when amplified as an empowerment process, the interpersonal component improves leadership efficacy, civic efficacy, and self-esteem (Zimmerman,

2000). The second component, behavioral, incorporates leadership, community, and school engagement to exact the social behaviors found within empowerment (Zimmerman, 2000).

A social worker understands these two components that incorporate areas for intervention using microlevel tools, such as therapy, case management, and insight techniques. All are used to emphasize a client's strength, help develop necessary skills to confront social and political difficulties and offer alternatives to dysfunctional and self-defeating thought patterns. As a result, the client learns to cultivate their self-worth and empower themselves, and the client learns to take part actively in identifying their needs, striving to build strength and independence.

The interactional component occurs at the macro-level, within political advocacy, program development, and research projects. The three tools are put forth to government agencies to engage in efforts to change laws and policies that disproportionately impact marginalized or disadvantaged groups in negative ways. This component educates the public regarding social issues, identifies factors contributing to social inequities, and pushes for learning to rise above and overcome barriers (Nyahunda, 2021). Adult mentors, adult resources, and resource mobilization become more readily understood within the interactional component (Zimmerman, 2000). An intervention approach using empowerment theory enhances positive development with learning skills, practicing such skills, establishing the resources to navigate social contexts effectively, and developing into healthy adults. Social workers encounter clients with a history of trauma, both acute and chronic PTSD (Leveson, 2017).

Using the empowerment theory with clients, social workers position individual issues in a person-in-environment viewpoint, recognizing the mutual influence of individuals and communities. In direct practice with individuals, empowerment interventions assist individuals in progressing through self-efficacy while applying coping skills to survive through or attempt to alter the prevailing social environment. For example, using the empowerment theory in clinical therapy may involve the client moving from feelings of helplessness to having control over their emotions and the behaviors driven by such emotions (Zoabi & Gal, 2020).

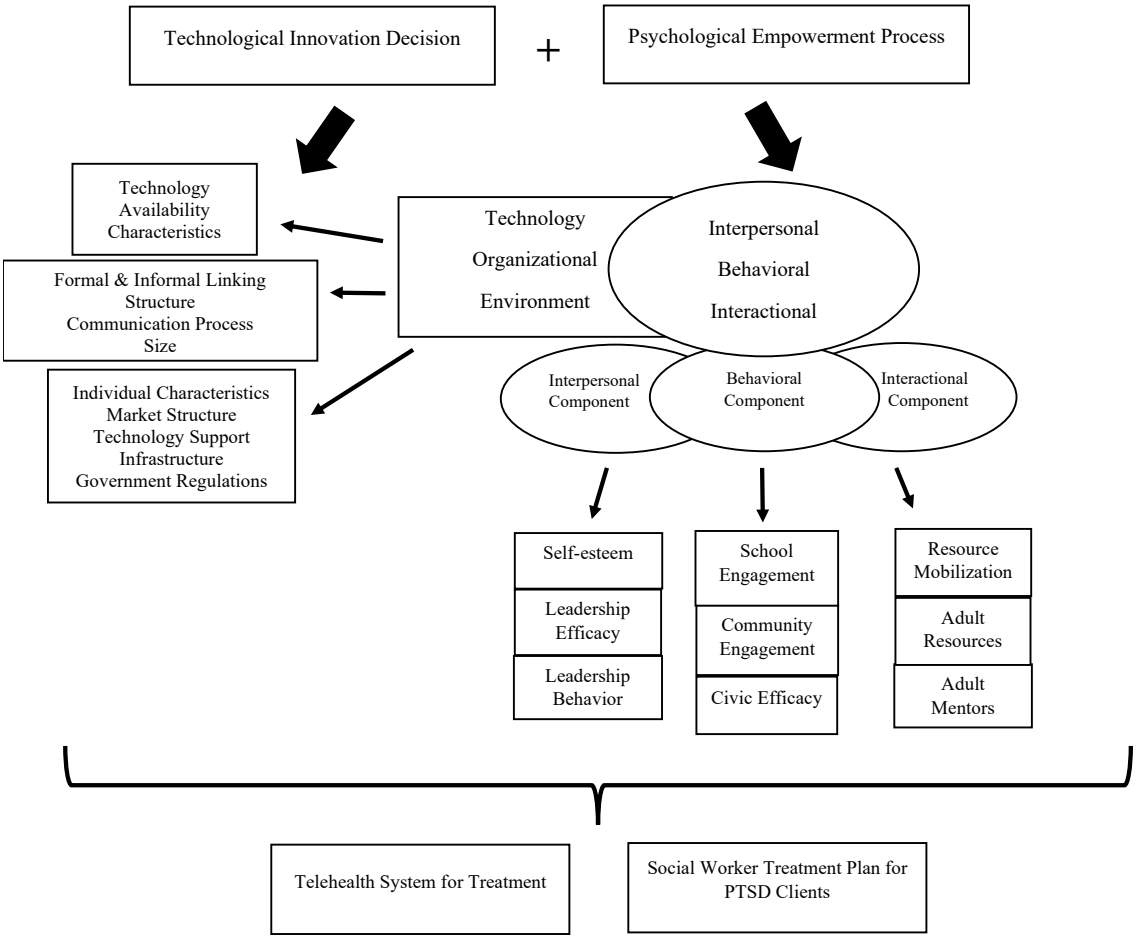
Application of Technology-Oriented Environment Framework and Empowerment Theory to Current Study

Telehealth application encompasses accepting such technology, proven successful by social workers who counsel clients with mental health conditions. Mental health professionals have successfully harnessed telehealth technology, increasing practice for those clients who are less likely to attend counseling services (Mouratidis & Papagiannakis, 2021; Sampaio et al., 2021). Telehealth care for therapy can be expanded to empower patients and promote self-management treatments with improved mental health outcomes (Perry et al., 2020). The combination of TOE and empowerment theory for the framework of the current study provided a foundation from which the research questions were built. The foundation related to the current study's purpose offers a means to understand and accept telehealth usage as an acceptable therapy for social workers to treat PTSD through EMDR therapy (Zoabi & Gal, 2020).

The researcher of the current study used empowerment theory combined with TOE to produce a workable framework (Figure 1). This framework consisted of empowerment theory's interpersonal, behavioral, and interactional components. It was applied to the TOE's technological, organizational, and environmental to determine if telehealth would produce successful outcomes for PTSD patients (Zoabi & Gal, 2020). Figure 1 shows the combination of the technology-organizational environment mechanism of technological innovation-decision with the psychological empowerment process to form the current study’s framework.

Figure 1.

Combination of TOE and Empowerment Theory



This framework combined the TOE construct with the interpersonal behavioral and interactional constructs of the psychological empowerment process established through the variables making up each construct. With TOE, these variables included technology, availability, and characteristics; formal and informal linking; the structure, size, and communication process found within the organization; and the individual

characteristics, market structure, technology support, infrastructure, and government regulations overseeing the organization's production. These are combined with the psychological empowerment process's interpersonal, behavioral, and interactional facets. These facets include self-esteem, leadership efficacy, and leadership behavior within the interpersonal components. In addition, the use of school engagement, community engagement, and civic efficacy within the behavioral and interactional components comprises resource mobilization, adult resources, and adult mentors. When functioning together, the formation of this framework applied to the acceptance of a telehealth system for treatment and social workers to establish telehealth treatment plans for PTSD clients.

The TOE framework and empowerment theory relate to the current study's purpose, with both prevalent for telehealth, as an understood and accepted form of therapy to treat PTSD. The researcher used TOE as its study's technological, organizational, and environmental framework to determine if telehealth applications will produce successful outcomes for patients with a PTSD diagnosis (Tornatzky & Fleischer, 1990). The combined TOE framework and empowerment theory will help determine if clinicians can effectively adopt a telehealth system in their organization, a novel technology (Appleton et al., 2021; Figueroa & Aguilera, 2020; Gentry et al., 2021).

Telehealth is often prescribed based on whether the individual has the necessary equipment to implement telehealth, such as internet service, computer ownership, or smartphone availability. The environmental context relates to how individuals equate teletherapy to treating their mental health concerns, specifically PTSD. Focusing on environmental factors prompts the applicability of the empowerment theory, as the individual should feel empowered to use this new technology (Cheng et al., 2021; Jensen

et al., 2019). As a social work theory, empowerment theory provides clients with enablement and a sense of structure (Zimmerman, 2000). The TOE framework and empowerment theory were applied as a related means for EMDR teletherapy because understanding its strengths, weaknesses, and functions requires examining all aspects of the system, including the patient, practitioner, EMDR therapy process, and telecommunication system.

Chapter 2: Literature Review

The phenomenon of interest within this proposed research is the efficacy of virtual EMDR therapy when delivered via telehealth to patients with PTSD. This phenomenon of interest provided a framework for the literature review. A comprehensive search was provided using EBSCO Host, Google Scholar, JSTOR, Psych Info, PubPsyc, and Science Direct. The articles contained key terms and phrases, such as barriers to eye movement desensitization and reprocessing therapy, challenges due to regulations and policies, challenges of eye movement desensitization and reprocessing therapy, and challenges of eye movement desensitization and reprocessing therapy using telehealth for posttraumatic stress disorder treatment. Further search terms and phrases included challenges with the ability for the client to afford the necessary equipment and pay for the internet service, location issues, challenges with lack of technology use knowledge for both the clinician and the client, eye movement desensitization and reprocessing therapy for posttraumatic stress disorder, posttraumatic stress disorder, and posttraumatic stress disorder treatment. The last group of phrases used for this literature search entailed *social work clinicians and eye movement desensitization and reprocessing therapy*, *social work*

clinicians' use of eye movement desensitization and reprocessing therapy, and *treatment methods for posttraumatic stress disorder*.

The literature on social work clinicians, especially those related to EMDR therapy, was sparse. Therefore, the search criteria for this literature review were expanded to include all clinicians that deliver EMDR therapy. The key terms used in each database extracted over 4,000 resources. The researcher developed specific inclusion criteria to select the most appropriate resources. The researcher included research that fit the following criteria: (a) Only scholarly work was selected, (b) 85% of all work selected was published after 2018, (c) all work related to the current topic of the study, and (d) all work was written or translated into English.

Using these criteria, the researcher first examined the titles of the resources, eliminating duplicate titles and those that did not meet the criteria. Second, studies were selected based on reading the sources suspected to fit the purpose of the current research, as indicated by article titles. However, over 50% of the sources did not meet the criteria. The third step was to read each remaining article, excluding those that failed to meet the criteria. Much of the literature selected (85%) was published within the past five years and in a peer-reviewed journal or other reputable sources, like governmental agencies. When finished, 83 resources were used in this literature review. Table 1 shows the number of resources elicited for each database.

Table 1

Resources Cited in the Databases

Database	*Number of found resources*
EBSCO Host	1,382
Google Scholar	1,579
JSTOR	678
Psych Info	342
PubPsyc	212
Science Direct	136
Total	*4,329*

Post-Traumatic Stress Disorder

Once thought of as a condition only occurring in soldiers, PTSD can happen to anyone. History recorded early recognition of PTSD from ancient Mesopotamia, 1300 BCE depicting PTSD-like symptoms in warriors. By the late 1800s and early 1900s, Freud popularized a psychoanalytical treatment known as the talking cure (Phillips & Williams, 2022). Freud established the psychoanalytical therapy method of talking with a professional to treat symptoms that PTSD might have caused. These early therapeutic interventions were the first step toward helping people who had survived traumatic events.

During the second half of the 20th century, psychologists and sociologists began to examine PTSD symptoms in individuals serving in military conflicts and civilians facing traumatic incidents, such as domestic violence, car accidents ending in death, or witnessing a loved one's dismemberment (Phillips & Williams, 2022). In addition, studies began recognizing PTSD outside of the military environment, and researchers found that individuals exposed to trauma developed symptoms consistent with PTSD. For example,

statistics showed that 60% of men and 50% of women experienced at least one trauma, with 6% developing PTSD (Kuhn & Owen, 2020).

In many cases, in individuals who have gone through traumatic incidences, irrational thinking processes trigger the reliving of a trauma (Contractor et al., 2022). For example, an inability to sleep can occur from recurring and distressing dreams or visualizations due to experiencing such traumatic events. In addition, individuals may experience anxiety, transferring their feelings into significant emotional distress (Loignon et al., 2020). When reminded of the incident, this anxiety may trigger a physical panic attack with heart racing, lightheadedness, or feelings of chest constriction. Although individuals manifest some PTSD symptoms uniquely, there is an array of commonalities in symptomology among those with PTSD, including avoidance of recognition and discussion of the traumatic event and the impact on an individual's life after such occurrence.

One typical behavior pattern for patients with PTSD involves individuals avoiding discussing the stressors or trauma. Such individuals decidedly try to avoid thinking about the event and will not speak about it, repressing their feelings regarding this event (Loignon et al., 2020). The goal in these cases is for the patient to numb themselves, ignoring their problems rather than facing the traumatizing incident and its psychological outcome. Further, these individuals often choose other coping methods (e.g., alcohol or prescription drugs) as the panacea to their problems rather than facing the traumatizing incident and its psychological outcome (Kuhn & Owen, 2020; Neria, 2021). This cycle of numbing and avoidance may cause marriage or relationship issues (Loignon et al., 2020).

PTSD clients often suffer from decreased responsiveness, also known as psychic numbing. Losing interest in activities that were once important, for example, running, is another facet that leads to a PTSD diagnosis. With many, the susceptibility and showing of signs of depression, panic disorder, and alcohol abuse are inclusive to the criteria for such a diagnosis. The essential areas in one's life may be negatively impacted (Morland et al., 2020; Powers et al., 2019). Simply remembering how well a person coped with something in the past can trigger a similar response.

The emotional stress from any traumatic occurrence frequently does not go away. When such an increase in intensity and such emotional reactions, behaviors, or actions interfere with a person's daily routine, the best recommendation is to seek professional help. Many mental health professionals (or clinicians), such as social work clinicians, are well-versed in treating all forms of the effects of PTSD (Miao et al., 2018). Management of the emotional countenance one may experience after a traumatic event does not necessitate an emotional being. Professional help can propel a person into a more promising, albeit different, future (Morland et al., 2020).

According to the National Institute of Mental Health (2021), PTSD develops in any person based on exposure to a shocking, dangerous, or frightening event. Comorbidities often accompany PTSD diagnoses, such as anxiety, social anxiety disorder, depression, obsessive-compulsive disorder, substance abuse, or borderline personality disorder (McQuaid, 2021; Miao et al., 2018). During an assessment for proper treatment, a mental health clinician will consider the diagnosis, the patient's demographic information, and the availability of therapeutic services (Miao et al., 2018). Considering the client's irrational thoughts and recognizing the influence on their feelings, the

therapist will examine these processed behaviors, enabling the inclusion of certain interventions for the client (Miao et al., 2018). A diagnosis of PTSD also allows for the treatment modality to be tailored to the individual's mental health needs.

Treatment for Post-Traumatic Stress Disorder

Many mental health clinicians, such as social work clinicians, are well-versed in treating the symptoms and comorbidities associated with PTSD. Patients with PTSD may require different therapies depending on the propensity and effect time-variant. Experts claim that in those diagnosed with PTSD, a perceived or imagined slowing of time is experienced (Powers et al., 2019; Waegemakers Schiff & Lane, 2019). Dissociative symptoms of effect time-variant suggest a fracturing of a client's temporal processing with PTSD and an increase in the delusion of both a lapse of time and the duration of stimuli within a working memory of the client's trauma (Vicario & Felmingham, 2018). For example, with immediate effect, coping can develop through remembrances of how a person in the past handled stressful situations and developed an understanding of the coping abilities they recognized themselves as having (Kuhn & Owen, 2020).

Medication and psychotherapy are used to treat PTSD. Often a provider will prescribe medications. Most medications are selective serotonin reuptake inhibitors, yet other providers will prescribe serotonin-norepinephrine reuptake inhibitors. The four name brands recommended for PTSD treatment of symptoms consist of Sertraline, Paroxetine, Fluoxetine, and Venlafaxine (U.S. Department of Veteran Affairs, 2022). Most providers treating patients with pharmaceuticals will combine this treatment plan with psychotherapy, while others will focus on only using psychotherapy for treatment (Lewis et al., 2020).

Psychotherapy treats a mental disorder, such as PTSD, through psychological means (Lewis et al., 2020). The types of therapies include cognitive behavior therapy (CBT), exposure therapy (ET), prolonged exposure therapy (PET), and eye movement desensitization and reprocessing (EMDR). The most predominant treatment for PTSD is cognitive behavioral therapy (CBT); however, current studies indicate that EMDR achieved equally effective results as CBT in treating PTSD (DiBenedetti et al., 2020; Maxfield, 2021).

Cognitive Behavior Therapy

Researchers have suggested CBT as a treatment therapy plan for patients with PTSD. CBT helps clients understand and challenge unhealthy thought processes and emotions brought on by traumatic incidents, helping reduce symptoms and improve quality of life (Cuijpers et al., 2020; DiBenedetti et al., 2020). This type of therapy allows mental and behavioral psychological treatment methods to benefit the patient's unconsciousness and consciousness. As an action-oriented and action-focused therapy method, CBT treats specific problems related to a diagnosed mental disorder (DiBenedetti et al., 2020). In using CBT, there is a belief that maladaptive behaviors and irrational thinking play roles in developing the disorder (Horst et al., 2017). In addition, therapists can offer coping mechanisms and information-processing skills to patients, focusing on structured skill training and moral recognition training to assist patients in reducing their associated stressors (Horst et al., 2017).

From a strictly behavioral approach, the focus of a patient's cognition combined with environmental contingencies is believed to trigger unwanted behaviors that lead to the problems through a stimulus-response paradigm (Loignon et al., 2020). From the

cognitive-behavioral perspective, presenting such behavioral problems is primarily understood as the product of faulty learning concerning one's own repetitive illogical thinking patterns (Horst et al., 2017). A therapist assesses maladaptive thinking patterns, which are considered the client's ideas of arbitrary inference, selective abstraction, and overgeneralization. A therapist will examine the cognitive triad to determine how a client's negative stream of cognition leads to irrational thinking (Cuijpers et al., 2020; Horst et al., 2017).

Many clinicians adhere to CBT as a therapy method for treating clients with PTSD, believing it provides a combined aspect of dialectical behavioral therapy (Watkins et al., 2018). However, the success of CBT for PTSD treatment has mixed reviews from clinicians. Some claim that using EMDR is better than CBT in reducing posttraumatic symptoms and anxiety, even though studies show no difference in reducing depression between the two therapies (de Jongh et al., 2019; Khan et al., 2018). Nevertheless, those who support CBT over EMDR to treat PTSD suggest that CBT is a therapy modality. Support for CBT can be explained by clinicians' attempts to improve the patient's tolerance by challenging unhealthy thought processes and emotions connected to an individual's trauma (Watkins et al., 2018).

CBT involves the individual talking about issues while discussing emotions they may be experiencing. EMDR does not focus on verbalizing feelings (Cuijpers et al., 2020; DiBenedetti et al., 2020). Challenging these thought processes allows the client to acknowledge the reality of their past trauma. CBT helps by increasing the client's emotional insight by exploring responses to reminders of the trauma (Cuijpers et al., 2020). By increasing the connection between the client's responses and emotions, CBT

can help reduce the adverse effects of a panic response while reducing the severity of such responses and helping reduce avoidance behaviors (Cuijpers et al., 2020; Watkins et al., 2018).

