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A Mixed Methods Case Study Examination of the Role of the Therapeutic Alliance in EMDR within Primary Care

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Portfolio Abstract

The therapeutic relationship within psychotherapy is well recognised as a pertinent component of successful treatments. In particular, the alliance component of the therapeutic relationship has demonstrated a moderate and robust correlation to positive outcomes. The alliance is considered the change mechanism within the more relationally focused therapies (e.g., psychodynamic). In contrast, therapies that focus on specific techniques related to underlying theory regarding the development and amelioration of mental health difficulties, prioritise the protocols as the change mechanism.

Mental health services can be seen to have moved towards offering more time-limited, protocol driven therapies (e.g., CBT) to widen access to therapy and to meet financial incentives. EMDR is a relatively new psychotherapy which has amassed evidence of efficacy since its development by Francine Shapiro in the 1980s and is now recommended within the NICE guidelines. EMDR is predominantly a protocol driven therapy based on its underlying theory which suggests that mental health difficulties are a result of dysfunctionally stored memories. Currently, little is known about the role of therapeutic relationship within EMDR and whether additional focus on relational aspects within the therapy could enhance outcomes.

A single-case design with two therapist-client dyads was used to explore the therapeutic alliance within two EMDR therapy cases in a primary care setting. The study had three aims; to investigate the relationship between the therapeutic alliance and outcome; to investigate the fluctuations of the alliance throughout EMDR; and to explore how the alliance is experienced by the client and therapist during EMDR treatment.

The principal findings, presented via visual analysis, display a strong alliance and positive outcomes in the two EMDR cases, suggesting the presence of the alliancewithin a predominantly protocolised therapy. This is further supported by the qualitative data, in which the alliance was a highly valued aspect by therapist and clients in both cases. Whilst this study is limited by generalisability given the small sample size and correlational design, it draws researchers' and clinicians' attention to the paucity of information guiding the practice of EMDR in terms of the relational imperative.

Statement of Contribution

Project Design

Deborah Skinner (supervised by Rachel Sabin-Farrell and Thomas Schröder)

Application for Ethical Approval

Deborah Skinner (supervised by Rachel Sabin-Farrell and Thomas Schröder)

Literature Review

Deborah Skinner (supervised by Rachel Sabin-Farrell and Thomas Schröder)

Participant Recruitment

Deborah Skinner (supervised by Rachel Sabin-Farrell and Thomas Schröder)

Data Collection

Deborah Skinner

Transcription

Deborah Skinner

Data Analysis

Deborah Skinner (supervised by Rachel Sabin-Farrell and Dave Dawson)

Write-up

Deborah Skinner (supervised by Rachel Sabin-Farrell and Dave Dawson)

Journal Paper

A Mixed Methods Case Study Examination of the Role of the Therapeutic Alliance in EMDR within Primary Care

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Abstract

Introduction

The psychotherapy literature generally agrees that the therapeutic alliance is an important variable, with strong alliance consistently correlating with positive outcomes. The role of the therapeutic alliance is less well understood in heavily protocolised therapies. Some authors have begun to question the role of the alliance in Eye Movement Desensitisation Reprocessing (EMDR) and have suggested that additional focus on the relational aspects of the therapy may strengthen outcomes. This study aims to investigate the role of the alliance and to explore the therapist and client experiences of the alliance in EMDR.

Method

A mixed methods single case design was used with two therapist-client dyads within routine clinical practice in the UK.

Results

The results are displayed using Visual Analysis, which revealed a strong alliance within two successful outcome cases of EMDR. The presence of the alliance is further supported by the qualitative data, in which the TA was a highly valued aspect by therapist and clients in both cases.

Discussion

The findings suggest the ongoing importance of relationship variables within a predominantly protocolised therapy. Although this study is limited by generalisability given the small sample size and correlational design, it concludes that EMDR theory and practice may benefit from considering the therapy as both technical and relational to maximise outcomes.