Exposure Therapy and Prolonged Exposure Therapy

Clinicians often use CBT methods to treat PTSD, including exposure therapy (ET) and prolonged exposure therapy (PET). ET is a psychological treatment designed to assist individuals in facing their fears. When individuals fear something, they avoid the objects, activities, or situations. Therefore, a clinician recommending a program of ET to help break the pattern of avoidance and fear will consider this therapy appropriate for helping PTSD patients (Koebach et al., 2021). In this form of therapy, clinicians create a safe environment to expose patients to their fear and avoid traumatic experiences. Exposure to frightening experiences, activities, or situations in a secure environment helps reduce fear and decrease avoidance (Koebach et al., 2021).

PET is like ET for treating PTSD patients. This psychotherapy method uses repeated exposure to trauma-related feelings and thoughts to help reduce the power they have in causing distress (Wells et al., 2020). The clinician uses imagery that prompts a patient to recount the traumatic memory and revisit the experience. The clinician uses visual exposures prolonged over longer therapy sessions, where the patient repeatedly confronts trauma-related stimuli previously avoided (Booysen & Kagee, 2020). The basic premise of PET is to learn how to approach trauma-related memories, feelings, and situations gradually that an individual has avoided since their trauma (Koebach et al., 2021).

Although both ET and PET have shown positive outcomes for PTSD patients, empirical studies showed many contraindications for both ET and PET (Resick et al., 2021; Siehl et al., 2021). Simulated conditions do not always reflect reality, and ET conditions may not reflect reality. An individual with PTSD may learn to manage the simulated conditions in a therapist's office but may not be able to cope with the situation if it presents itself (Hundt et al., 2020; Resick et al., 2021). Additionally, using PET or ET for treating PTSD patients was unsuccessful in patients with comorbid problems. Because PTSD has high rates of comorbidity, it is important to consider whether PE is contraindicated for patients with various comorbid problems. Such problems co-occurring with PTSD patients include dissociation, borderline personality disorder, psychosis, suicidal behavior, non-suicidal self-injury, substance use disorders, and major depression. When PET or ET therapy is used to treat patients with one or more of these comorbidities, findings show symptoms returning (Hundt et al., 2020; Resick et al., 2021).

Eye Movement Desensitization and Reprocessing Therapy

There are several types of EMDR treatment methods, and such methods are based on the condition being treated. However, a common denominator in all these treatment methods is the necessity for EMDR therapy training (Laliotis et al., 2021).

Eye movement desensitization and reprocessing therapy is a complex treatment method for such mental health conditions as PTSD, psychosis, anxiety, depression, and bipolar disorder. Therefore, training protocols were developed over the years to establish how EMDR components must be recognized and taught to practitioners who wish to use EMDR in therapy for their patients (De Jongh et al., 2019). However, reliance on a single

set of protocols provided inaccurate treatment, so specialized and specific protocols were developed based on the different needs of clients with various disorders and conditions (Hase, 2021).

Guiding EMDR therapy's case conceptualization and processes is the adaptive information process (AIP) model. The AIP model focuses on the resources an individual client possesses individual client's resources, assuming that stressful information can be processed into a complete integration (Dansiger et al., 2020). Shapiro and Lailotis (2010) explained that through EMDR, the AIP model provides an integrative method for treatment that enhances positive responses. It further creates self-characterizations inclusive of being unworthy or inept yet is not the cause of the clinical issues but rather symptomatic of specific unprocessed experiences from earlier in an individual's life (Shapiro & Lailotis, 2010).

There are eight phases of EMDR therapy, and clinicians who practice EMDR therapy must be highly educated and knowledgeable regarding the application of this treatment method. Therefore, practitioners and clinicians undergo immensely rigorous training and learn the meaning and application of the eight phases. The eight phases are as follows: (a) history taking and treatment planning, (b) preparation (for reprocessing), (c) assessment (setting up target), (d) desensitization (reprocessing memory), (e) installation (strengthening positive cognition), (f) body scan, (g) closure, and (h) reevaluation and reconsolidation (Laliotis et al., 2021).

The first phase involves the clinician taking the patient's history through assessment and evaluation. Through this evaluation, the clinician becomes familiar with the patient's condition and what historical issues may have caused the condition (Laliotis

et al., 2020). The clinician will identify the presenting problem(s), collect patient information, formulate a deeper understanding of the client's problem(s), and develop a collaborative and sustained treatment plan (Laliotis et al., 2020). Additionally, in this first phase, a treatment plan is established and discussed with the patient based on the condition and the patient's resources (EMDRIA, 2021).

The second phase of EMDR is called the preparation phase. During the preparation phase, the clinician offers the client an education on EMDR therapy and mechanics of their treatment modality (EMDRIA, 2021). During this stage, the EMDR process is explained to the patient. The clinician should, at this stage, provide an understanding of the treatment and offer transparency with the entirety of this treatment plan to the patient. During these first two phases, trust must be established between the clinician and patient. Therefore, the preparation phase may take several meetings as comfort and trust are established (EMDRIA, 2021). Additionally, in phase two, the clinician will assess readiness for processing, provide stabilization strategies, and gather the client's informed consent (Laliotis et al., 2020).

Phase 3, the assessment phase, begins the reprocessing steps. These steps aim to learn the critical aspects of the patient's mental health condition and incorporate initial baseline measures using tools such as the subjective units of disturbance (SUD) scale and the validity of cognition (VOC) scale. These two scales measure and identify the target memory which triggered the patient's emotional distress (Rowe, 2019). These measurements assist the clinician in determining the sequence for treatment. The clinician uses the EMDR standard three-prong protocol to outline the past experiences processed initially and drive the patient's current condition symptoms. Specifically, in this phase,

the clinician establishes a baseline measurement for how the target memory is experienced by the patient (EMDRIA, 2020). As the patient's mental distress may come from more than one memory, the clinician should examine each separately and provide the patient with positive affirmation to further establish safety and trust with the patient.

Phase four begins the reprocessing phases founded on the protocol using dual attention bilateral stimulation (BLS). This protocol initiates the patient's information processing system but anchors it in the present moment (EMDRIA, 2021). Desensitization also begins in phase four. The clinician focuses on lowering the patient's SUD score by using side-to-side eye movements and having the patient concentrate on the trauma that created the condition. In this way, the client's disturbance can be reduced, while avenues for new learning can start taking shape (Laliotis et al., 2020).

Phase five is known as installation. Installation is established through client association of a positive belief within the targeted traumatic event (Laliotis et al., 2020). In addition, phase five uses BLS to link the newly processed memory to the client's belief about themselves, strengthening connections and promoting new learning (Laliotis et al., 2020). Phase five continues until the patient believes the newly processed memory is true.

Phase six incorporates the body scan in which the patient concentrates on the target event and the positive belief (EMDRIA, 2021). The clinician walks the patient through scanning their body from head to toe in a relaxation mode which the body is reprocessed from the disturbing picture of the traumatic event (EMDRIA, 2021). Additionally, sets of BLS are used to ensure that somatic congruence occurs concerning the novel processing effects (Laliotis et al., 2020).

Phases seven and eight ensure patient safety when a session ends. In phase seven, the clinician easily moves the patient from reprocessing to a state of calm in the present (EMDRIA, 2021). This state consists of the patient having neutral feelings regarding the event and continuing their positive belief. At the end of phase 7, the patient's body should be completely free of disturbance (EMDRIA, 2021). Additionally, phase 7 includes the clinician and client shifting attention from memory work and, instead, focusing on the present day and the possibility of future reprocessing efforts if needed (Laliotis et al., 2020).

The last phase is phase eight, which is considered the reevaluation stage, whereby each new session beginning after reprocessing is used to discuss the processed memories (EMDRIA, 2020). The clinician ensures the patient has low distress with a strong positive cognition. Additionally, the clinician and patient discuss the possibility of future treatment at the end of phase eight.

Mental healthcare providers, such as social work clinicians, have found EMDR therapy to provide favorable treatment for several mental health disorders, including suicidality, anxiety, and PTSD (Every-Palmer et al., 2020; Waterman & Cooper, 2020). In addition, clinicians and social work clinicians reported that primary outcomes suggested that most participant-rated symptoms of mental health conditions lessened when EMDR therapy was the selected treatment modality (Every-Palmer et al., 2020; Scelles & Bulnes, 2021; Waegemakers Schiff & Lane, 2019). Although most literature shows positive outcomes using EMDR therapy treatments for mental health disorders, some current research shows mixed results in EMDR therapy for patients with PTSD (Every-Palmer et al., 2020; Waterman & Cooper, 2020).

Use of Eye Movement Desensitization and Reprocessing Telehealth Therapy for Patients Diagnosed with Post-Traumatic Stress Disorder

The COVID-19 pandemic created issues for social work clinicians, clinicians, and other professionals, as social distancing requirements created barriers to treatment delivery. While telehealth was predominant for certain clients (e.g., those living in rural areas with limited access to mental health services), there was a barrier to promoting this type of therapeutic service more widely (Cristofalo, 2021; Zhai, 2020). In 2020, there was a lack of literature supporting social work clinicians and other professionals using EMDR telehealth therapy for clients with PTSD (Cristofalo, 2021; Knight, 2015).

Cristofalo (2021) described practices using telehealth as the standard medium of intervention during the pandemic. In addition, the author outlined the threats posed by clients being quarantined and the struggle social workers, clinicians, and other mental health professionals found in providing mental health services to their clients. Thus, EMDR telehealth therapy became a more recognized modality for servicing clients but facilitated security, privacy, legislative requirements, and restrictive practices (Cristofalo, 2021; Zhou et al., 2020).

Telehealth services involve a wider range of third-party participation than traditional therapy encounters. Notably, telehealth service providers and possibly their business affiliates are involved in threatening patient privacy. Some encounters are protected under privacy laws and regulations, but others may not be protected and carry additional risks. This concern is legitimate; thus, most clinicians favor using privacy and security methods to protect their patient's information furnished by the Department of Health and Human Services (Jalali et al., 2021).

Post-Traumatic Stress Disorder and Telehealth

As stated previously, the COVID-19 pandemic created challenges for patients to safely seek physical and mental health services for fear of being exposed to a highly contagious illness (Zhai, 2020). Telehealth program staff demonstrated positive implications for increasing healthcare accessibility (Bongaerts et al., 2021; Kuhn & Owen, 2020; Turgoose et al., 2018). During the pandemic, most of society adhered to a stay-at-home mandate, which caused therapy sessions for PTSD patients not to attend their regular sessions (Gerber et al., 2020). This issue caused increased concern for clinicians treating these patients, and the resulting solution was to implement telehealth services for therapy (Sampaio et al., 2021).

Several researchers have confirmed the feasibility of using telehealth to provide EMDR therapy treatment to patients (Bongaerts et al., 2021; Paulik et al., 2021; Sunjaya et al., 2020). For example, Bongaerts et al. (2021) conducted a study to assess the effectiveness of telehealth treatments on patients with severe or complex PTSD. The participants received four consecutive days of EMDR telehealth therapy and other virtual treatments while sheltering in place during the COVID-19 pandemic. The other popular virtual treatment for treating PTSD is virtual reality exposure therapy (VRET). VRET encompasses an individual immersed in a computer-generated virtual environment, either through a head-mounted display device or entry into a computer-automated room, where images are present in the virtual environment (Botella et al., 2015). This environment can be programmed to help the person confront feared situations or locations that may not be safe to encounter in real life (Kothgassner et al., 2019). Although researchers have

considered VRET successful as a treatment modality for PTSD, it is expensive psychotherapy due to equipment costs (Botella et al., 2015).

Using VRET and telehealth to treat PTSD showed favorable results. Findings showed that most patients lost their PTSD statuses because of significant decreases in PTSD indicators (Bongaerts et al., 2021). The researchers concluded that EMDR telehealth therapy telehealth treatments were feasible (Bongaerts et al., 2021). Sunjaya et al. (2020) and Paulik et al. (2021) conducted literature reviews on similar studies to assess the feasibility of telehealth in delivering EMDR treatments, coming to the same conclusion as Bongaerts et al. (2021). Additionally, quantitative researchers demonstrate that EMDR treatment may effectively deliver to patients over a virtual health platform (Morland et al., 2020; Sunjaya et al., 2020).

Feasibility of Telehealth Environment

Scholars evaluated telehealth usage versus traditional face-to-face therapy to provide EMDR telehealth treatment (Morland et al., 2020; Paulik et al., 2021; Sunjaya et al., 2020). Morland et al. (2020) evaluated telehealth usage to provide EMDR telehealth treatments and claimed a primary consideration was whether staff could feasibly perform treatments virtually. Studies showed that mental health counselors using telehealth EMDR services provided feasible and successful treatments over a virtual platform (Bongaerts et al., 2021; Morland et al., 2020; Sunjaya et al., 2020). Clinicians who opposed telehealth claimed that this therapy method did not provide the in-person interaction necessary for mental health therapy. However, other experts claimed EMDR telehealth therapy was successful as a therapy method, showing that many PTSD patients learn to live with PTSD without regressing past symptoms (Goga et al., 2022; Proudlock

& Peris, 2020). Its premise was based on memory recollections, and telecommunication software easily guided eye movements (Cuijpers et al., 2020). Researchers concluded that EMDR telehealth therapy for clients with PTSD was effective, and patients reported improved mental functioning after treatment (Goga et al., 2022; McGowan et al., 2021; Proudlock & Peris, 2020; Tarquinio et al., 2020).

Effectiveness of Eye Movement Desensitization and Reprocessing for Post-Traumatic Stress Disorder in the Telehealth Environment

Social worke clinicians and other mental health professionals who effectively treated PTSD using a telehealth platform found the outcomes compared to traditional or in-person EMDR treatments (Bongaerts et al., 2021; Paulik et al., 2021). Studies conducted to observe EMDR telehealth therapy treatments through telehealth showed improvements in clients' PTSD statuses during the COVID-19 pandemic. Most patients saw significant improvement in mental functioning, while few experienced worsened symptoms. Bongaerts et al. (2021) and Paulik et al. (2021) reviewed the expert use of EMDR telehealth therapy to treat PTSD clients using telehealth treatments and found such therapy sessions to be no less effective than traditional therapy services.

Tarquinio et al. (2020) also examined the effectiveness of a telehealth platform for treating mental health clients through EMDR telehealth therapy, particularly those who had PTSD based on recently experienced trauma. Tarquinio et al. evaluated the effectiveness of such treatments with a sample of frontline healthcare workers during the COVID-19 pandemic. As COVID-19 has limited in-person services and led to the disability and deaths of many, mental healthcare needs were exceptionally high in this population. The sample included 17 nurses remotely provided EMDR telehealth

treatments to assess PTSD and depressive symptoms. After treatment, these patients, who were nurses, reported improved cognitive functioning, which lasted for at least 1 week (Tarquinio et al., 2020).

Accessibility of Eye Movement Desensitization and Reprocessing in the Telehealth Environment

Studies have shown that offering telehealth as a mental health care modality can help improve the accessibility of EMDR telehealth therapy for local clients quarantined during the pandemic (Mavranezouli et al., 2020; Sunjaya et al., 2020). Sunjaya et al. (2020) suggested that EMDR telehealth therapy via telehealth treatments was cost-effective, convenient, and easily usable for treating PTSD. Cost savings associated with telehealth EMDR telehealth therapy to remotely treat patients reduce the need for physical office locations and staff to run the physical offices (Bestsennyy et al., 2021; Phillips & Williams, 2022). However, Farrell et al. (2021) further showed that most mental healthcare providers were unclear about EMDR telehealth therapy implementation. In addition, social work clinicians were found to have a significant gap in training and experience, resulting in fewer opportunities for clients to benefit from EMDR telehealth therapy via telehealth.

During the pandemic, social work clinicians faced challenges implementing EMDR therapy via telehealth as they were tasked with learning a new platform for providing therapy to their patients (Erreger, 2021). The need to pivot to technology was complex but understanding the frameworks of digital transformation assisted with the transition. Many organizations provide their social work clinicians with training (Fipps et al., 2022). Training sessions may have included implementing the substitution

augmentation modification redefinition (SAMR) model for technology integration. The model teaches social work clinicians how to use telehealth as a direct tool substitution with no functional change in the learning activity. An example is a social work setting recording a role play rather than performing in person (Erreger, 2021). Social work clinicians learning to use the technology for telehealth services recognized their clients required this new therapy method (Erreger, 2021).

Researchers claimed that clients needing therapy were less constrained by geographic locations, transportation, or time when attending telehealth treatments (Sunjaya et al., 2020). Most profoundly, clients with mental health issues such as PTSD who lived in low-income rural areas were more likely to participate in virtual treatment sessions than commuting far distances to see providers. As a result, such clients were likelier to be consistent in their participation while saving time and money as they connected with providers across wide geographic ranges (Bryant, 2019; Sunjaya et al., 2020).

Mavranezouli et al. (2020) claimed telehealth treatments saved clients' and their mental health providers' money. Treating clients eliminated the need for physical office locations and staff remotely. Also noted was that this situation allowed many social work clinicians, psychologists, and other mental healthcare providers to work from home during the pandemic. Healthcare organization leaders can theoretically hire providers to work remotely, expand the pool of candidates, and avoid high costs of living areas (Harned & Schmidt, 2019). This action saves the clients' financial savings and reduces the economic burdens noted with EMDR telehealth therapy (Mavranezouli et al., 2020).

Safety of Eye Movement Desensitization and Reprocessing Telehealth Therapy

Researchers have examined EMDR for safety and regulations, showing that EMDR telehealth therapy poses minor risks to clients (Bongaerts et al., 2021; Mavranezouli et al., 2020; Sunjaya et al., 2020). As EMDR telehealth therapy is a new nontraditional therapy modality, some clinicians question the side effects. Kaptan et al. (2021) noted the most prevalent risk as triggering vivid dreams or memories that could create emotional stress. However, an expert association, the EMDRIA (2022), vetted EMDR telehealth therapy, with mental health professionals receiving training, approval, and high standards for the clinical use of EMDR. This association aims to advance learning and promote safe practices of EMDR telehealth therapy.

Marotta-Walters et al. (2018) and Turgoose et al. (2018) claimed that EMDR treatments were less regulated than other mental health modalities. These experts suggested that because the full effects of EMDR telehealth therapy were not yet known, the propensity for disaster and side effects was higher than in using other therapeutic methods (Marotta-Walters et al., 2018). Marotta-Walters et al. (2018) considered telehealth and mobile applications for EMDR delivery. The authors focused on determining if mobile applications could deliver EMDR treatments and found that applications self-administered by patients were not recommended. However, Marotta-Walters et al. noted that some applications might have been safe and effective if delivered to clients through a licensed and EMDR telehealth therapy trained clinician. Further, these researchers claimed that clients with comorbidities like PTSD should not engage in self-practice therapy without supervised treatment.