Key Practitioner Message

- The therapeutic alliance is fundamental to successful outcomes in psychotherapy
- The role of the therapeutic alliance in protocolised therapies is less clear
- EMDR is a relatively new, protocolised therapy based on neurobiological theory
- The understanding of the alliance in EMDR is currently absent from the literature but has clinical implications for therapy delivery

Keywords: Therapeutic Alliance; Eye Movement Desensitisation Reprocessing; Single Case Design.

Introduction

The common factors conclusion in psychotherapy proposes that the factors shared by different therapeutic approaches (e.g., instilling hope, demonstrating understanding, alliance) account for a large proportion of the variance in outcome (Imel & Wampold, 2008; McAleavey & Castonguay, 2015). Empirical evidence supporting the influence of common factors derives largely from comparative treatment studies demonstrating that divergent psychotherapies produce largely equivalent results (Laska, Gurman & Wampold, 2014; Luborsky et al., 2002; Wampold et al., 1997). However, other authors have criticised this; Crits-Christoph (1997) suggested that Wampold's findings are misrepresented by the averaging of outcome measures across primary and secondary outcomes (Crits-Christoph, 1997). The common factors conclusion has also been questioned by Beutler (2002), who warns against assumptions of patient and therapeutic homogeneity. In contrast, proponents of specific factors evidence have indicated the superiority of particular models, including Cognitive Behavioural Therapy (CBT) for depression (Tolin, 2010) and anxiety disorders (Siev & Chambless, 2007; Mayo-Wilson et al., 2014). Whilst it can be inferred from studies that specific techniques produce superior outcomes, some psychotherapeutic models may have an advantage in producing positive findings as they lend themselves better to controlled evaluations. For example, CBT involves the delivery of structured techniques, in contrast to other less directive therapies (e.g., psychodynamic) and therefore may skew the outcome literature in their favour. [for further discussion of the equivalence debate, see extended paper section 1.1]

Further evidence for the influence of common factors in psychotherapy comes from meta-analyses summarising correlational data in which several common factors have accounted for a large proportion of the outcome variance, for example Lambert (1992) suggested that common factors accounted for 30% of outcome variance and specific techniques, just 15%. [for further literature regarding common factors, see extended paper section 1.2]

The Therapeutic Alliance

The Therapeutic Alliance (TA) is one of the most widely researched of the common factors. The TA refers to the interaction between client and therapist. The concept can be tracked back to Freud's (1913) theorisation of transference. Later, Greenson (1967) defined the alliance as a reality based collaboration between patient and therapist. In 1975, Orlinsky and Howard (1975) synthesised ideas from previous research and theory to propose three dimensions of alliance: working alliance (investment of client and therapist in the process of

therapy), empathic resonance and mutual affirmation. Bordin (1979) further reworked this tripartite division into goal, task and bond, and applied the concept generically across different psychotherapeutic modalities. Bordin's alliance theory offers an overarching conceptual framework. However, it can be seen to lack explanatory depth byfailing to fully explain the underlying mechanismsinvolved in the enanctment of the alliance. Although a uniform definition of the concept has not been reached, the central aspects of the TA construct can be seen as involving a bond between client and therapist, as well as agreement about the therapeutic goals and tasks (Hatcher & Barends, 2006). [for further discussion of the construct of the alliance, see extended paper section 1.3]

The treatment literature has repeatedly shown a moderate relationship between the TA and positive outcomes in psychotherapy (Horvath & Bedi, 2002; Horvath & Symonds, 2001; Martin, Garske, & Davis, 2000; Wampold & Imel, 2015). However, a complication of these findings relates to the temporal direction of influence (i.e. whether a strong TA precedes positive change or vice versa). Research demonstrating that early symptom change is associated with greater subsequent alliance (Barber, Connolly, Crits-Christoph, Gladis & Siqueland, 2009) supports the notion that the TA is reinforced (or diminished) by symptom change. In addition, some researchers have demonstrated the superiority of specific therapeutic approaches, particularly CBT (Hoffman & Smits, 2008; Siev & Chambless, 2007; Tolins, 2010), concluding that technique is therefore the change mechanism in psychotherapy. However, establishing causality is particularly difficult because the TA cannot easily be demarcated from other aspects of therapy, or experimentally manipulated on ethical grounds, as withholding the TA in therapy would be unethical given the general consensus of its importance for successful outcomes.