Challenges Using Eye Movement Desensitization and Reprocessing Telehealth Therapy for Post-Traumatic Stress Disorder Treatment

Morland et al. (2020) and Tarquinio et al. (2020) discussed telehealth's positive and negative considerations for mental health treatments. This delivery method for EMDR telehealth therapy provides a means for many clients with mental illnesses to access a vital therapy option. However, the delivery of EMDR telehealth therapy over a virtual platform, such as a telehealth system, comes with unique challenges (Parisi, 2020; Paulik et al., 2021; Rosen et al., 2020; Rutledge et al., 2017). Mental health providers, such as social work clinicians offering preventative services, recommend telehealth to accommodate patients unable to travel to their therapy appointments. Social work experts emphasize the need for accessibility in treatment plans. Clients with disorders such as PTSD and who live in rural communities with no means for travel would be less likely to ignore the option of therapeutic sessions if they had telehealth services available (Spinney, 2019; Uehara et al., 2014).

Telehealth has been ever-increasing, particularly with providers who work with clients needing mental health care but have no means of receiving it (Frakt, 2019; Freske & Malczyk, 2021). Although telehealth has become an extremely popular and positive service for many mental health patients suffering from depression, anxiety, and PTSD, social work clinicians and other mental health care professionals believe in necessary changes to promote and continue using telehealth (Adams et al., 2021; Cristofalo, 2021). Such claims include changes in the current legislation and policies associated with telehealth services. Unfortunately, individuals in government positions who create legislative mandates for health care services continue to negate its use because of the

drastic changes necessary for security and safety measures and such challenges with Medicare and Medicaid payments (Gajarawala & Pelkowski, 2021; Kichloo et al., 2020). This research aimed to offer a well-developed argument for the vast changes needed at the governmental level.

Kichloo et al. (2020) also suggested that those involved in the information and communication technologies (ICTs) promoting electronic communicative methods were not as supportive of such services. Opponents of mental health teletherapy services consider the inception of such services to need full disclosure for internet security (Kichloo et al., 2020). Providing full disclosure over public accessed internet services was deemed problematic to those who disagreed with telehealth's feasibility and potential for success because of breaches in privacy and security (Gajarawala & Pelkowski, 2021). For example, telehealth use could cause policies, such as the Health Information Privacy and Protection Act (2013), to be violated by allowing open public access to private health records and recorded therapy sessions.

Shachar et al. (2020) and Waterman and Cooper (2020) expressed their displeasure with a lack of official public support and current telehealth policies that included location and geographic site restrictions and the type of provider allowed for telehealth usage financial reimbursement for the clinicians. Experts and leaders in mental healthcare services agreed that the Health Reform Act on Health Information Technology (U.S. Department of Health & Human Services, 2009) improved the safety, quality, efficiency, and reduction of health disparities. However, the economic growth of this method of treatment has met problematic issues based on funding and expansion of specific broadband infrastructures at mental healthcare provider's facilities (Kichloo et

al., 2020; Shachar et al., 2020). Therefore, regulatory and policy changes are necessary to adopt telehealth services by mental healthcare providers successfully (Harned & Schmidt, 2019; Kichloo et al., 2020).

Hyder and Razzak (2020) discussed the potential need for regulations as several gaps cannot ensure access to telehealth services for mental health needs. The Kaiser Family Foundation (2022) claimed, "[S]ervice parity and payment parity for telehealth across all insurers would help increase access for patients and incentivize providers to offer these services, though it would also increase spending" (para. 6). Further concerns include gaps in technology and the cost for certain clients, as the financial burden of having the necessary technology may prove costly (Shachar et al., 2020). Hyder and Razzak (2020) asserted it led to the question of to what extent low-income clients or those with limited experience with or access to technology could access telehealth services.

Another significant barrier observed by mental healthcare providers was that many mental healthcare providers were not entirely enthusiastic when forced into using telehealth or other virtual reality methods for therapy. Researchers found that most leaders in mental healthcare had issues with telehealth services because they were unclear about how the technology worked. These clinicians also believed that the equipment was too expensive, posing a decrease in the profit base (Hyder & Razzak, 2020; Shachar et al., 2020).

State legislation has focused on expanding telehealth reimbursements through their Medicaid programs, allowing, for example, online prescribing and online written consent. However, these changes and expansions were for physical health-related

services and left mental health services out (Hyder & Razzak, 2020; Waterman & Cooper, 2020). Implementing telehealth required the interest of politicians to assist in new regulatory mandates, policies, and laws.

Many leaders in the healthcare industry worked with other professionals to incorporate the business of healthcare services. However, they were found unsupportive of utilizing a system that would take monies out of their pockets (Hyder & Razzak, 2020). Researchers claimed that an opportunity for telehealth use had not been met with encouragement from such health care providers. Moreover, many such legislators were not prone to push for new federal government policies and mandates to support telehealth services. With governing entities reluctant to give up regulatory authority, federal government interventions are necessary even when their regulations favor producers over consumers and limit nationwide innovation. However, the enormous opportunity of telehealth meant that, although challenging, the suitable policy changes were worthwhile, especially for mental health clients needing treatment for such disorders as PTSD (Hyder & Razzak, 2020). Therefore, the push must be within the legislative and the respective federal government forums to bring those changes necessary to implement telehealth and to remove any barriers that legal regulations have imposed on this positive method of patient care (Shachar et al., 2020).

Those governing mental healthcare services also recognize the loss of profits because telehealth services will negate continued charges for in-house therapy visits (Ashwood et al., 2017; Bestsennyy et al., 2021). Finally, experts noted that studies on telehealth did not assess the impact telehealth has on a client's care and mental health (Adams et al., 2021; Khullar et al., 2020). These challenges justify an increased need to

provide awareness, education, and promotive conceptualization for those who benefit from telehealth services and demand the necessary changes in health policy and legislation.

Overall, challenges within government regulations have many mental health providers facing barriers the U.S. legislation has imposed. The widespread adoption of telehealth has created a need for current policies and regulations that will adapt to using this convenient means for therapy. Scholars claimed that the positive aspects of telehealth should cause government entities to reconsider the legislation surrounding telehealth implementation and optimally recognize the justified use of teletherapy beyond the COVID-19 pandemic (Paulik et al., 2021; Rutledge et al., 2017).

Mouratidis and Papagiannakis (2021) and Paulik et al. (2021) recognized the usefulness of developing connectivity in telehealth systematic. The researchers gathered input from mental health providers who understood the broad reach of one-on-one online therapy and how to communicate with out-of-reach clients. However, researchers noted barriers to the ability of many rural clients who (a) had limited availability for internet connection and (b) could not afford upfront costs to purchase a computer system and have Internet services connected in their homes (Bongaerts et al., 2021; Mouratidis & Papagiannakis, 2021).

Clients also experienced challenges beyond financial issues when working with telehealth systems and EMDR telehealth therapy (Paulik et al., 2021). Although many clients defined virtual delivery as more convenient than standard delivery, especially for rural areas, there were times when being in a home environment was challenging and distracting (Paulik et al., 2021). Paulik et al. (2021) found that EMDR telehealth therapy

participants experienced challenges related to family distractions, insufficient internet connections, and a lack of privacy, potentially adding more stress and anxiety.

Another challenge was discerned when researchers found a shortage of providers trained to provide EMDR telehealth therapy services to patients (Sunjaya et al., 2020). However, Rutledge et al. (2017) found that clinicians need training in the virtual delivery of EMDR telehealth therapy services in logistics of delivery and effective communication. Rutledge et al. also stated that some providers found it challenging to deliver EMDR telehealth therapy services over a virtual platform, even if they competently delivered EMDR telehealth therapy services to patients.

Research Gap

The research gap of the present study is characterized in two ways. First, such research has tended to take similar forms. For example, Bongaerts et al. (2021) conducted a quantitative study of the safety and effectiveness of telehealth EMDR therapy. Their study was important for validating the therapy, given that its results affirmed that telehealth EMDR therapy was safe and effective. However, their research did little to characterize how such safety and efficacy could be achieved.

Similarly, Whealin et al. (2017) studied veterans' pre- and post-intervention perceptions of home telehealth for mental health issues using a diverse group of veterans. Again, their results were valuable in establishing that telehealth EMDR therapy was perceived as effective by veterans and veterans from diverse backgrounds. Again, however, Whealin et al. did not examine which factors made EMDR telehealth effective.

As Paulik et al. (2021) noted, the existing research on telehealth EMDR therapy focused on the patient perspective. Understanding patient perspectives is key to knowing

the therapy works for a mental health issue like PTSD. However, now that the efficacy of the therapy has been shown, this primary focus leaves an important research gap concerning how providers perceive the therapy. If patients' perspectives offer the key to understanding if the therapy works, providers' perspectives are essential in determining how the therapy can be effectively and realistically offered. The present study's main contribution to the literature addressed this gap, creating a better understanding of how providers could feasibly and effectively offer telehealth EMDR therapy to patients with PTSD.

Theory

In addition to its overall benefits concerning the research gap, the present study expanded the TOE technology adoption theory. The TOE theory suggests that technology adoption and usage derive from the interaction of the three titular factors (Tornatzky & Fleischer, 1990). The present study tested and further developed the theory by examining the environmental and organizational factors surrounding the effective implementation of telehealth technology for EMDR therapy.

If the TOE theory is accurate, these factors are the keys to the wider adoption of telehealth EMDR therapy. The present study tested the theory by determining if such keys could be found. At the same time, the study extended the TOE theory by applying it to a novel yet-to-be-studied problem in social work. Suppose the results of this study support the TOE theory as expected. In that case, the theory can be more strongly recommended to future researchers addressing telehealth technology adoption problems or problems regarding the adoption of technology in social work. If not, the results may warn future researchers that some other theory of technological adoption may be more

valuable when studying these two specific problem spaces and, more specifically, the problem of how to promote wider usage of telehealth EMDR therapy. Summary

In summation, the identified problem was related to the lack of research on how clinicians perceived the efficacy of EMDR therapy when delivered to patients using telehealth. Many studies were related to applying EMDR therapy efficacy, treating PTSD clients, and even using telehealth as a tool for therapy (Castelnuovo et al., 2019; Haour et al., 2019). In addition, other research was associated with telehealth and its effectiveness in treating PTSD (Mavranezouli et al., 2020; Sunjaya et al., 2020). However, there was no research on the three topics combined.

The purpose of the present qualitative descriptive study was to explore how clinicians perceived virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States. The study has important implications for social workers across the micro, mezzo-, and macro-levels. Overall, these implications concern the ability to improve access to telehealth EMDR therapy to improve the treatment of PTSD, especially in rural areas. These areas suffer from overburdened healthcare systems and a lack of healthcare. In addressing this practical problem, the study also addresses an important research gap regarding physicians' perspectives on virtual EMDR therapy delivered via telehealth. Finally, the study also expands and tests the TOE technology adoption theory in the social work telehealth context.

Chapter 3: Methodology and Research Approach

Introduction

The identified problem was related to the lack of research on how social work clinicians perceived the efficacy of virtual EMDR therapy when delivered to patients using telehealth. Many studies were related to applying EMDR therapy efficacy, treating PTSD clients, and even using telehealth as a tool for therapy (Castelnuovo et al., 2019; Haour et al., 2019). Other research was associated with telehealth and its effectiveness in treating PTSD (Mavranezouli et al., 2020; Sunjaya et al., 2020); however, no combined research on the three topics focused on social work clinicians. The purpose of the present qualitative descriptive study was to explore how clinicians perceived virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States. This chapter discusses the research methods used for data collection and analysis.

Rationale for Research Design

As this study was focused on better understanding social work clinicians' perceptions of the delivery of virtual EMDR therapy, a qualitative methodology was most appropriate. Qualitative research is descriptive (Padgett, 2017). A qualitative researcher addresses a central phenomenon, not specific variables (Hammarberg et al., 2016; Padgett, 2017). Within this study, the researcher was interested in exploring the perceptions of EMDR-certified clinicians who delivered virtual EMDR therapy. Therefore, the use of the qualitative approach was ideal.

A qualitative study was appropriate for addressing the research questions associated with this research because the key research questions were all open-ended,

allowing EMDR therapy clinicians to describe their experiences and perceptions regarding virtual therapy delivery fully. Within this current study, all research questions addressed qualitative issues of what or how. Additionally, the study aligned with a qualitative methodology. The study was intended to explore how social work clinicians had succeeded in implementing virtual EMDR therapy or why they had been unsuccessful. An open-ended inquiry effectively identified the reasons for both and offered a full spectrum of potential outcomes rather than being limited to a predefined set. As such, social workers acting as EMDR clinicians fully conveyed information regarding their perceptions, creating novel data. Given the lack of prior research, using a quantitative approach would have missed important factors.

Within the qualitative method, the specific research design was descriptive. A qualitative descriptive study is a generic qualitative study focusing on describing the central phenomenon (Doyle et al., 2020). A descriptive approach was ideal when the study was concerned with fully describing the phenomenon of interest in-depth (Doyle et al., 2020). Descriptive design can draw aspects from other qualitative designs, such as multiple data sources (Doyle et al., 2020). Descriptive design was appropriate for this study because the researcher was concerned with understanding the central phenomenon descriptively. The researcher was not especially focused on any one context but intended to capture and describe the general situation experienced by the study population. In addition, the researcher was focused on describing what the phenomenon comprises and how the phenomenon was experienced rather than a more in-depth exploration of why these strategies or barriers were present. Though the study results slightly touched upon why it was not the central focus of the research.

Research Setting and Context

Despite the benefits, the widespread use of EMDR therapy is currently lacking. There are several reasons, with one of the most substantial being the lack of trained EMDR therapy practitioners able to provide remote EMDR therapy, such as social work clinicians (Sunjaya et al., 2020), the lack of technological competencies for providers, and distractions in a home environment (Parisi, 2020; Paulik et al., 2021; Rosen et al., 2020; Rutledge et al., 2017). Understanding social work clinicians' perspectives on virtual EMDR therapy may be an important way of helping move past these challenges while facilitating the wider use of EMDR therapy via telehealth.

Research Population, Sample, and Data Sources

The population under study was all social work clinicians trained in EMDR therapy. Within this population, the target population was social work clinicians with a social work license (LCSW, LCSW-C, LCSW-S, LCSW -R, LICSW) who provided EMDR services using telehealth to a patient within two years. According to Padgett (2017), researchers should remain diligent in selecting participants with the proper knowledge and skill to answer interview questions. Therefore, the focus on experienced social work clinicians ensured that the resulting qualitative description was based on the perceptions of those who had relevant experience delivering virtual EMDR therapy.

The identified target population ensured that the study could realistically describe successful virtual EMDR therapy carried out by social work clinicians, not merely the speculation of those aware of it. Therefore, the researcher developed a set of inclusion and exclusion criteria to ascertain which individuals would make appropriate participants (Yin, 2014). The inclusion criteria for the study included that the prospective participants

(a) be licensed social work clinicians, (b) have formal training in EMDR therapy, (c) use telehealth as either a primary or secondary but common delivery modality for EMDR therapy, and (d) have provided virtual EMDR therapy services for at least 2 years. In addition, the goal was to ensure they had the experience and knowledge necessary to answer questions appropriately, per the suggestion of Padgett (2017).

Within this target population, convenience sampling was used to recruit participants among social work clinicians providing virtual EMDR therapy. However, if convenience sampling did not yield enough participants, snowball sampling could have been used. Snowball sampling entails gathering qualified participants to aid in recruiting additional persons who fit the inclusion and exclusion criteria (Padgett, 2017).

The preliminary sample size was 10 to 12 participants, as suggested by Yin (2014), to ensure that the study was in-depth and captured the full phenomenon and its context. However, as the target population was rather small, if 10 to 12 participants were not located, the researcher deferred sampling size recommendations from Padgett (2017), who suggested that six to 10 persons were adequate for a qualitative sample. According to Yin (2014), 10 to 12 participants are typically adequate to reach data saturation within qualitative studies. Data saturation was the point when novel data yielded no new findings. Therefore, by reaching data saturation, it was likely to provide an especially in-depth account of using virtual EMDR therapy (Yin, 2014).

Recruitment occurred 2 weeks after approval from the institutional review board (IRB). Potential participants were identified through a combination of the researcher's professional networks and publicly available data posted on professional websites for social work clinicians who delivered EMDR therapy virtually. Formal recruitment

involved drafting a recruitment email describing the study and what participation would entail. This email was sent to the possible participants (Appendix C). Then, if a possible participant did not respond, a short follow-up email was sent 1 week later. Those interested replied to the email verifying that they met the study's inclusion criteria. Then, they were sent informed-consent documentation (Appendix D), which explained what participation would entail and how the participants would be protected. A signature and acceptance of the informed consent document were required to proceed to the interview.

The main data source for the study was qualitative, semi-structured interviews (Appendix B). According to Padgett (2017), there is a need for the study design to be selected carefully to reflect deliberate choices made by the researchers. The key strength of semi-structured interviews is that they offer structure and flexibility in the data collection, representing the standard technique for collecting qualitative data (Kallio et al., 2016). Furthermore, interviews were selected to collect data, allowing the interviewer to gain in-depth knowledge regarding participants' perceptions and lived experiences (Creswell & Poth, 2018). As this current study aimed to understand the experiences of social workers certified to deliver virtual EMDR therapy regarding their perceptions of virtual EMDR therapy, interviews were an ideal data source.

An interview guide (Appendix B) guided the interviews developed to address the research questions, as suggested by both Kallio et al. (2016) and Creswell and Poth (2018). In addition, the researcher ensured that all questions would elicit relevant responses from social workers certified to deliver virtual EMDR and other EMDR-certified social work clinicians by creating an interview protocol before the interviews.

The researcher followed the recommendations of Padgett (2017) to create an effective interview protocol.

Padgett (2017) and Kallio et al. (2016) recommended that researchers use a combination of preliminary and follow-up or prompting questions. Therefore, the researcher used both questions in the interviews with participants. All questions were open-ended, allowing the participants to share knowledge or information they deemed important to answering the question. The preliminary questions represented the structured aspect of the interviews, ensuring that the researcher had the resources to address the issues in the research questions (Creswell & Poth, 2018; Padgett, 2017). For example, the researcher was prepared to ask participants about their experiences with the efficacy of virtual EMDR therapy or its shortcomings. By contrast, prompting or follow-up questions increased flexibility and allowed the researcher to explore participants' perceptions (Kallio et al., 2016). Within the interview, the researcher asked an additional follow-up, clarifying, or probing questions to understand better the participants' perspectives and experiences (Kallio et al., 2016; Moustakas, 1994) while collecting deep and rich data regarding the efficacy of virtual EMDR therapy.

According to Padgett (2017), qualitative researchers aim to provide data that explore a phenomenon and provide as much generalizability as possible. As discussed previously, the interview guide contained a list of preliminary questions and key topics, such as the strengths, shortcomings, and practicality of virtual EMDR therapy. Interview questions were created by first exploring the literature for relevant content and gaps in the literature. Then, the researcher drafted possible research questions, ensuring that all questions aligned with the theoretical framework and existing literature. These questions

were also easily understood. Participants could have volunteered for additional relevant information, so long as that information fell within the key topics in the interview guide.

The interviews were conducted virtually using Zoom or a similar platform. Creswell and Poth (2018) recommended creating a comfortable situation for participants. By using the Zoom platform, participants completed their interviews within the comfort of their homes or offices and at a time of their choosing. Additionally, the Zoom platform was free and relatively user-friendly, creating satisfactory interview experiences for researchers and participants (Archibald et al., 2019).