Whilst this debate remains, some authors have refused to align themselves to either side and instead focused on how specific techniques interplay with common factors (e.g., Carr, 2008; Budd & Highes, 2009). Boswell et al. (2014) described the debate as a false dichotomy, recognising that these factors must be integrated to maximise effectiveness. Likewise, some authors highlight that a better understanding of common factors is important for gaining a better understanding of the effects of psychotherapies, regardless of whether they account for a larger percentage of the variance in outcome (e.g., McAleasvey & Castonguay, 2015). Therefore, a more pragmatic endeavour would be examining factors which influence outcome, alongside specific treatments. Research has turned its attention to considering factors that support and hinder its development and maintenance of the TA. It is thought that by understanding the processes involved in the alliance, therapists can foster a

strong rapport with clients and augment therapeutic impact (Horvath, Del Re, Fluckiger & Symonds, 2011).

The Therapeutic Alliance in Protocol Driven Therapies

The degree to which relational factors bring about clinical change is arguably one of the key factors that distinguish different approaches. Whilst some psychotherapies posit that the relationship serves as a key mechanism of change (e.g., psychodynamic), relational factors are given limited attention in other approaches in which specific techniques are prioritised (e.g., CBT). EMDR arguably prioritises specific techniques with the main focus on delivering protocols as directed by underlying theory. Protocol driven therapies rely on treatment manuals, developed to support treatment standardisation and minimise therapist deviation.

The inconsistent influence of the alliance in various therapies has led some to suggest that the TA may have differing influence across treatment modalities (Safran & Wallner, 1991; Ulvenes et al., 2012). Authors have expressed reservations about the use of manualised therapies due to a narrow, prescriptive, focus (Westen, Novotny, & Thompson-Brenner, 2004) and neglect of the therapeutic relationship (Addis & Krasnow, 2000; Nelson, Steele & Mize, 2006), given the above research regarding the importance of such factors to clinical outcomes. However, others have found no difference for treatment type or use of disorder-specific manual to the alliance-outcome relationship (Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012). Additionally, the TA appears to remain influential in more protocol driven therapies, (e.g., computerised therapy; Barazzone, Cavanagh & Richards, 2012), suggesting the ongoing influence of the TA in such therapies. Nevertheless, the findings regarding the strength of the relationship between alliance and outcome remains mixed and therefore the research currently offers limited understanding regarding how the TA influences outcomes in protocolised therapies.

Eye Movement Desensitisation Reprocessing

One such heavily protocolised therapy is EMDR; an integrative therapeutic approach developed by Shapiro in the 1980s to treat the symptoms of trauma. The underlying theory guiding EMDR delivery is the Adaptive Information Processing (AIP) model (Shapiro, 2007; Shapiro & Forrest, 2001). The proposed mechanisms of action during EMDR include the assimilation of adaptive information found in other memory networks, linking into the network holding the previously distressing events. Bilateral Stimulation (BLS) is a central technique, which is applied to assist in stimulating the brain's intrinsic processing system, allowing information from other neural networks to link in. A number of meta-analyses

validate the use of EMDR for Post-Traumatic Stress Disorder (PTSD) (Bisson, Ehlers & Matthews, 2007; Bisson, Roberts, Cooper, and Lewis, 2013). It is currently a National Institute for Health and Clinical Excellence (NICE) recommended treatment for PTSD (NICE, 2005). EMDR has also been applied to a wide range of other mental health difficulties, such as depression (Wood & Ricketts, 2013) and anxiety (Gauvreau & Bouchard, 2008; De Jongh & Broeke, 2009). [for an overview of the effectiveness of EMDR, see extended paper section 1.4]

During EMDR, 'interweaves' are offered at the clinician's discretion. These are cognitive, behavioural and sensory strategies to help re-establish safety and/or move processing on when it is deemed to be stuck (going over material without change). A distinction is drawn between 'process interweaves', which keep the client within the 'window of tolerance' (e.g., distancing the client from the memory image) and 'content interweaves', where processing blocks relate to content of cognitions, for example, defectiveness beliefs, and are routinely addressed via purposeful questioning (e.g., how long should you punish yourself for this?) (Shapiro & Forrest, 2001). The eight phases of EMDR are summarised in Table 1.

Table 1

The Eight EMDR Phases

EMDR Phase	Description of Phase
1. **History & Treatment Planning**	Explore client's history and develop a treatment plan.
2. Preparation	Increase coping strategies to manage emotional disturbances during proceeding phases.
3. Assessment	Identify components of the target memory and the intensity of the disturbance. A positive cognition (PC) that the client would like to believe instead is also identified.
4. Desensitisation	The client focuses on the target memory while attending simultaneously to BLS. The therapist only intervenes with interweaves if processing of the target memory becomes stuck.
5. Installation	The focus is on strengthening the PC using BLS whilst the client brings the chosen PC to mind.
6. Body Scan	The client scans their body and reports any sensations, if there is any, BLS are applied until the disturbance clears.
7. Closure	The client returns to equilibrium in order to make the transition to daily life.
8. Re-evaluation	This occurs at the beginning of the next session when the clinician asks the client to re-access the target memory in order to determine if treatment effects have been maintained.

The Therapeutic Alliance in EMDR

The TA has not traditionally been incorporated specifically into the EMDR treatment protocol and therefore is not reflected in EMDR training. Participants in EMDR training have shared the fear that attunement with clients may be negatively impacted when focusing on EMDR procedures and protocols (Dworkin, 2005). Although Shapiro acknowledges the importance of the therapeutic alliance in EMDR treatment (Shapiro & Forrest, 2001), the information-processing mechanisms remain central. The prioritisation of EMDR technique neglects the evidence of the importance of the therapeutic relationship to enable information processing to take place (see; Bohart, 2002). Although authors have made reference to relational matters in their practice of EMDR (e.g., Leeds, 2009; Parnell, 2007), the protocols

still take precedence. The aim in EMDR is to keep the brain of the client in a state of adaptive information processing by staying out of the way as much as possible as directed by the underlying theory. Engagement in EMDR includes knowing when to deviate from the pure protocols. For example when processing becomes stuck, the use of cognitive interweaves is instructed (Shapiro & Forrest, 2001).

The leading author asserting the importance of the relational aspects in EMDR is Dworkin, who advocates for a more collaborative approach to EMDR in which the alliance is given as much focus as the techniques (Dworkin, 2005). For example, Dworkin and Errebo (2010) proposed that EMDR would be strengthened by being conceptualized as both a technique and a relational intervention however, currently these assertions are based on clinical experience rather than empirical investigation. [for further discussion of the TA in EMDR see extended paper, section 1.5] To date, no studies have examined how the TA might be used in EMDR, or how it relates to outcome within that therapy. This research extends the writings by Dworkin in exploring the potential relational imperative in EMDR. Given the evidence that the TA can contribute significantly to clinical outcomes, it is important to explore the TA in newer, protocol driven therapies, such as EMDR. [for further discussion of the clinical relevance of this study, see extended paper section 1.6]

The primary aims of the study were to:

1. Investigate the relationship between the therapeutic alliance and outcome in EMDR for two clients with symptoms of mental health difficulties related to distressing life events.
2. Investigate the fluctuations of the TA throughout EMDR treatment to consider the role it may play in the two therapy cases presented.
3. Explore how the TA is experienced by the client and therapist during EMDR treatment.