Data Collection

Data collection for the study proceeds as follows. First, IRB approval to conduct the research was sought through the university. No changes to the study were made to secure IRB approval, and no data were collected before obtaining IRB approval. Because the researcher sampled social workers acting as certified virtual EMDR clinicians individually rather than through any central organization, no site authorization was necessary.

Formal recruitment involved drafting a recruitment email describing the study and what participation will entail, participants' rights, participants' inclusion and exclusion criteria, and the researcher's contact information (Appendix C). This email was sent to the participants. Those interested replied to the email, verifying that they met the study's inclusion criteria. Then, they were sent informed-consent documentation (Appendix D), which explained what participation would entail and how the participants would be protected. Finally, a signature and acceptance of the informed consent document were required to proceed to the interview.

Padgett (2017) recommended creating an identical set of circumstances for data collection to the best of the researcher's ability. Therefore, each interview lasted 60 to 90 minutes, depending on how the participants responded to the predetermined interview questions. Additionally, the researcher audio-recorded all interviews using the Zoom platform.

Once the interviews were complete, they were transcribed by the researcher in Microsoft Word. Then, transcribed interviews were sent to respective participants for member-checking, per the suggestion of Padgett (2017). During member-checking, participants were provided with a copy of their transcripts within 2 weeks and the opportunity to review and make any desired corrections or other alterations (Padgett, 2017). Then, participants were thanked again for their time.

Data Analysis Methods

As stated previously, all transcribed data will be reviewed by respective participants per the suggestions by Padgett (2017). Participants were emailed their individual transcribed data with a message to review their responses and add any notes should they feel an answer was incorrect. All participants had 10 business days to review their transcripts and email them back to the researcher. All participant notes were incorporated, and any transcripts that were not returned were considered accurate.

When the interviews and member-checking were completed, data analysis began. Data analysis included thematic analysis to ascertain emergent themes from participants' perceptions of delivering EMDR therapy over a virtual platform (Creswell & Poth, 2018). According to Creswell and Poth (2018), thematic analysis is ideal for uncovering meaning among various participants' interview responses. As the objective of this study

was to understand more about the clinicians' perspectives on virtual EMDR therapy, the thematic analysis allowed the researcher to understand emergent themes that spanned many clinicians' perspectives. As the researcher hoped to gain insight into emergent themes from interview data, the approach to thematic analysis was informed by Clarke et al.'s (2015) six-step approach. Data analysis was conducted using NVivo 12 qualitative data analysis software.

The data analysis was conducted using Clarke et al.'s (2015) qualitative thematic analysis. An inductive approach was selected as it allowed the researcher to let the data guide the creation of descriptive codes, which became emergent themes and reduced researcher bias (Padgett, 2017). Clarke et al.'s (2015) approach to thematic analysis is a six-step process that entails (a) developing familiarity with the data, (b) open coding, (c) developing initial themes, (d) validating themes against the data, (e) cross-validating themes against each other, and (f) compiling and reporting the ensuing set of final themes.

In the first step, the researcher carefully reviewed the transcripts from the data collection. This familiarization ensured that the remainder of the analysis was fully grounded in the original data (Clarke et al., 2015). The second step was to code the data. Coding was identifying key ideas in the data and marking them in each place they appeared (Clarke et al., 2015). An initial codebook of expected codes was developed based on the literature reviewed in Chapter 2. However, emergent codes that were unexpected and arose from the data were also included through inductive reasoning, per the suggestions of Padgett (2017). Then, in Step 3, the codes were used to create an initial

list of themes. The themes represented ideas found by considering the arrangement of the codes relative to one another within the data (Clarke et al., 2015).

Once initial themes were identified, the fourth step was to validate each theme. This process entailed carefully taking each theme and checking it against the original data to be sure that the theme was supported as something representing the ideas in the data (Clarke et al., 2015). In the fifth step, the themes were instead evaluated against each other. This process helped ensure that each theme was not only a complete idea but also represented an idea unique from those in all other themes (Clarke et al., 2015). The sixth and final step was to compile the themes and address them vis-à-vis the literature (Clarke et al., 2015). This step comprises Chapter 4 and Chapter 5 of the study, in which the results are presented and used to draw conclusions.

Issues of Trustworthiness

Trustworthiness is critical for qualitative research. Trustworthiness, within this context, is composed of four components: credibility, dependability, transferability, and confirmability (Morse, 2015). These four concepts are interrelated and can often overlap. As such, the components of trustworthiness can be bolstered by similar strategies, including member-checking, triangulation, and audit trails (Padgett, 2017). The following subsections describe these facets of trustworthiness and how Padgett's (2017) recommendations are utilized within this current research.

Credibility

The first component of trustworthiness is credibility. According to Morse (2015), credibility refers to the accuracy of the results elicited from participants' perceptions. Credibility can be reduced if the participants misunderstood the questions or if the

researcher interprets participants' perceptions incorrectly (Korstjens & Moser, 2018). The researcher participated in two activities to maintain credibility to ensure this issue did not happen. These activities included member-checking and keeping research notes as an audit trail (Merriam & Tisdell, 2015; Padgett, 2017).

Member-checking is a process in which participants review transcribed data before data analysis to ensure that their perceptions are portrayed accurately (Creswell & Poth, 2018; Padgett, 2017). To accomplish this goal, the researcher transcribed each interview after interview completion. Then, the researcher emailed respective transcripts to participants within two weeks and gave the ten business days to reply. The researcher obliged if the participant reported that a change was needed. If the participant did not respond, the researcher continued forward with the information in the transcript (Merriam & Tisdell, 2015).

The researcher also kept notes to audit the researcher's choices (Padgett, 2017). As suggested by Korstjens and Moser (2018), these notes encompassed any thoughts or perceptions the researcher had during the research process. Notes included thoughts or reflections on data collection, analysis, and transcription processes.

Dependability

Dependability is the second component of trustworthiness. According to Morse (2015), dependability refers to how easily the results of a study can be replicated within the same research focus. However, Merriam and Tisdell (2015) posited that dependability could be threatened if the study could not be replicated or the findings could not be reproduced under the same circumstances. As with credibility, addressing this threat involved the researcher's detailed account of the research process by keeping research

notes (Merriam & Tisdell, 2015). In addition, using the NVivo 12 software package created by QSR International (2018) allowed the researcher to organize and code data within the software, which might have reduced circumstances in which data could have been overlooked.

Transferability

The third aspect of trustworthiness is transferability, referring to how other researchers or readers can infer meaning from one researcher's results into another context (Korstjens & Moser, 2018). According to Morse (2015) and Korstjens and Moser (2018), transferability can be bolstered by detailed study methodology descriptions, including robust sampling, data collection, and data analysis. To increase transferability within this research, the researcher provided detailed descriptions of how participants selected, the interview format and data collection process, and the techniques used to ascertain emergent themes during data analysis as part of the audit trail (Padgett, 2017). Readers and future researchers can then make more informed decisions about when and how the current results are transferable to other research contexts.

Confirmability

The final facet of trustworthiness is confirmability. According to Yin (2014), confirmability refers to how well the researcher's thoughts are mitigated to allow participants' perceptions to be reported accurately. The most common threat to confirmability is bias. Within this context, bias can occur from the researcher or participants. To mitigate researcher bias, Merriam and Tisdell (2015) recommended that the researcher keep reflexive notes or a journal. As already discussed, the researcher kept

copious notes during all parts of the sampling, data collection, and analysis phases, per the recommendation of Padgett (2017).

Participant bias is also known as social desirability bias. Social desirability bias occurs when participants answer questions based on how they believe they should, regardless of what is accurate (Grimm, 2010). To mitigate social desirability bias, the researcher stressed the importance of truthful answers and reinforced the idea that they could cease participation or refuse to answer any question they were uncomfortable with at any time. Additionally, findings were reported in aggregate form, helping protect participants' identity and confidentiality while reducing bias in participants' responses (Grimm, 2010).

As stated previously, trustworthiness is critical for qualitative research. Therefore, the researcher bolstered the trustworthiness of this research by keeping copious notes and providing detailed and robust descriptions of sampling, data collection, and data analysis procedures. In addition, the researcher mitigated researcher and participant bias to the extent possible, specifically through member-checking (Padgett, 2017). In this way, future researchers can be assured of the accuracy and strength of the results of this research.

Summary

The identified problem was related to the lack of research on how social work clinicians perceived the efficacy of virtual EMDR therapy when delivered to patients. Many studies related to applying EMDR therapy efficacy, treating PTSD clients, and even using telehealth as a tool for therapy (Castelnuovo et al., 2019; Haour et al., 2019). Other research was associated with telehealth and its effectiveness in treating PTSD

(Mavranezouli et al., 2020; Sunjaya et al., 2020); however, no combined research on the three topics focused on social work clinicians exclusively. Therefore, the purpose of the present qualitative descriptive study was to explore how social work clinicians perceived virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States. The following chapters contain the results, followed by a discussion of those results and the implications.

Chapter 4: Findings

The purpose of this qualitative descriptive study was to explore how clinicians perceived virtual Eye Movement Desensitization and Reprocessing (EMDR) therapy when delivered to patients with post-traumatic stress disorder (PTSD) using telehealth in the specific context of the United States. In addition, this study was conducted to address the problem of the lack of research on how social work clinicians perceived the efficacy of virtual EMDR therapy when delivered to patients using telehealth.

Demographic Data

The participants of this study were 12 licensed social work clinicians providing virtual EMDR therapy across the U.S. All of the participants met the following inclusion criteria: (a) be licensed social work clinicians, (b) have formal training in EMDR therapy, (c) use telehealth as either a primary or secondary but common delivery modality for EMDR therapy and (d) have provided virtual EMDR therapy services for at least 2 years. One participant has two social worker licenses in different states. The participant is a licensed independent social worker (LISW) and licensed clinical social worker (LCSW). Nine participants are LCSW, one is a licensed medical social worker (LMSW), and one is an LISW. The participants' years of experience working as a licensed social worker ranged from 3 to 43. Eight participants were Caucasian, two were Asian, one was Hispanic, and one was Jewish.

All of the participants experienced using a virtual modality to deliver EMDR therapy. The participants' most recent virtual EMDR experience ranged from one day ago to a few weeks ago. The majority of the participants (n = 9) started using a virtual modality for EMDR therapy during the beginning of the COVID-19 pandemic in early

2020 which was about 2 to 2.5 years ago. Three participants used virtual EMDR therapy before the pandemic. The participants' demographic information is summarized in Table 2.

Table 2

Demographic Information

Participant	Age Range	Ethnicity	License	Years of Experience as a Licensed Social Worker	Years of Experience Using Virtual EMDR Therapy	Most Recent Use of Virtual EMDR Therapy	Region of EMDR Therapy Practice
1	55-59	Caucasian	LCSW	36	19	a day ago	Northeastern region
2	35-39	Hispanic	LCSW	5	2.5	a day ago	Mid-Atlantic region
3	35-39	Caucasian	LCSW	14	2.5	a few days ago	Northeastern region
4	45-49	Caucasian	LMSW	3	2.5	a few days ago	Western region
5	65-69	Caucasian	LCSW	41	2.5	a few days ago	Southern region
6	30-34	Asian	LCSW	10	2.5	a few days ago	Western region
7	60-64	Caucasian	LCSW	16	2.5	a day ago	Mid-Atlantic region
8	70-74	Caucasian	LISW	43	30	a few weeks ago	Northeastern region
9	35-39	Jewish	LCSW	3	2.5	a few weeks ago	Mid-Atlantic region
10	70-74	Caucasian	LCSW	43	2.5	a few days ago	Western region
11	35-39	Caucasian	LISW, LCSW	14	2	a day ago	Northeastern region, Southeastern region
12	40-44	Asian	LCSW	6	3	a day ago	Western region

Findings

The results of data analysis revealed two overarching themes. The overarching themes were the strengths of using virtual EMDR therapy and the challenges of using virtual EMDR therapy. Within these two broad themes, eight subthemes emerged. The sub-themes under the strengths of using virtual EMDR therapy were: (1) efficient and comfortable, (2) accepted, (3) same expectations and practices, (4) better quality of life and (5) wider reach. The first theme and associated subthemes are presented in Table 3.

Table 3.

Strengths of Using Virtual EMDR Therapy and Associated Subthemes

Theme1: Strengths of Virtual EMDR Therapy	Percentage of Participants' Responses
Subtheme 1: Efficient and comfortable.	91.67%
Subtheme 2: Accepted	100%
Subtheme 3: Same expectations and practices	83%
Subtheme 4: Better quality of life	91.67%
Subtheme 5: Wider reach	91.67%

The other broad theme was the challenges of using virtual EMDR therapy. The sub-themes under the challenges were: (1) family and home influences, (2) problems with using technology, and (3) policies and regulations. Table 4 below displays the subthemes associated with the challenges associated with using virtual EMDR therapy.

Table 4.

Challenges Using Virtual EMDR Therapy and Associated Subthemes

Theme 2: Challenges Using Virtual EMDR Therapy	Percentage of Participants' Responses
Subtheme 1: Family and home influences	100%
Subtheme 2: Problems with using technology	100%
Subtheme 3: Policies and regulations	75%

Theme 1: Strengths of Using Virtual EMDR Therapy

All of the participants perceived that using virtual EMDR therapy has strengths when delivered to patients with PTSD using telehealth. The strengths of virtual EMDR therapy include efficiency and comfort. Consequently, virtual EMDR therapy promotes quality of life and has a wider reach than in-person therapy. Virtual EMDR has also increased in acceptance and support within the healthcare setting in the United States. Furthermore, virtual EMDR was believed to be practiced and to have outcomes that were similar to the in-person modality. These strengths emerged as sub-themes and are described in the next sub-sections.

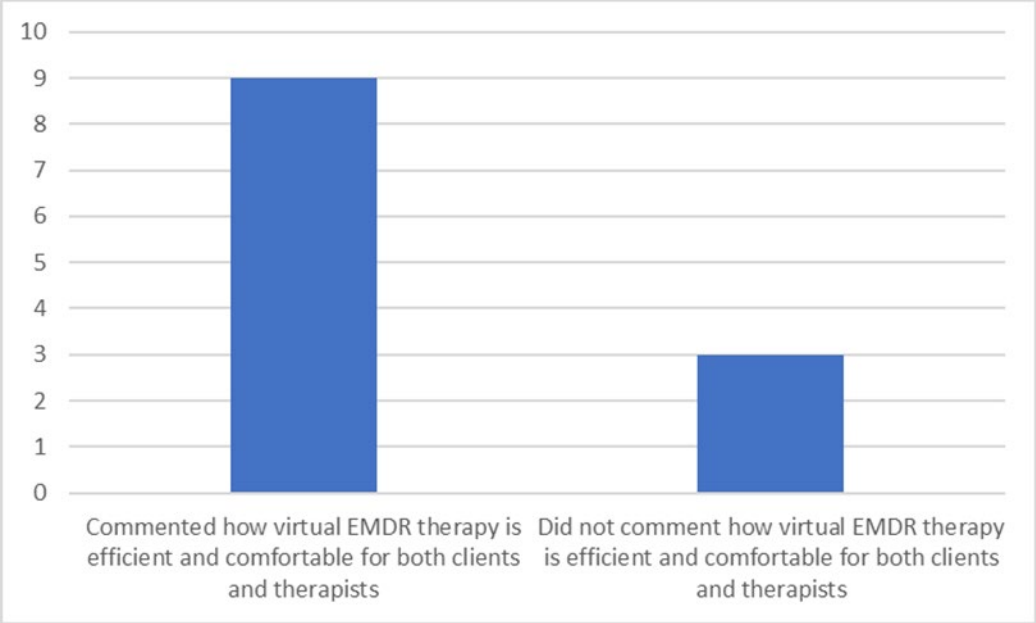
Sub-Theme 1: Efficient and Comfortable

Regarding the first, sub-theme, 91.67% (n=11) of the participants described virtual EMDR therapy to be efficient and comfortable for both clients and therapists. This theme emerged from the participants' descriptions of time saved, flexible schedules, convenience, being in one's own home, decreased distress, and decreased stigma. Codes that pertained to maximizing one's time were clustered as *efficiency*, while codes that

meant feeling at ease were grouped under *comfort*. Figure 2 below illustrates the percentage of participants that discussed the first theme.

Figure 2.

Participants' Comments on Virtual EMDR Efficiency and Comfortability



Additionally, 75% (n=9) of participants attributed efficiency to the time saved from not needing to travel to the clinic for EMDR therapy, as well as to the flexibility of therapy schedules. As clients did not need to travel for in-person therapy, the participants believed that they did not only save time, they also experienced less stress. Participant 1 stated, “There was no stress for them to have to get to the office. No extra time or dealing with traffic, so they come a bit more relaxed.” Participant 8 shared, “They don’t get caught in traffic, they can be much more spontaneous in their scheduling with EMDR and it’s much less burdensome.” Additionally, Participant 9 perceived that clients waste less time, energy, and money in virtual therapy. Participant 9 stated, “Less commuting for me and for the patient which means less energy and less money put into treatment.”

The virtual modality for EMDR therapy was also perceived to be efficient because of better attendance than the in-person modality. Participant 3 explained, “I think the ability to just log into a phone call and not have to factor in travel time makes it something that people are more able to commit to.” Participant 2 believed in the efficiency of the virtual modality for EMDR due to observing the same outcomes as the in-person therapy but with more consistent follow-up for the virtual modality. Participant 2 stated:

> Before virtual EMDR I was doing it in-person and the people that were doing EMDR did not come consistently and that was the issue. “I can’t come because blank...” So, now it’s like that is no longer an issue and I just find that people are getting more out of the virtual aspect.

As clients did not need to travel with the virtual modality, Participant 4 believed that clients with “acute traumatic incidences” who did not typically seek therapy attended and resolved their trauma through the virtual modality. Participant 11 preferred in-person therapy to virtual therapy but perceived that virtual therapy had advantages in attendance. Participant 11 believed that one of the reasons for higher attendance in virtual EMDR therapy than in-person therapy was the efficiency of being able to log in at the virtual session even at the last minute before the set appointment, which tended to be helpful for clients who were poor in tracking appointments. Participant 11 detailed:

> I think access and consistency for appointments did improve when people didn’t have to worry about driving to and from appointments. While this is less than ideal, it’s reality; clients who were not good about keeping track of their appointments and were going to come to an in-person appointment but then

> couldn't because they missed it, could just log in and we'd at least get some work done. They weren't rushing to get to their appointments and wasting time because virtual gave them a backup plan.

Eighty-three percent (n=10) of participants described virtual EMDR therapy as comfortable due to having the choice to do the sessions at home. Apart from minimizing the stress of traveling to the clinic, clients who opted for virtual EMDR tended to feel comfortable speaking up in their homes. Participant 9 shared, "It's also nice that folks can have therapy in their own home/environment, where they're most comfortable." Participant 5 believed that some clients felt safer and more comfortable talking while facing a screen than an actual person. Furthermore, when in their homes, clients tended to show what they liked, such as pets or furniture, which Participant 5 believed to "enhance the connectedness experience" in therapy. Participant 11 also believed that being at home offered comfort to the clients, especially when their pets served as emotional support. Participant 11 shared:

> I also think it's been beneficial for some of my clients to be able to have their pets nearby during sessions to be able to have the emotional support of a companion animal present during the session to be in a home environment, provided the client is comfortable and safe in their home environment.

Participants 4, 6, and 7 expressed that the virtual modality benefited them as therapists. Participant 7 described staying at home following the COVID-19 restrictions but felt "connected" to work due to shifting to a virtual modality. Participants 4 and 6 shared being able to work with the clients and tend to their children when using a virtual modality. Participant 6 shared:

> Virtual EMDR has actually worked out for me because I could work from home, still be with my babies and spend time with them but then hop back on to work virtually and be available for my clients and still continue my practice. For me personally, it gave me a lot of flexibility. I didn't have to be in an office all day or work a 9-5 job and I was able to see clients and kind of make my own schedule.

Sub-Theme 2: Accepted

All of the participants (n=12) described how the virtual modality for EMDR therapy has become accepted. The virtual modality has become widely accepted particularly during the onset of the COVID-19 pandemic. Participant 6 described that the pandemic "normalized" the use of virtual modality for EMDR therapy. Participant 6 stated, "I think it almost normalized virtual therapy. During the pandemic, many people and many clinicians in the healthcare system really switched to virtual appointments." With the normalization of virtual EMDR therapy, Participant 12 devised a "checklist" to guide clients in preparing for a therapy session at home. Participant 12 specified:

> I give them a checklist of things that they need to do to prep that safe environment for them to see what's required of them to engage in this therapy virtually. I go down to the point of even having water around having something that's soothing for them, it could be anything. I tell clients it's like creating a therapy office in their own space.

At the onset of the pandemic, the entire healthcare sector was adjusting to the restrictions and stay-at-home orders. Participants 6 and 8 perceived that during the adjustment, policies surrounding license to practice, insurance coverage, and the use of virtual platforms were "less rigid" than before the pandemic. Participant 8 shared, "The

pro is that most companies jumped in really quickly to clarify coverage, especially in the beginning of the pandemic." Participant 6 articulated:

> I think during the pandemic, during covid, a lot of the policies and laws were a little bit more lenient. For example, if a client didn't live in the same state, there was a part of time where you could still provide services for them virtually. It depends on the board in each state and just getting permission from the other state to continue providing services. I had a lot of active-duty military clients at one point and some of them were relocated and needed to be stationed somewhere else. Normally I would just end the relationship because they're no longer living in my state. But because of the pandemic, I was able to continue providing services and not worry about federal laws and get in trouble for that.

Participant 8, aged between 70 to 74, perceived that the virtual modality became an accepted means of receiving therapy during the pandemic because of being "safe." Participant 8 added that the virtual modality for EMDR therapy allowed clients to take care of their mental health while maintaining their physical health. Participant 8 stated:

> It was safe during the worst of the pandemic. People were able to continue services that otherwise would have had no services. Especially until we had vaccines. It was a huge benefit for clients that they could still receive services and heal and not have a worsening of symptoms. As we all know, the pandemic did not help anyone's mental health.

Participants 2 and 5 perceived that the normalization of virtual modality for EMDR also resulted from the availability of general and scientific publications. Participant 2 stated, "I think…Psychology Today is big because it tells the general public

that you can do it in virtual sessions." Participants 2 and 5 also cited the publications and discussions at EMDR International Association (EMDRIA) where practitioners shared knowledge about EMDR. Participant 5 specified:

> I think there was a greater acceptance from peers. For example, the community this serves on EMDRIA's website there was a discussion of it working very well to support each other as peers. Originally there was a lot of worry about folks with PTSD having high levels of disassociation and how that would be addressed in the virtual atmosphere.

Apart from discussions at EMDRIA, four participants shared their experiences of collaborating with other local social workers through virtual consultations. Participant 7 shared:

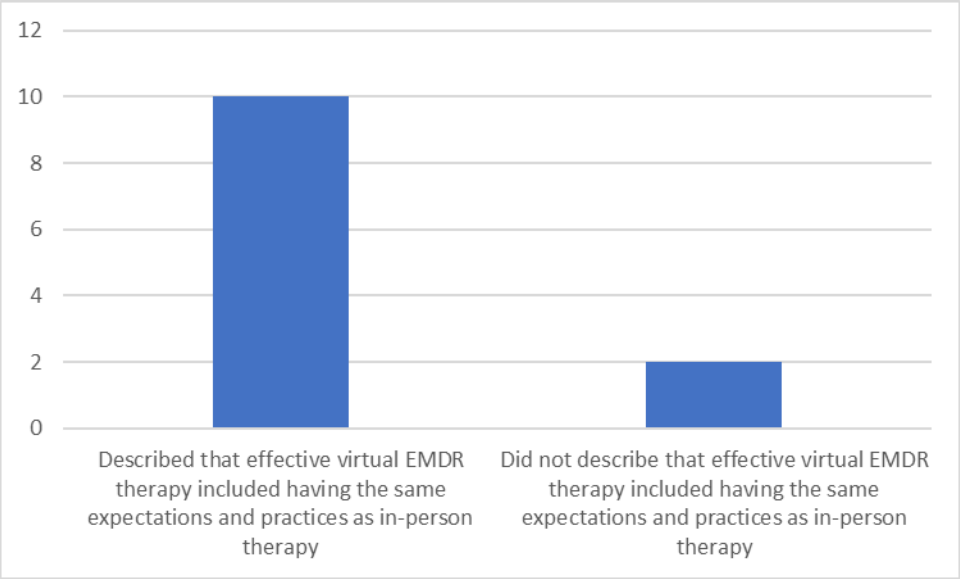
> I belong to a consultation group and we moved to Zoom. We used to meet in person and everybody would bring food and it was really fun. That wasn't possible, so we met via Zoom. That local resource was very helpful to me. I also have another consultation group and we really supported each other through the pandemic, we talked about the challenges of the virtual, we talked about what we were doing with ourselves, we talked about our fears of the pandemic, and we supported each other.

Sub-Theme 3: Same Expectations and Practices

Regarding sub-theme 3, 83% (n=10) of the participants described that effective virtual EMDR therapy included having the same expectations and practices as in-person therapy. Figure 3 below depicts participants' comments on subtheme 2.

Figure 3.

Participants' Comments on Expectations and Practices



Five participants emphasized the importance of "protocol fidelity" and cited fidelity to Dr. Francine Shapiro's adaptive information processing model for EMDR therapy. Participant 12 stated, "We're just using different ways of delivering it for lack of better words. We're still doing the same thing that Dr. Francine Shapiro taught all of us many years ago." Participant 11 cited the Shapiro model and being "faithful" to the model regardless of modality tended to result in the expected outcomes. Participant 11 shared:

> Because EMDR is so protocol-driven and rather technically different than talk therapy, I think people are a little intimidated to modify the protocol to suit the online format. But in general, I think we need to trust the protocol. We can do almost all of the same things that we do in person, virtually. Almost all of it, short of tactile bilateral stimulation.

Participant 4 similarly believed that adhering to the protocol could prevent acute trauma from progressing into PTSD. Participant 4 stated, “It needs to be structured, maintaining the fidelity to the model of the phase work… make sure that [the intervention] is processed enough so the acute stress doesn’t turn into PTSD” Participant 11 shared using the same methods for in-person and virtual EMDR therapy to assess the intervention’s effectiveness on the client. Participant 11 shared:

> On the small scale of things with the EMDR protocol, I’m looking at the exact same things. I would be, potentially on the client, using some other scales or screening questionnaires to kind of monitor for change and try to make that a little bit more objective. As opposed to just broadly asking if they’re feeling better. So, maybe we’re looking at things like a PHQ9 or GAD7 for change.

As in using an in-person modality, five participants perceived that social workers using virtual modality needed to attend training to administer EMDR therapy. Participant 3 stated that training involved mastering the EMDR therapy protocol. Participant 4 perceived that along with virtual modality for EMDR therapy, virtual training sessions were also offered for free or at a low cost. Participant 4 believed that the advantages of attending virtual training included learning from practitioners from other places who might have other insights. Participant 4 shared:

> The master trainers the “goats” of EMDR, they stood up and they offered all of these free or very low-cost trainings to get this done. I, like many, took all of the trainings that I could attend. It was awesome. I was able to get trained by clinicians that I wouldn’t have been able to be trained by because of locality or

> cost. Even in Europe I was getting trained by clinicians from Europe doing research.

Participant 9 was the only participant who referenced the use of audio and touch bilateral stimulation (BLS) as well as hypnosis when clients were not improving at the use of eye movement during virtual therapy. However, similar to the experiences of the other 11 participants, Participant 9 also found virtual EMDR therapy to be generally effective.

Another similar practice in virtual and in-person therapy was the need to build a relationship with the client. Thirty-three percent of participants (n=4) shared the importance of establishing a working relationship with clients regardless of modality. Participant 5 stated, "I believe that the relationship is essential in face-to-face therapy and that the relationship is essential in virtual therapy. I think the development of a relationship is a key factor." An established relationship with the client may help them feel safe Participant 12 justified, "If myself and the client have a connection where they feel they can go into this feeling safe… I just like to break it down to what they feel is important to make that successful." Participants 12 and 6 believed that trust was essential for the effectiveness of the virtual EMDR therapy. Participant 12 explained that their clients experienced being "powerless" when they experienced trauma, and that a therapist's job included assuring the client that they had control over their treatment. Participant 12 elaborated:

> Coming back to the effectiveness, it's really creating that setup and building that trust with them, knowing that when they went through that traumatic time, though they were powerless and didn't have a lot of voices and things were out of

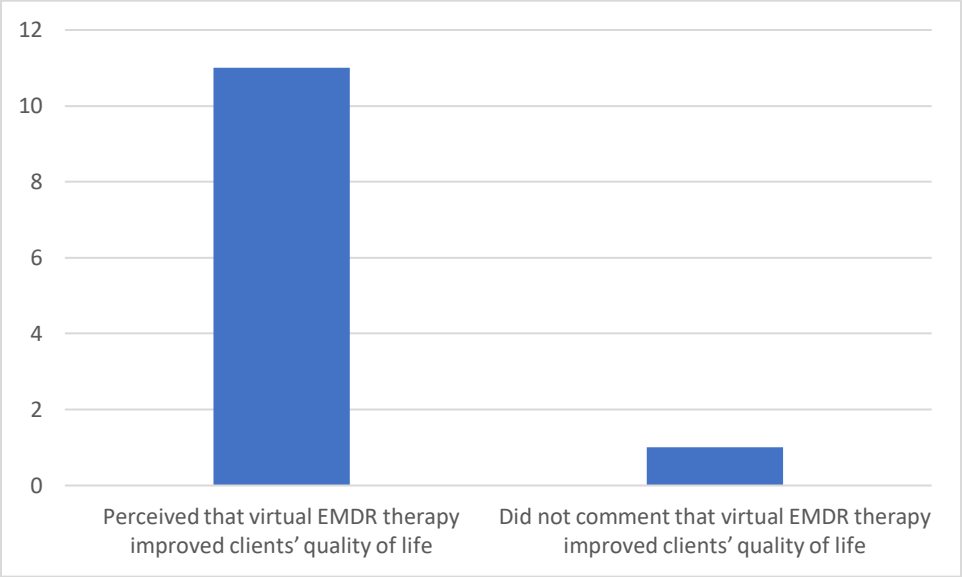
> control, this time, they will run the show. They have their stop sign. They get to create their own therapy office with me guiding them, they get to run the BLS on their own or use a software. They get to run the show this time on how the healing will look like. When the trauma happened, they didn't have voices, but this time when revisiting the trauma, they have all of these tools in front of them and they get to run the show. When I say that, they're almost kind of amazed. It's very empowering, very strength-based.

Sub-Theme 4: Better Quality of Life

Regarding subtheme four, 91.67% (n=11) of the participants perceived that virtual EMDR therapy improved clients' quality of life. The participants generally included personal relationships, improved symptoms, increased satisfaction, and work-life balance in describing their clients' quality of life. Figure 4 below depicts the rate of participants responses regarding subtheme 4.

Figure 4.

Participants' Responses on Improving Clients' Lives



Participant 2 perceived that improved relationships was an outcome of virtual EMDR therapy as clients understood their triggers. Participant 2 stated, "Once the EMDR experience begin, these triggers are no longer existing, they tend to note improvement in the relationship and satisfaction." In addition to improving the relationship as an outcome of therapy, Participant 1 perceived that the client's family tended to be less stressed with the virtual modality because of not needing to drive the client to the clinic. Participant 1 shared, "I think it might be easier on a family because the person doesn't have to figure out timing to drive somewhere back and forth." According to Participant 6, virtual EMDR therapy also helped clients improve their communication skills which resulted in better connectedness to other people. Participant 6 shared, "I have clients who had really unstable relationships and difficulty in communicating. But once they completed EMDR, their relationships got healthier, and their communication skills got better."

On the contrary, 25% of participants (n=3) perceived that clients' relationship with their families might be strained especially at the beginning of receiving virtual EMDR therapy due to the changes experienced by the client. Participant 5 perceived that "ups and downs" in relationships were normal parts of the therapeutic process. Participant 3 perceived that strains in family relationships could be short-term and could not be compared to the long-term benefits of receiving EMDR therapy. Participant 3 stated:

> I mean, in general it can affect the family if the client is maybe in the midst of a reprocessing through something that is stirring a lot up for them and they're having a lot of symptoms and they're asking their family members for additional support or understanding for a certain time period. I'm sure that impacts the family as a whole. Of course, I never see that part. I only really see the client perspective. But I also know that if they're not getting treatment, PTSD would certainly impact the family. It's certainly a temporary ask for a long-term benefit.

Some participants perceived that both virtual and in-person EMDR therapy tended to have the same outcomes in addressing trauma, but that the virtual modality resulted in higher work-life balance than the in-person modality. Participant 7 perceived that both virtual and in-person EMDR therapy helped address PTSD symptoms allowing clients to enjoy a better quality of life. Participant 7 stated, "I think EMDR, whether it's virtual or in-person improves life satisfaction of people with PTSD because it lowers their symptoms, usually below a diagnostic criterion and allows them to enjoy their life." Virtual EMDR therapy can be conducted anywhere and anytime the client chooses;

therefore, clients did not need to miss work or other life demands to attend therapy. Participant 2 stated:

> It's just more convenient. I they're at work, they can just go on their phone and do therapy. It actually improves their work-life balance because they don't have to drive to an office, drive back to work, or take time off. They don't have to take time off and still get their needs met.

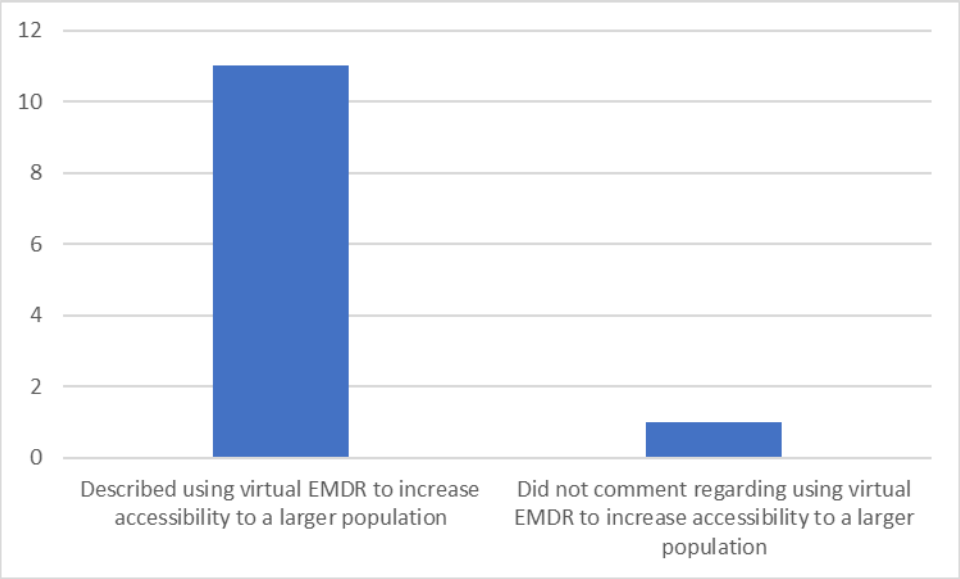
Eliminating the worry of missing work for therapy allowed clients to reduce stress and anxiety. Participant 8 described, "It's been helpful because they don't have to be absent as much, it's less of a stressor."

Sub-Theme 5: Wider Reach

Concerning sub-theme five, 91.67% (n=11) of the participants described virtual EMDR to increase accessibility to a larger population. The participants stated that the virtual modality for EMDR therapy helped reach clients who would not have sought in-person therapy. Figure 5 depicts participants' perceptions regarding reaching larger populations.

Figure 5.

Participants' Perceptions Regarding Using Virtual EMDR to Reach a Larger Population



Participant 8 shared that the virtual modality helped small town first responders exposed to trauma access the treatment they needed. Participant 1 who had a physical disability noted that the virtual modality was an advantage for both physically disabled clients and therapists. Participant 1 stated:

> We have folks with disabilities who are stuck at home and can't drive or have transportation access, it allows them to now get therapy they couldn't before… I think that, for me, I'm a legally blind person. I'm in the community of folks with a disability. Because we now have online, I am able to have a much more flexible schedule for clients, there's much more availability because there's less time going to and from offices.

Participant 3, whose clinic is located on a metropolitan island in the Northeast stated that the virtual modality allowed them to reach clients from various geographic locations.

Participant 3 also stated that they have reached a “broad, diverse client base” upon the use of virtual modality.

Participant 4 reported that the number of trained EMDR therapists was limited, which could be a disadvantage when a large group of people needed to address their traumatic experience. Participant 4 specified an experience of being called to respond to victims of a mass shooting incident at a high school overseas. Participant 4 shared:

> I have done group work with recent acute protocols that allow you to reach more people, especially within a tragic event. I used my organizer rapid response team to help with- when I still lived in [Northeaster state], and with the [redacted: overseas high school] shooting, I was able to help more people than I would on an individual basis.

Theme 2: Challenges of Using Virtual EMDR Therapy

Apart from strengths, using virtual EMDR therapy also included challenges. The participants identified the challenge of the family and home settings which were typical in virtual EMDR therapy sessions. The challenge was that the family may or may not be supportive of therapy, while the home may not have the necessary tools needed to deliver EMDR therapy. As virtual EMDR therapy is conducted online, another challenge identified by the participants was poor internet connection. Lastly, the participants were challenged with policies and regulations in practicing EMDR therapy particularly in states were licenses issued from other states were not recognized as valid. The challenges emerged as sub-themes and are described in the following sub-sections.

Sub-Theme 1: Family and Home Setting Influences

All of the participants (n=12) perceived that the effectiveness of virtual EMDR therapy may be enhanced or reduced depending on the family and home setting of the client. All of the participants believed that virtual EMDR therapy may be expensive for clients. Clients were expected to spend for the tools needed for the delivery of virtual EMDR therapy such as computers, toys for children, and fidget tools which were typically available at the clinic. Thus, one of the influences of family and home setting was the ability to pay for therapy. Participant 8 shared, "The other adaptations were having fidget tools or balls or tissues or whatever in my office for them to use, I would have clients come to session with those sorts of helps available to them in their own environment." Participants 9 and 11 shared that some clients may not be able to afford therapy and the tools needed for therapy. Participant 9 specified that some clients lost their jobs during the pandemic. Participant 9 stated, "Cons would be that lots of folks have lost jobs and are maybe not able to afford therapy." Participant 4 added that virtual EMDR therapy was expected to be a long-term expense for the client. Participant 4 shared:

> Problem of being able to know that we could confidently move forward because it was important to know how deep we could go with the EMDR work, because we couldn't just leave someone in reprocessing and they only have so many sessions left available. That was something that was a concern for patients.

Participant 9 also perceived that therapy was a long-term expense and the client's eligibility for health insurance was a barrier to receiving the recommended therapy sessions. Participant 9 also stated that the majority of the population was experiencing

economic struggles following the COVID-19 pandemic, which exacerbated the problem in being able to afford health insurance. Participant 9 noted:

> People that don't have out-of-network benefits are less able to find care, even with those benefits, the cost of therapy is too high for many. It's a significant investment where patients may not see an immediate result. Therapy often takes time to begin to work. During this economic struggle, access to healthcare and therapy services is tougher, despite the need being so high.

In addition to Participant 9, nine other participants cited the problem with health insurance coverage for virtual EMDR therapy. Participant 6 shared that several EMDR therapists including himself practiced privately and did not acknowledge the clients' health insurance. Participants 1 and 9 expressed that policies regarding the coverage of in-person and virtual EMDR therapy tended to be a barrier. Participant 1 shared that insurance policies may not be applicable at the national level. Participant 1 stated:

> The only limitation that for me is not an issue is with being virtual, you can see people from any other state or country, but insurance doesn't cross state lines. So, if somebody in [Western state] wanted to work with me, they'd have to pay out of pocket.

Being at home, clients may also have issues with privacy and distraction during therapy sessions. The participants shared that some clients may not have a personal space at home to maintain privacy during therapy. Participant 11 had clients who received virtual EMDR therapy in their cars parked at their own garages to have a private space. Participant 6 shared:

> If they don't have a private area where they can engage in a virtual session, maybe they live in a crowded area or they live in a big family where they share a room and there's no privacy. I think that those are some challenges that you wouldn't find in a clinic because if someone walks in, they go into your office, and you can close the door and there's privacy.

At the time of the implementation of stay-at-home orders, Participant 9 reported that family members also worked at home, which meant that clients may not be alone. Participant 8 stated that family members "needed to respect the privacy" of the clients for virtual EMDR to be effective. Participant 11 also believed that the client's family needed to value the client's healing even when the therapy was received at home. Participant 11 stated:

> Sometimes I think that can be a really wonderful thing because then the healing is happening right at home and the family is respecting a boundary with the therapeutic time. Other times it may be a problem when the family doesn't value therapy. Perhaps the client is well-invested in therapy, but the client's family does not value it or respect privacy or the household space doesn't allow for enough privacy or quiet.

Forty two percent of participants (n=5) shared that clients receiving therapy at home may be distracted by noises or situations happening around them that would not typically interrupt them in in-person therapy. Participant 12 stated, "Sometimes they have interruptions from something else that's going on in their environment, so the setting needs to be very important." Participant 11 was the only participant to share an experience with a client who scheduled a virtual EMDR therapy session during the lunch

break while at work. The participant perceived that the client seemed distracted from having to "do a very quick transition" from being an employee to being a patient addressing trauma and back to being an employee. Participant 11 also stated, "They're missing the time where they should be resting and eating in order to come to therapy. That's not necessarily wellness either."

Sub-Theme 2: Problems with Using Technology

All of the participants (n=12) described problems with using technology when delivering virtual EMDR therapy. According to the participants, the virtual modality required the use of internet and electronic devices. Nine participants identified issues with internet connectivity and the availability of internet-ready devices. Participant 3 stated:

> I have difficulty if there's technical issues. That's one thing where if we were in the office we'd be proceeding as normal. If the client has reception issues, their video isn't coming in clearly that day, then I'm probably going to proceed differently that day. I avoid it if I can't have clear audio/video feed.

Participant 1 described clients from "remote areas" to have poor or intermittent internet connection, which disrupted the virtual therapy session. Participant 11 cited the barriers of socioeconomic status in which clients with low income may not have the appropriate device or proper internet connection to benefit from virtual EMDR therapy. Participant 11 described:

> I've had some folks whose socioeconomic status makes it challenging for them to maintain access to reliable internet or devices that are sufficient for some of the parts of EMDR. A lot of it can be done even through a phone screen, but once

> we're getting into providing bilateral stimulation and having a screen large enough, having headphones available if we're doing audio bilateral. Access through technology, knowledge of the internet is probably one of the bigger challenges.

In addition to the problems with internet connectivity, the app or software used in virtual EMDR therapy may also malfunction. In delivering audio BLS, Participant 7 found that some clients had difficulty hearing the sound on their end. Participant 6 explained, "If Zoom fails or whatever website or tool, you're using online for bilateral stimulation goes down, then that can create challenges."

Participants 5, 9, and 11 experienced having clients who doubted the trustworthiness of the virtual modality or were uncomfortable with using electronic devices. Participant 11 shared:

> Varying comfort levels with technology among my clients. Some of my younger clients have grown up with technology and are comfortable with navigating this kind of thing and have been going to school online and things like that and are very comfortable with a Zoom-style interaction and things like that. With my older clients, it's very difficult to help them first access a session and also remaining comfortable during a session while interacting over a platform. Comfort level and familiarity with technology has been one of the bigger barriers, I think.

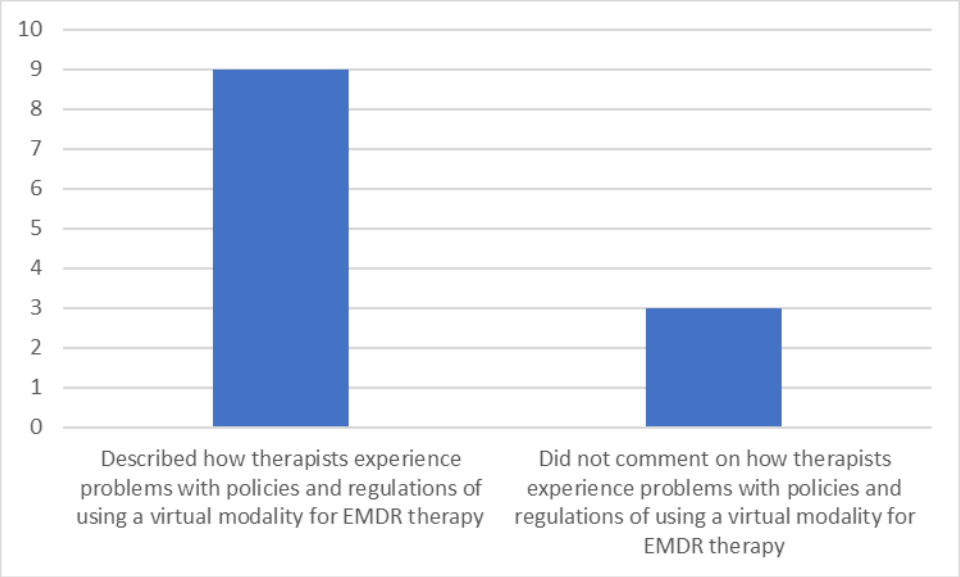
Sub-Theme 3: Problems with Policies and Regulations

Regarding sub-theme 3, 75% of the participants (n=9) expressed the barriers of policies and regulations when practicing virtual EMDR therapy. Figure 6 below depicts

how participants commented on experiencing problems with policies and regulations related to using a virtual modality for EMDR therapy.

Figure 6.

Participants' Perceptions of Barriers Related to Policy and Regulations



Eight participants specified the barriers of license restrictions in which their social worker license was not recognized in a different state; therefore, they could not work with clients outside of their state. Participant 4 shared an experience with not being able to administer virtual EMDR therapy from their clinic at the Northeast to individuals exposed to trauma from a mass shooting at an elementary school in the South. The participant felt upset that despite being qualified and certified in EMDR, they could do nothing to help. Participant 4 expressed:

> Right off the bat, when the shooting happened in Uvalde, Texas, I wanted to do the same thing and organize a rapid response team. Since I'm licensed in [Northeastern state], I couldn't help out virtually. Also, trying to apply for a

> temporary license- the state didn't allow it. So, I wasn't able to help out in that way. So, that was very upsetting for me and the fact that knowing the effect of EMDR, especially in acute crisis with the acute protocols would prevent PTSD.

Participant 5 stated that license to practice as a psychologist was recognized interstate, but social workers practicing EMDR therapy were limited to one state. Participant 5 noted, "Psychologists already have some sort of system where they can practice across state lines. But we don't have that. That's the biggest disadvantage." The majority of the participants believed that having a nationally recognized license to practice virtual EMDR therapy would help more individuals address their trauma.

Additionally, 33% of participants (n=4) shared their perceptions that the barriers to effective virtual EMDR therapy included the lack of policies from the national government. Participant 9 perceived that virtual EMDR therapy was "specialized" and "not accessible to the general population." Participants 4 and 8 perceived that the use of virtual platforms needed to be regulated at the national level. Participant 4 stated, "Overall, as a universal healthcare system, there is a barrier for approving a virtual platform across the board." Participant 8 shared:

> I think the federal policies have been helpful for the most part. I know that there's legislative efforts now that have been useful for us and will continue. For example, the interstate compact issue. The state has been different, the state has not been as cooperative and helpful. Again, a lot of that is insurance companies. But what we need are federal and state policies to support telehealth and support an appropriate reimbursement of telehealth.

Summary

This chapter contained the presentation of the findings of this qualitative descriptive study. Thematic analysis of the interview data revealed two overarching themes: strengths of using virtual EMDR therapy and challenges of using virtual EMDR therapy. Five sub-themes emerged as strengths of using virtual EMDR therapy. These subthemes were (1) efficient and comfortable, (2) accepted, (3) same expectations and practices, (4) better quality of life and (5) wider reach. Three sub-themes emerged as challenges of using virtual EMDR therapy, which were: (1) family and home influences (2) problems with using technology, and (3) policies and regulations.

Overall, effective use of EMDR telehealth or virtual therapy entailed the factors of efficiency, comfort, general acceptance, and protocol fidelity. The participants of this study disclosed that both therapists and clients found the virtual modality for EMDR to be generally efficient in terms of saving time. Clients did not need to spend time commuting, driving, or being driven to the clinic to receive therapy. Additionally, the remote setting allowed therapists and clients to have flexibility in scheduling therapy sessions. The participants perceived that clients did not need to take more time away from work or from their families. Thus, clients were able to enjoy more work-life balance when attending virtual EMDR therapy. The participants also shared that clients typically received virtual EMDR therapy from their own homes, which could have added to the feelings of comfort during therapy sessions. Some participants noted that some clients were comfortable opening up while in their homes.

Most of the participants began practicing virtual EMDR therapy during the onset of the COVID-19 pandemic when restrictions and stay-at-home orders were

implemented. The participants generally perceived that the pandemic was the catalyst for the normalization of using a virtual modality for EMDR therapy, as the majority of interactions within and outside the U.S. involved the use of the internet and electronic devices. Regardless of the modality, the participants cited Shapiro's EMDR model and attempted to maintain protocol fidelity. As a result, the participants generally observed their clients to have decreased PTSD symptoms, improved personal relationships, and improved quality of life.

However, the participants also shared factors perceived as barriers to the effective use of virtual EMDR therapy. While clients may be comfortable in receiving virtual EMDR therapy at home, they may encounter problems with connectivity, privacy, and distractions. The participants shared that clients' families were also generally linked with therapy regardless of modality. Their family's reactions to the changes resulting from therapy may affect the clients. Clients and therapists may also experience problems with their devices and software used for therapy. Older clients may not be as comfortable or able to use technology as younger clients. Additionally, the use of virtual EMDR therapy has not been regulated on the local, state, and national levels. The participants generally experienced restrictions in interstate practice, as their license were only valid in one state. The participants generally believed that EMDR therapy would be more accessible and available to a larger population when one license would be recognized nationally and when one virtual platform will be regulated by one governing body.

Chapter 5: Discussion and Implications

The purpose of this qualitative descriptive study was to explore how social work clinicians perceived virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States. The overarching themes were the strengths of using virtual EMDR therapy and the challenges of using virtual EMDR therapy. The sub-themes under the strengths of using virtual EMDR therapy were (1) efficient and comfortable, (2) accepted, (3) same expectations and practices, (4) better quality of life, and (5) wider reach. The sub-themes under the challenges were: (1) family and home influences, (2) problems with using technology, and (3) policies and regulations. Each sub-theme was associated with a specific research question and was discussed in detail within this chapter. This chapter will discuss each sub-theme related to the research question (or sub-question). In addition, the chapter presented the implications associated with the sub-themes and the research questions they answer.

Discussion

This discussion is broken down into sections based on the research question and an in-depth analysis of how the extracted themes and sub-themes respond to the question. The overarching research question asks how social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States. Additionally, three sub-questions explored particular facets of delivering virtual EMDR therapy. The three sub-questions were as follows: (1) what organizational, environmental, or self-factors do social work clinicians perceive as necessary or conducive for the effective use of EMDR telehealth therapy when delivered

to patients with PTSD using telehealth, (2) what organizational, environmental, or self-factors do social work clinicians perceive as barriers to the effective use of virtual EMDR therapy when delivered to patients with PTSD using telehealth, and (3) sub-question 3 asks how social work clinicians perceive that virtual EMDR therapy, when delivered to patients with PTSD using telehealth, could best be expanded.

Response to the Overarching Research Question

This first research question asked how do social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States as responded to by three sub-themes:

Sub-theme 1. Efficient and comfortable.
Sub-theme 2. Accepted.
Sub-theme 4. Better quality of life from using virtual EMDR therapy.

The overarching research question was how do social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States? Regarding sub-theme 1, the participants agreed that working with social work clinicians for PTSD therapy provided a convenience that most patients supported. Participants described convenience in relation to time-saved commuting, flexible scheduling, convenience, being in one's own home, decreased distress, and decreased stigma. During the interviews, the participants shared perceptions that many of their PTSD patients were comfortable and likelier to continue their therapy due to the ease with which virtual therapy allows.

Subtheme 2: Accepted

Regarding sub-theme 2, virtual modality for EMDR therapy is becoming accepted; the participants agreed that the normalized use of a virtual therapy setting has

become common, and more people are accepting of virtual treatment methods. Further, the participants recognized that with the onset of virtual delivery, most policies associated with treatment coverage (based on insurance allowance) became less ridged. Whereas before the pandemic, virtual therapy needed implicit approval for many insurance companies to pay, during the pandemic, the use of a virtual modality, particularly with EMDR therapy, was recognized as an acceptable means. Participants agreed that such acceptance made it easier to continue treatment for patients.

Sub-theme 4: Better Quality of Life

The final sub-theme that answers this overarching research question is sub-theme 4, which states that clients enjoy a better quality of life from virtual EMDR therapy. The participants recognized how their patients' quality of life improved through virtual EMDR therapy. In addition, improvements were noted, such as improvements in PTSD symptoms, increased patient satisfaction with work and home life, and improved quality of interpersonal and personal relationships. However, said improvements were not always immediate.

Contextualizing the Overall Research Question in Previous Research

Existing research on virtual EMDR therapy was examined to ascertain any direct support of the findings, and it must be noted that much of the past qualitative research focused on patient perceptions, not providers, and was consistently focused on in-person EMDR therapy (Paulik et al., 2021). However, it also should be noted that much of the existing literature focusing on EMDR therapy showed a significant number of successful clinical outcomes for patients with PTSD when attending treatment in person (Hafkemeijer et al., 2020; Haour et al., 2019; Yunitri et al., 2020). Additionally, in-

person EMDR therapy was shown to provide higher efficacy in PTSD patients reducing symptoms than other therapeutic measures such as CBT, ET, or PET (Bisson & Olff, 2021; Khan et al., 2018; Lempertz et al., 2022).

There were a few studies that examined how professionals in mental healthcare fields recommended the use of telehealth EMDR therapy during the pandemic claiming telehealth was an effective method for treating clients with mental health issues (Castelnuovo et al., 2019; Fischer, 2021; Haour et al., 2019; Proudlock & Peris, 2020). Researchers recognized that using telehealth modalities for healthcare during the pandemic became the norm and had become recognized as a positive means for treating patients with many mental health conditions during this period, mainly because in-person therapy sessions for many patients had been suspended (Critofalo, 2021; Knight, 2015; Zhou et al., 2020). The feasibility of using telehealth to provide EMDR therapy treatment to patients exampled how virtual treatments were necessary during COVID shelter in place (Bongaerts et al., 2021; Paulik et al., 2021; Sunjaya et al., 2020). Studies showed that clinicians who effectively treated patients diagnosed with PTSD using a telehealth platform found patient perceptions that they received similar care to traditional or in-person EMDR treatments (Bongaerts et al., 2021; Paulik et al., 2021).

It was further noted that with a virtual platform, and based on the social work clinician's perceptions, the use of EMDR treatment impacted the micro-level almost immediately. Clinicians' use of EMDR treatment with PTSD patients was at the individual level, whereby this therapy provides similar practical benefits as participating in in-person or traditional EMDR therapy sessions. The findings in this qualitative exploration study provided a means for implementing telehealth EMDR therapy and

offering positive benefits at the individual level for those with PTSD (Powers et al., 2019). Provisions for EMDR therapy via telehealth or a virtual component align with a social worker's values-based nature, which asserts a need to seek new and better ways to improve practices and assist patients (Nguyen, 2022).

The existing research also showed the effectiveness of treatment through telehealth platforms (Bongaerts et al., 2021; Tarquinio et al., 2020). Additionally, research supporting treating mental health patients using EMDR telehealth therapy offers a significantly effective method for treating clients experiencing a mental health crisis (Castelnuovo et al., 2019; Proudlock & Peris, 2020). The effectiveness of EMDR treatments occurring through telehealth modalities during the pandemic was considered a positive solution when people were afraid to leave their homes but needed to attend therapy (Tarquinio et al., 2020). This effectiveness of EMDR treatment showed outcomes comparable to the traditional therapy service (in-person) when patients used the telehealth platform.

Response to Sub-Question 1

The first sub-question asks what organizational, environmental, or self-factors do social work clinicians perceive as necessary or conducive for the effective use of EMDR telehealth therapy when delivered to patients with PTSD using telehealth.

Sub-theme 3. Same expectations and practices

Sub-theme three was determined based on the participants' descriptions of virtual EMDR therapy compared to in-person EMDR therapy. The participants concluded that therapists have the exact expectations and practices for both therapies and were similarly effective when practiced with PTSD patients, which they referred to as protocol fidelity. As

expectations and practices were the same for virtual and in-person therapy, the environmental factors were conducive to effective EMDR therapy among PTSD patients and establishing client relationships. The method of delivering therapy, whether through telehealth or in the office, did not impact the patient, the therapy, or the expectations of outcomes. The participants also contended that building a relationship with the patient was crucial regardless of the treatment delivery method.

Contextualizing Sub-question 1 in Previous Research

The existing research focused on the feasibility of the telehealth environment rather than the expectations for its success or effectiveness of use. When evaluating telehealth EMDR therapy with in-person EMDR therapy, the literature found more concern for the patient's ability (or feasibility) to use the equipment necessary for this modality (Morland et al., 2020; Paulik et al., 2021). Additionally, much of the research showed mental health counselors' preferring a telehealth platform versus their patient's inability to meet their in-person treatment appointments (Bongaerts et al., 2021; Morland et al., 2020; Sunjaya et al., 2020). Social work clinicians and other mental health professionals who effectively treated PTSD using a telehealth platform found that outcomes were similarly effective as with traditional or in-person EMDR treatments (Bongaerts et al., 2021; Paulik et al., 2021). Even so, there were issues noted with patients who participated in telehealth EMDR therapy, and issues associated with the home environment.

Response to the Sub-Question 2

Sub-question 2 asks what organizational, environmental, or self-factors do social work clinicians perceive as barriers to the effective use of virtual EMDR therapy when

delivered to patients with PTSD using telehealth. All three sub-themes related to challenges of delivering virtual EMDR therapy are used to address sub-question two. The subthemes are as follows.

Sub-theme 1: Family and home setting influences

Sub-theme 2: Problems with using technology

Sub-theme 3: Policies and regulations

Sub-theme 1: Family and Home Setting Influences

The clinician participant felt that there was a significant barrier to virtual EMDR therapy for clients at home during the pandemic due to other family members being forced to stay at home as well. It was noted that the participants found that many of their clients who participated in virtual EMDR therapy were more distracted than when participating in a traditional in-person session. Participants were less likely to focus on their needs, particularly during the pandemic when most family members were home. In addition, boundaries were often ignored even when clients made it evident that therapy was essential, and privacy was unavailable due to a lack of space in their homes.

Sub-theme 2: Problems with Using Technology

Sub-theme 2 was extracted from the interview responses with this study's participants suggesting that a barrier to virtual EMDR therapy was that some clients might experience problems with the technology. The use of technology was an obvious requirement for virtual EMDR therapy on the part of both the therapist and the client. However, participants claimed multiple issues for many clients using this technology. These issues included patients having intermittent internet due to remote locations, inability to afford the necessary computer systems, or having the ability to work the app

or software properly. Furthermore, participants found that because the technology was not always reliable, interruptions in therapy sessions were common and were challenging for patients to move forward in their therapy.

Sub-theme 3: Policies and Regulations

Sub-theme 3 also answered this sub-question with the participants perceiving problems with policies and regulations of using a virtual modality for EMDR therapy. The barriers of policies and regulations with virtual EMDR therapy were fundamentally convoluted, and many participants experienced issues with licensure barriers due to restrictions on the treatment of patients in other states. The participants further noted that EMDR therapy provided by social work clinicians was limited to the one state they were licensed in, while psychologist practices were interstate. With the advent of technology and increased use of virtual EMDR therapy, many participants believed that having a nationally recognized license for this practice would benefit and provide a broader range of therapy nationwide.

Contextualizing Sub-research Question 2 in Previous Research

Existing literature found that many clients defined virtual delivery as more convenient than standard delivery yet was fraught with consistent barriers such as environmental distractions, issues with the legislation, financial burden, and security risks (Parisi, 2020; Paulik et al., 2021; Rosen et al., 2020; Rutledge et al., 2017). While mental health providers considered the convenience of telehealth would accommodate patients that required regular therapy, the barriers continued to impact negative perceptions from patients and providers. Researchers noted that telehealth increased during the COVID-19 pandemic and provided positive outcomes for many mental health patients (Frakt, 2019;

Freske & Malczyk, 2021). However, these same researchers also noted that the pandemic's stay-at-home orders impacted the increased participation in telehealth therapy (Frakt, 2019; Freske & Malczyk, 2021).

Researchers discussed the issues with legislation and how mandates for healthcare services continue to negate telehealth services due to potential problems with security and safety measures (Gajarawala & Pelkowski, 2021; Kichloo et al., 2020). The few studies on teletherapy for mental health services found researchers having a negative perspective on such use. These researchers considered that providing full disclosure over publicly accessed internet services was regarded as problematic because of privacy and security breaches (Gajarawala & Pelkowski, 2021; Kichloo et al., 2020). Researchers stated that telehealth services allowed open public access to private medical records and recorded therapy sessions and thus would cause policies, such as the Health Information Privacy and Protection Act (2013), to be violated (Kichloo et al., 2020; Shachar et al., 2020).

The existing literature also supported the participants' perceptions of practices being impacted by financial barriers (Hyder & Razzak, 2020; Shachar et al., 2020). Studies showed that mental healthcare clinicians and their respective patients had issues with telehealth services because they needed clarification about how the technology worked. Furthermore, researchers stated that there was a shortage of mental health providers with EMDR trained for use with telehealth services (Sunjaya et al., 2020). The research on financial barriers illustrated that many clinicians believed telehealth equipment was costly and would decrease their underlying profits (Hyder & Razzak, 2020; Shachar et al., 2020). However, much of the literature focusing on financial

barriers was based on the perception of unaffordability for the client, not the providers (Hyder & Razzak, 2020; Shachar et al., 2020; Waterman & Cooper, 2020).

Researchers claimed that an opportunity for telehealth use had not been met with encouragement from healthcare providers (Hyder & Razzak, 2020; Shachar et al., 2020). In contrast, acceptance of telehealth services for therapy was noted during the pandemic, and a lack of research on how essential such therapy can be effectively and realistically offered. Further, there was a lack of research directly focused on the barriers regarding PTSD therapy in connection with EMDR telehealth therapy. However, even with the success rate regarding PTSD therapy through virtual treatments, some researchers considered the barriers from the legislation the main concern associated with implementing this therapy (Bongaerts et al., 2021; Mouratidis & Papagiannakis, 2021). However, the participants of this study believed the positive aspects of implementing telehealth or virtual EMDR therapy outweighed such barriers.

Response to the Sub-Question 3

Sub-question 3 asks how social work clinicians perceive that virtual EMDR therapy, when delivered to patients with PTSD using telehealth, could best be expanded. Sub-theme 5 provided the answer to this question. The following section will describe how sub-theme 5 addresses the final sub-question.

Sub-theme 5: Wider Reach than In-person Therapy.

The third sub-question was answered through the fifth sub-theme of virtual EMDR having a wider reach than in-person therapy. Therapists serve patient populations better when using a virtual EMDR therapy modality. The participants recognized that virtual EMDR was the key to reaching a larger population of patients. The participants

also agreed that there was an increased need for EMDR training to expand to a virtual delivery method. Because there was still a shortage of social work clinicians trained in EMDR training, the participants believed that by incorporating training with virtual and telehealth modalities, hard-to-reach patients or those patients typically ignoring the need for therapy could be reached.

The participants believed that a disadvantage to EMDR therapy was the lack of fully trained therapists. In the world's climate, with mass shootings, riots, and continual acts of violence increasing, experts need to understand how to address traumatic experiences in people. However, due to the lack of trained therapists in proven successful modalities, such as EMDR therapy, most of society will not receive the necessary trauma therapy for recovery. The participants believed that virtual EMDR therapy could help breach this gap in treatment.

Contextualizing Sub-question 3 in Previous Research

Previous research showed that while implementing virtual EMDR therapy for mental health issues could increase treatment needs, many mental healthcare providers were not fully trained in EMDR and were unclear regarding how to use the virtual environment (Erreger, 2021; Farrell et al., 2021). Further, research showed that during the pandemic, social work clinicians were challenged with executing EMDR telehealth therapy because they needed to learn this virtual platform for providing therapy to their patients (Erreger, 2021). Researchers also noted that patients were less constrained by geographic locations, transportation, or time when participating in telehealth treatments (Sunjaya et al., 2020). It was further contended that patients who lived in low-income rural areas and were diagnosed with a mental health condition were more likely to

participate in virtual treatment than driving distances for in-person treatment (Bryant, 2019; Sunjaya et al., 2020).

The research and this study's findings suggested that a relevant mesosystem context was found within certain aspects of patients in rural areas. There were noted issues for many mental health patients living in rural areas, particularly during the COVID-19 pandemic, where those in treatment could not travel to their regular appointments (Frakt, 2019; Paul et al., 2020). Lacking availability of therapy was alleviated with treatment methods provided by telehealth systems. The contextual aspects within the results of this study identify the degree to which the participants' patients were rural. Additionally, there were mesosystem implications associated with family and group context. Positive improvements in the health and well-being of patients with PTSD who were willing and able to participate in virtual EMDR therapy were possible at this level.

The findings and researchers within the existing literature posited that PTSD is inadequately addressed in the U.S. As a macrosystem, using EMDR virtual therapy could alleviate this inadequacy and provide a broader spectrum of mental health services. The ability to implement EMDR therapy using the telehealth modality may provide a potential macro-impact if the strategies identified can be applied widely. Improvement in EMDR therapy offered to patients in areas such as rural communities would increase the potential successful and positive outcomes in treating patients with PTSD.

Limitations

As noted in Chapter 1, the study has specific limitations discussed by the researcher. The sample included only 12 participants, which may be considered a limitation when considering research using larger samples, such as with a quantitative

study. However, saturation occurred with the latter two participants, who repeated similar responses to the interview questions.

Additionally, the researcher found the sample delineated into participants who were (a) licensed social work clinicians, (b) formally trained in virtual EMDR therapy, (c) used to using telehealth as either a primary or secondary but common delivery modality for EMDR therapy, and (d) provided virtual EMDR therapy services for at least two years. The inclusion criteria were relative to the selection of participants so that this sample could intelligently understand and respond to the interview questions, which were geared towards those social work clinicians with the experience and knowledge necessary to answer questions appropriately. Focusing only on social work clinicians was especially crucial given the program in which the study was undertaken. However, the limitations of the sample extended to failure in recruiting clinicians from diverse backgrounds and healthcare services, as the sample was predominantly white.

Unfortunately, despite the best intention to recruit a diverse clinician sample, most participants interviewed were White and proficient with technology. Additionally, practitioners' participants did not conceptualize their clinical work around essential factors such as language, ethnicity, gender class, and socioeconomic status (this should also be more areas of future research). For example, adding more non-White, non-English speaking, and people who are not proficient with technology could expand the scope of this current study. Further, findings were not generalizable with non-social work EMDR providers or clinicians unfamiliar with EMDR therapy offered through a virtual modality.

Recommendations

Recommendations for practice and research include implications associated with policy and practice, as there are many issues noted in this research regarding the feasibility of virtual therapy services. The required safety, security, and privacy issues foremost need further research, as these complexities within the legislation are only found in a portion of the existing research. Therefore, future practice is recommended to incorporate security, privacy, legislative requirements, and restrictive practices (Cristofalo, 2021; Zhou et al., 2020).

Implications for Social Work Practice

Implications regarding future practices necessitating further exploration were justified based on the study's results. The ability to offer EMDR therapy to PTSD patients should be considered by every clinician who works with these patients to overcome their significant traumatic experiences. Social work clinicians' perceptions of the virtual environment when delivering telehealth EMDR therapy to PTSD patients were found to be a positive treatment plan. The clinician participant described virtual EMDR therapy as efficient and comfortable and recognized it as promising. These same clinicians recognized having the exact expectations and practices with virtual and traditional EMDR therapy. However, they identified many barriers that prevented patients and other social work providers from using online therapy.

Practical implications include incorporating EMDR therapy for PTSD patients with extensive and mandatory training to ensure social work clinicians are comfortable and efficient with its virtual application. Specifically, social work clinicians should be encouraged to engage in more training to deliver EMDR therapy virtually. In addition,

the fidelity found with EMDR therapy from other clinicians who are experts in its use can provide positive reviews that may help change the perceptions of those hesitant to try EMDR therapy for PTSD.

Additionally, social work clinicians should be required to participate in continuing education training for licensed clinicians to obtain or retain licenses and practice using telehealth, especially for EMDR delivery. New users must be aware of the structured protocols and recognize the adaptive information processing model required for use (Shapiro & Laliotis, 2011). For successful use of EMDR therapy, the social work clinician must fully understand these protocols before engaging in the patient memory reprocessing stage.

Implications for social work practice also include expanding patient populations, including other individuals who need EMDR virtual therapy and would benefit from its convenience. Few practitioners can offer EMDR virtual therapy in non-English languages, persons who may not be comfortable with technology, or patients with visual impairment. Social workers should continue investing in education and training to address these issues.

Recommendations for Social Work Leadership

Future social work leadership should encourage the expanding practices for social work clinicians as described above while continuing to expand the fundamental leadership skills required for becoming an experienced expert in providing EMDR treatment. Developing leadership skills should be considered a part of their daily practice. Such development of skills may include the following: recognizing the need for insight into and understanding of human behavior and establishing the ability to help others

develop and succeed, having the capacity to see situations from various perspectives, having a solid ethical framework, having a healthy respect for diversity, knowing when and how to engage in participative decision making, and establishing consensus building. Leadership should also practice managing change, listening and communication skills, emphasizing teamwork, recognizing power differentials, and understanding how to implement conflict intervention.

The social work leader must understand their leadership skill set is a continuing learning experience. The correlation of future leadership practices with EMDR constitutes an ability to continue learning this therapeutic method with knowledge and practice. As a social work leader, this implies understanding, promoting, and incorporating EMDR practices such as implementation, screening, assessment, and treatment for PTSD. This would include evaluating the fidelity of using EMDR therapy from different cultures and providing therapy to all patients with PTSD. Integrating EMDR therapy for PTSD patients necessitated the required education and instruction to guarantee practical use by social workers.

Recommendations for Social Work Policy

As stated, social work leaders and clinicians should empower those wanting to deliver virtual EMDR. This focus should include the element of social justice with questioning the practical use of EMDR. Future practices for leadership should include a commitment to action within political advocacy, assisting in policy procedures, and supporting laws toward adapting telehealth treatments.

For example, more emphasis should be used on increasing broadband access to ensure Wi-Fi connections and broader reach to clients needing treatment, especially those related to EMDR. Emphasis should also be placed on changing licensing requirements to practice telehealth and incorporating mandatory training and continuing education for social work clinicians. Relatedly, political and social work leaders should develop or create a national database that tracks clinicians trained in EMDR, so prospective clients can easily access providers for treatment.

Further, the impact of advocacy should be supported by lawmakers and policymakers who could incorporate a social workers' lens in legislative requirements and restrictive practices. For example, leadership could work to change and adapt privacy laws, regulations, and policies associated with virtual platforms regarding healthcare records and privacy. Additionally, leadership should investigate ways to improve insurance coverage and supplemental care, to increase virtual EMDR accessibility.

Recommendations for Future Education

Social work education should focus on the applicability of technology (NASW, 2016) specific to service delivery. This also necessitated an increase in training for virtual EMDR to increase the number of qualified clinicians and improve access. Continued development of the social work curriculum for EMDR certification would also be beneficial. This would include particular emphasis on ethical considerations like privacy and navigating sessions should issues arise. Additionally, emphasis should be placed on how to deliver EMDR using telehealth. New EMDR social work clinicians must be aware of the structured protocols of telehealth and other modalities and recognize the adaptive information processing model and methods required for use (Shapiro & Laliotis, 2011).

Recommendations for Future Research

There is a need for future research on the legalities and policies associated with virtual platforms regarding healthcare records and privacy. Because telehealth services involve third-party participation and with telehealth service providers engaged in threatening patient privacy, future research must relay these policies clearly to practitioners using telehealth therapy in their practices. Even though some telehealth encounters are protected under privacy laws and regulations, it needs to be made clear which practices are not covered or carry additional risks. Social work clinicians must further examine the methods that social workers support and use to secure and protect their patient's information.

Research is needed to measure and evaluate social work clinicians' ability and fidelity in using EMDR therapy from different cultures and how they treat patients from different cultures. Such research should discern if a provider is financially able to be trained in EMDR therapy and if their ethnicity impacts their financial ability. Further, examination of the actual cost of EMDR training should be evaluated. Finally, the element of social justice should be considered within this future research questioning if EMDR is only affordable for those practitioners with a higher socioeconomic status. Thus, the inclusion of white privilege can be examined.

Future research must determine how well the training prepares providers for using EMDR therapy based on the patient's mental health condition. Examining EMDR therapy differences for each type of mental health illness would be beneficial. EMDR therapy should be observed in multiple diverse communities to determine the utilization

of this treatment method for all mental health conditions and how well patients with PTSD and other mental health conditions can afford and use virtual EMDR therapy.

The researcher also recommends that future research should focus directly on how EMDR telehealth therapy impacts PTSD patients. Whereas there is research on EMDR telehealth therapy, and this study provides insight into the perceptions of clinicians who use EMDR telehealth therapy, no studies directly focus on telehealth services using EMDR therapy for PTSD patients. The perceptions of social work clinicians would be valuable as more clients could be shown that this modality would benefit their treatment plan. In addition, observing the impact of this therapy as used through a virtual platform based on clinicians' perspectives would provide future practitioners with an understanding of the positive aspects of this therapy for PTSD patients.

Conclusion

The findings from the data analysis produced two main themes: the strengths of using virtual EMDR therapy and the challenges of using virtual EMDR therapy. Additionally, eight sub-themes were identified to answer the overarching research question and the subsequent sub-questions. The participants explained that EMDR therapy provided over a virtual platform was effective, efficient, and positive for many concerning issues. However, the participants also described problems with virtual therapy that included cost and feasibility, as well as needing to understand how to use the technology associated with a virtual platform. The immediate notion taken from this chapter was that the social work clinicians participants provided a perspective regarding the use of virtual EMDR therapy and its positive benefits. However, there is a significant lack of use of virtual EMDR therapy. Much of the literature contended that this lack of

use was due to a lack of trained professionals who failed to understand the basics of both EMDR therapy and the use of a virtual platform (Sunjaya et al., 2020).

Additionally, there were notable and significant issues associated with the implementation of virtual therapy, such as the lack of technological competencies for providers, the cost being beyond a patient's means, and distractions in a home environment (Parisi, 2020; Paulik et al., 2021; Rosen et al., 2020; Rutledge et al., 2017). While existing research related to EMDR telehealth therapy suggested the benefits of using such treatment modality, there was a lack of studies focusing on social work clinicians' perceptions or lived experiences (Bongaerts et al., 2021; Whealin et al., 2017). The available research typically expressed quantitative results or focused on patient perceptions (Bongaerts et al., 2021; Morland et al., 2020; Sunjaya et al., 2020; Whealin et al., 2017). The present qualitative descriptive study explored how social work clinicians perceived virtual EMDR therapy when delivered to patients with PTSD using telehealth in the United States. Adopting virtual EMDR therapy would substantively improve patients' access to this therapy.

The present study's main contribution to the literature addressed this gap, creating a better understanding of how providers could feasibly and effectively offer telehealth EMDR therapy to patients. The findings and correlated literature suggested that EMDR therapy is an effective treatment for PTSD, yet telehealth treatment was not widely accepted as a treatment protocol. The overall understood reason for this was a lack of well-informed clinicians, barriers associated with cost, access, or use, and perceived challenges with understanding how to use such a system. Consequently, the research showing the positive outcomes associated with EMDR therapy for mental health patients

was limited. However, the participating social work clinicians in this study agreed that a virtual delivery method for EMDR therapy would be instrumental in expanding access to such therapy.

This research also found that there was a need to increase training for clinicians on both EMDR therapy methods and the use of a virtual delivery system for mental health care practices which was further supported by the findings of this research. However, the participants noted that the delivery system was not responsible for poor patient outcomes. This lack of training and experience in EMDR and virtual therapy was problematic and needed correcting. Such correction would expand the learning basis of clinicians, who could increase patient loads reaching clients who would typically disengage from EMDR therapy by not meeting their appointment needs.

The results of this study also found that through the use of the TOE theory combined with empowerment theory, a framework established both the technological innovation decisions and the psychological empowerment process. The former was noted as the availability of technology to reach patients that generally would not participate in therapy. The latter considered the interpersonal behavioral interactions within the participant's understanding of telehealth EMDR therapy. Combined, these theories, as applied to the perceptions of this study's participants, were impressed upon the future application of telehealth therapy based on noted successful outcomes of PTSD patients who completed EMDR therapy. As the study's participants stated, the delivery method of EMDR therapy did not matter; the application of this treatment method, however, did. The researcher tested and further developed the theory by examining the environmental and organizational factors surrounding the effective implementation of telehealth

technology for EMDR therapy and found that a broader adoption of EMDR therapy provides virtually would further extend a much-needed expansion of this therapy. The adoption of TOE and empowerment theory was applied to this research, and the participants were recognized as accepting the technology used for virtual EMDR therapy. Additionally, the participants agreed that using this virtual platform provides a means to increase participation from hard-to-reach patients.

With the continual advancement in EMDR therapy as a treatment method for mental health conditions such as PTSD, the need to recognize certain factors may impact its usability. Examining how social factors affect practitioner access to EMDR therapy and the necessary training may provide an understanding of its need for equal access and treatment. The advancement of EMDR therapy provided equity for all cultures in need of mental health treatment can only benefit with an understanding of both the practitioner and patient's ability to access this type of treatment. Additionally, the need for EMDR-certified therapists, consultants, supervisors, and educators is much needed, and with advanced research, the support for diversity in EMDR therapy use will expand.

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Appendix A: Project Information

1. Project Title: Social Workers' Perspectives of the Effectiveness of EMDR in Telehealth for PTSD Patients
2. Nature of Risk: No
3. Protected Populations and Sensitive Subjects: No

Project Purpose and Background

According to the National Institute of Mental Health (NIMH) (2021), approximately 6% of Americans will experience post-traumatic stress disorder (PTSD) and 3.2 million Americans will suffer from the adverse outcomes of PTSD annually (NIMH, 2021). These adverse outcomes result in decreased functionality and quality of life (Kuhn & Owen, 2020l Mayranezouli et al., 2020). Social workers and other therapy practitioners who routinely work with individuals with PTSD, often use a variety of treatment modalities. However, researchers have found that eye movement desensitization and reprocessing therapy (EMDR) is one of the most effective modalities for reducing harmful symptoms and increasing patient functionality and quality of life (Cuijpers et al., 2020; Sunjaya et al., 2020). Despite these findings, EMDR is still not a widely used treatment protocol because patients struggle to access healthcare facilities with social work clinicians or other professionals capable of performing EMDR therapy (Waterman & Cooper, 2020).

In the past years, telehealth services have become a viable platform for delivering medical and mental health services (Bestsennyy et al., 2021). Telehealth services can be used by clinicians to administer EMDR therapy (Nickerson, 2016) and researchers have agreed about the feasibility of delivering EMDR therapy through a virtual platform (Bongaerts et al, 2021). However, there is a lack of trained social workers who can provide remote EMDR therapy. Understanding social work clinicians' perspectives on telehealth EMDR therapy may be an important way of addressing these challenges and promoting the use of EMDR therapy via telehealth.

As such, the purpose of this qualitative descriptive study is to explore how social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the United States. In line with this purpose, the research questions listed below will be addressed:

The research questions will include the following:

Overarching RQ: How do social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the specific context of the United States?

Sub-RQ1: What organizational, environmental, or self factors do social work clinicians perceive as necessary or conducive for the effective use of EMDR telehealth therapy when delivered to patients with PTSD using telehealth?

Sub-RQ2: What organizational, environmental, or self factors do social work clinicians perceive as barriers to the effective use of virtual EMDR therapy when delivered to patients with PTSD using telehealth?

Sub-RQ3: How do social work clinicians perceive that virtual EMDR therapy, when delivered to patients with PTSD using telehealth, could best be expanded?

The qualitative research questions will be addressed using data collected through individual interviews with clinicians who are trained in EMDR therapy. Interviews will be conducted through Zoom and will be audio recorded. Transcripts of the interviews will be analyzed using Clarke et al.'s (2015) six-step process of qualitative thematic analysis.

Characteristics of the Subject Population

1. Estimated number of participants: 10-12 participants
2. Participant inclusion criteria: Participants must be (a) a social worker with a license, (b) have formal training in EMDR therapy, (c) use telehealth as either a primary or secondary delivery modality for EMDR therapy, and (d) have provided EMDR therapy services using telehealth for at least two years.
3. Participant exclusion criteria: No other exclusion criteria will be implemented aside from the inclusion criteria listed above.
4. Exclusions based on sex or gender: No
5. Subject age range: 18 and above

Risks and Consent

1. Potential risks: The risks expected in this study are minimal, or no greater than those the subject would expect to encounter in daily living.

2. Protection against risks: It will be emphasized that participation in this study will be strictly voluntary. Participants will be allowed to decline to answer any questions they do not feel comfortable answering and they may withdraw from the study at any point with no penalties or negative consequences. To protect participant privacy, no names will be used in the individual interviews. Instead, participants will be referred to using pseudonyms. All data collected for this study will be stored as password-protected files in a password-protected external drive. Only the researcher will have access to this data. All data will be stored for a period of three years after the completion of the study. After this time, all electronic data will be permanently deleted.
3. Potential benefits: Greater adoption of telehealth EMDR therapy could substantially increase patient access to this treatment modality, and in turn improve functionality and quality of life for those suffering from the adverse effects of PTSD.

Methods and Procedures

1. Identifying and recruiting prospective subjects: As the target population is rather small if 10-12 participants cannot be located, the researcher will defer sampling size recommendations from Padgett (2017), who suggested that 6-10 persons may be adequate for a qualitative sample. Recruitment will be conducted over a two-week period and will be conducted through a combination of the researcher's professional networks and publicly available data listed on professional or hospital websites for clinicians who deliver EMDR therapy. A recruitment email will be sent to potential participants and interested individuals will be asked to reply to the email. Interviews will be scheduled with the individuals who express interest in participating in the study. The researcher will send a copy of the informed consent form through email and ask the participant to return and sign copy through email prior to their interview schedule.
2. Will you publicly advertise to recruit participants? No.
3. Locations where the study will be conducted: All interviews will be conducted online, using the Zoom teleconferencing platform.
4. Research outside of Millersville? Yes
5. Study design and all procedures (sequentially):
    a. Researcher will identify potential participants using professional network and publicly available data listed on professional or hospital websites for social workers who deliver EMDR therapy.
    b. Researcher will send invitation email to prospective participants, which contains the relevant details of the study, such as its purpose and the nature of participation and time commitment expected from study participants.

   c. Interested individuals will be asked to contact the researcher through email.
   d. Researcher will screen the prospective participants through email, and those who meet the inclusion criteria for the study will be scheduled for an interview.
   e. Researcher will send a copy of the informed consent form through email and remind participants to return a signed copy of the informed consent form through email.
   f. Researcher will conduct interviews as scheduled. All interviews will be audio recorded with the consent of participants.
   g. Researcher will transcribe all interviews.
   h. Researcher will send back interview transcripts to the study participants within two weeks for member checking and approval.
   i. Researcher will use Clarke et al.'s (2015) six-step process of qualitative thematic analysis.
6. Alternatives to participation: There are no alternatives to participation other than those described in this form.
7. Monetary or any other compensation for participation? No.
8. Withhold information from participants? No.
9. Procedure for post-study debriefing: There will be no post-study debriefings conducted for this study.
10. How confidentiality and privacy will be maintained: For the interviews, no names will be used to protect participant privacy. Likewise, no other identifying information will be collected and all participants will be referred to using pseudonyms. To maintain data confidentiality, only the researcher will have access to the data for the study. All data will be stored as password-protected files that will be stored on a password-protected external drive.

Appendix B: Interview Protocol

Introduction

- Thank you for your interest in the research study. To recap, the purpose of this qualitative descriptive study is to explore how social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the United States. You have expressed your willing participation in the data collection and have signed the informed consent form. Before we begin the interview, I would like to remind you to be as truthful, accurate, and detailed as possible in giving your response. Rest assured that your identity and all the information collected from you will be kept private and confidential. You may choose to pause the interview or completely withdraw your participation at any point without consequences. Do you have any questions?
- This interview is being recorded. Let's begin.

Relevant Demographic Questions

1. How long have you been a social worker clinician?
2. What is your age (Please provide a range of five years)?
3. What is your ethnicity?
4. How long have you been using virtual EMDR therapy for patients with PTSD?
5. Which professional license do you possess?
6. When was the last time you provided virtual EMDR therapy for a patient with PTSD?
7. In which state do you practice virtual EMDR therapy?

Interview Questions

(Observe and note the participants' tones, expressions, and body language. Paraphrase the participants' responses if needed for clarification purposes.)

Individual Systems

1. How can you tell if the virtual EMDR therapy you delivered was effective in treating a patient with PTSD?
2. How do you perceive the effectiveness of virtual EMDR therapy?
    a. Probe: If you find virtual EMDR effective, what practices do you attribute to the effectiveness of delivering EMDR therapy through a virtual modality?
    b. Probe: If you do not find virtual EMDR therapy effective, why not?
3. What challenges, if any, did you experience in delivering EMDR therapy through a virtual modality?

Family Systems

4. How do you think the relationships between your patients with PTSD and their families are affected by the virtual EMDR therapy?

Group Systems

5. How do you think your practice of virtual EMDR therapy would influence the population of patients with PTSD?
    a. Probe: What specific experience do you have in which you perceived that your practice could benefit a larger population?
    b. Probe: What specific experience do you have in which you perceived that your practice could not benefit a larger population?

Mesosystems

6. How has the healthcare system during the time of the COVID-19 pandemic influenced your practice of virtual EMDR therapy?
    a. Probe: What were the pros and cons of the general healthcare system during the time of the COVID-19 pandemic which affected your practice of virtual EMDR therapy?
7. What local resources, if any, did you utilize to improve or to overcome the challenges of the impact of the healthcare system during the time of the COVID-19 pandemic on your practice of virtual EMDR therapy?
8. How do you think virtual EMDR therapy influenced the life satisfaction of your patients with PTSD?
    a. Probe: How has virtual EMDR therapy affected your patients' work-life balance?
    b. Probe: How has virtual EMDR therapy affected your patients' relationships?
9. How else do you think virtual EMDR therapy influenced your patients' lives?

Macrosystems

10. What state or federal policies from the U.S. government do you think were disadvantages, if any, to your practice of virtual EMDR therapy?
11. What state or federal resources or policies do you believe help your practice of virtual EMDR therapy?

Closing Question

12. Do you have anything else to add?

Conclusion

- This concludes the interview. I appreciate your insights on virtual EMDR therapy. I will be in touch for the member checking process which is vital for the

trustworthiness of qualitative studies. The process entails your review of the transcription of this conversation for accuracy. It also allows you an opportunity to provide additional information or edit your responses as you see fit.

Thank you so much for your time.

Appendix C: Recruitment Email

My name is Linda Timme, and I am a doctoral student at Millersville University. I am conducting a research study to explore how social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the United States.

I am recruiting individuals who meet all of these criteria:

1. Social Work Clinician
2. With formal training in EMDR telehealth therapy
3. Use telehealth as either a primary or secondary delivery modality for EMDR therapy
4. Have provided virtual EMDR therapy services using telehealth for at least two years

If you decide to participate in this study, you will be asked to do the following activities:

1. Undergo an individual online interview which will be conducted through Zoom and audio recorded. This will last for about 60-90 minutes.
2. Check the transcript of your interview for accuracy. This will take about 20 minutes of your time.

While I will do my best to protect your identity and ensure your confidentiality. However, if any behaviors that breaks the law or are defined in the Child Protective Services law, are reported during the interview, I will be required to report them to the proper authorities.

If you are interested in participating in this study, please reply to this email or contact me at lgtimme@millersville.edu or 717-743-0765

Thank you!

Linda Timme

Appendix D: Consent Form

Millersville University

Informed Consent Template: General

**** Do not use for collection of biospecimens or research involving genetic analyses****

Consent to be Part of a Research Study

Title of the Project: Social Workers' Perspectives of the Effectiveness of EMDR in Telehealth for PTSD Patients
Principal Investigator: Linda Timme, Doctoral Student
Faculty Advisor: Bertha DeJesus, MSW, DSW and Karen Rice, PhD, LSW, ACSW
Professor/Department Chair, School of Social Work
Phone: 717-871-5297 | Fax: 717-871-7941 | karen.rice@millersville.edu

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must (a) be a licensed social worker, (b) have formal training in EMDR therapy, (c) use telehealth as either a primary or secondary delivery modality for EMDR therapy, and (d) have provided virtual EMDR therapy services using telehealth for at least two years. Taking part in this research project is voluntary.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to explore how social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the United States. If you choose to participate, you will be asked to participate in an individual online

interview conducted through Zoom and audio recorded for data collection purposes. This will take approximately 60-90 minutes of your time. You will also be asked to check the transcript of your interview for accuracy.

- Risks or discomforts from this research are minimal, or no greater than what you would experience in daily living.
- The study will help provide more information about how to best provide virtual EMDR therapy to help people coping with PTSD.
- Taking part in this research project is voluntary. You don't have to participate, and you can stop at any time.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why are we doing it?

The purpose of the study is to explore how social work clinicians perceive virtual EMDR therapy when delivered to patients with PTSD using telehealth in the United States.

What will happen if you take part in this study?

If you agree to take part in this study, you will be asked to undergo an individual online interview, which will conducted through Zoom and audio recorded for data collection purposes. This interview will take about 60-90 minutes of your time. After the interview, you will be asked to check the transcript of your interview for accuracy. This will take about 20 minutes of your time.

How could you benefit from this study?

Although you will not directly benefit from being in this study, others might benefit because the information you provide can help us learn more about how to use telehealth to more effectively administer EMDR therapy to individuals suffering from PTSD.

What risks might result from being in this study?

We don't believe there are any risks from participating in this research.

How will we protect your information?

I plan to publish the results of this study. I will not include any information that could directly identify you to protect your privacy. While I will do my best to protect your identity and ensure your confidentiality. However, if any behaviors that breaks the law or are defined in the Child Protective Services law, are reported during the interview, I will be required to report them to the proper authorities.

I will protect the confidentiality of your research records by storing all data in password-protected files in a password-protected external drive. Only I will have access to your data. Your name and any other information that can directly identify you will be stored separately from the data collected as part of the project**.**

It is possible that other people may need to see the information we collect about you. These people work for the University of Michigan and government offices that are responsible for making sure the research is done safely and properly.

What will happen to the information we collect about you after the study is over?

I will not keep your research data to use for future research. Your name and other information that can directly identify you will be kept secure and stored separately from the research data collected as part of the project.

I may share your research data with other investigators without asking for your consent again, but it will not contain information that could directly identify you.

Your Participation in this Study is Voluntary

It is totally up to you to decide to be in this research study. Participating in this study is
voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer. If you decide to withdraw before this study is completed, all data collected up to that point will be immediately deleted.

Contact Information for the Study Team and Questions about the Research

If you have questions about this research, you may contact Linda Timme at lgtimme@millersville.edu or 717-743-0765.

This study has been approved by the Millersville University of Pennsylvania Institutional Review Board. Dr. René Muñoz, Director of Sponsored Projects and Research Administration, can be contacted with any questions at either 717.871.4146, or at rene.munoz@millersville.edu.

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Millersville University
PO Box 1002

Contact Information for Questions about Your Rights as a Research Participant

Millersville, PA 17551

Dr. René Muñoz
717.871.4457 - mu-irb@millersville.edu

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. We will give you a copy of this document for your records [or you can print a copy of the document for your records]. If you have any questions about the study later, you can contact the study team using the information provided above.

By signing this document, you are agreeing to be in this study and you agree that you are 18 years of age or older. Make sure you understand what the study is about before you sign. I/We will give you a copy of this document for your records. I/We will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the studyteam using the information provided above.

I understand what the study is about and my questions so far have been answered. Iagree to take part in this study.

_____
Printed Subject Name

_____
Signature Date

Consent to be Audio/Video Recorded

I agree to be audio/video recorded.
YES__ ***NO***

Signature Date

Appendix E: Codebook

Sub-Themes	Codes	No. of Contributing Participants	No. of References in the Data
Final Sub-Theme 1: Virtual modality for EMDR therapy is perceived as efficient and comfortable		11	41
	time efficient	9	22
	working in a comfortable location	10	19
Final Sub-Theme 2: Virtual modality for EMDR therapy is becoming accepted		12	36
	adequate systematic support	1	1
	collaborate with other local social workers	4	5

	general publications about virtual EMDR	2	2
	normalized during the pandemic	12	26
	using technology	2	2
Final SubTheme 3: Therapists have the same expectations and practices for virtual and in-person EMDR therapy		10	31
	audio or touch rather than eye movement	1	1
	bilateral	2	2
	hypnosis	1	1
	medical leave act	1	1
	protocol fidelity	5	7
	patient's adherence	1	1
	training	5	6
	need to build a relationship with clients	4	9

Final Sub-Theme 4: Family and home setting influence virtual EMDR therapy		12	55
	distractions at the patient's location	5	7
	family's fear of change	1	1
	need for proper setting	2	4
	patient's lack of privacy at home	10	13
	patients spending for resources to be available at home	12	30
Final Sub-Theme 5: Therapists and clients experience problems with using technology for virtual EMDR therapy		12	26

	app or software issues	3	3
	internet connection and internet-ready devices	9	14
	limited energy to handle a number of patients	2	2
	patient doubts modality	3	5
	patient's discomfort in using technology	1	1
	therapist sitting all day	1	1
Final Sub-Theme 6: Therapists experience problems with policies and regulations of using a virtual modality for EMDR therapy		9	13
	lack of government action or assistance	4	4

	license not valid in another state	8	9
Therapists experience problems in the lack of physical contact with the patient		5	6
	'extreme' patient - cannot regulate	3	3
	no physical contact	2	3
	relationship with patient	0	0
Final Sub-Theme 7: Clients enjoy a better quality of life from using virtual EMDR therapy		11	43
	better quality of life	5	10
	better relationship with family	8	12
	decreased symptoms	9	12
	-family adjusting	3	3

	less time off from work	6	6
Final Sub-Theme 8: Virtual EMDR has a wider reach than in-person therapy		11	17
	wider availability and easier accessibility	11	17
Therapists serve better when using virtual EMDR therapy		2	3
	better ability to serve	2	2
	decreased secondary trauma	1	1