Methods and Procedure

A single case design with multiple data sources across two EMDR therapy cases was used.. Given that the TA is a multifaceted phenomenon, such a design allowed for a more in-depth exploration of the complex set of factors related to the TA within EMDR treatment. The qualitative component facilitated a richer understanding of the participants' experiences of the TA and provided more of a narrative framework for interpreting the data. Multiple baseline and process measures were used to track fluctuations in the quality of the TA, client distress, and work and social functioning, throughout the treatment (see measures section). In

addition, the EMDR sessions were video recorded to gather rich data to support measurement of the TA from an observer perspective.

The epistemological position adopted is critical realism. The mixed methods approach reflects the position that human beings continually give meaning to their reality, which helps understand their world and experiences, whilst acknowledging reality exists outside of human conceptualisation. Critical realism acknowledges both individual constructions of experience and also how the wider social context forms those meanings (Willig, 1999). [for further epistemological considerations, see extended paper section 1.7]

Participants

One therapist and two of her clients were recruited from a single community-based mental health service (Improving Access to Psychological Therapies; IAPT) in the UK, creating two therapist-client dyads. The therapist was recruited through email within the targeted service, who subsequently recruited the clients. The therapist was a British female, qualified as a CBT and EMDR practitioner with 10 years' experience of delivering psychotherapy (seven years specifically delivering EMDR). Client one (Lola) was a 63-year-old British female who was retired from full-time employment, with no previous experience of psychological treatment. She attended EMDR therapy for a total of 12 sessions on a weekly basis. Client 2 (Sarah) was a 46-year-old British female in full-time employment, with no previous experiences of psychological treatment. She attended 15 EMDR sessions in total on a weekly basis. Both clients were referred for primary diagnoses of anxiety and depression that reached clinical severity for entry into the service. The clients' difficulties were conceptualised as non-complex trauma resulting in symptoms of anxiety and depression. [for further information regarding the participants see extended paper, section 1.8]

Procedure

The EMDR treatment was conducted within a time-limited IAPT service. The treatment followed standard EMDR procedures with sessions adhering to the manualised eight-phase structure. It was not delivered in an integrative manner to minimise the impact of any variations in the data being reflective of different therapeutic approaches. Each session lasted between 45 minutes and 90 minutes depending on the amount of processing required for the memory targeting and the therapist's use of cognitive interweaves as per EMDR instruction. Lola and Sarah engaged in a number of general assessment sessions followed by EMDR specific assessment sessions with the therapist, as is routine within the service (prior to the start of the video recording of sessions). These sessions are considered preparatory and

are therefore denoted in the results section with the labels of ‘p1’ to ‘p5’ for Lola and ‘p1’ to ‘p7’ for Sarah. Lola and Sarah received a different number of preparatory sessions (five and seven respectively), in line with clinical judgement regarding the amount of assessment required to gather the client’s history and to make a decision regarding the most suitable therapeutic modality i.e. CBT or EMDR.

During the preparation/assessment and the EMDR therapy, in line with routine clinical practice in the target service, the clients completed three separate measures to track their wellbeing (see psychometric measures section for details) at the beginning of each session. Following completion of the EMDR therapy, interviews were conducted with the participants. Each client completed a semi-structured interview lasting approximately 1 hour for the purpose of exploring the clients’ experience of the TA within EMDR. The therapist completed two video-cued recall interviews; one relating to each therapy case. This involved playing video clips from the EMDR therapy sessions, enabling stronger memory recall for the therapist via retrieval cues. Furthermore, watching video clips of sessions during these interviews allowed the therapist to stop and replay episodes of interaction to further explore unspoken, fleeting experiences during the therapy. See Figure 1 for a summary. [for more information regarding the procedure see extended paper, section 1.9]

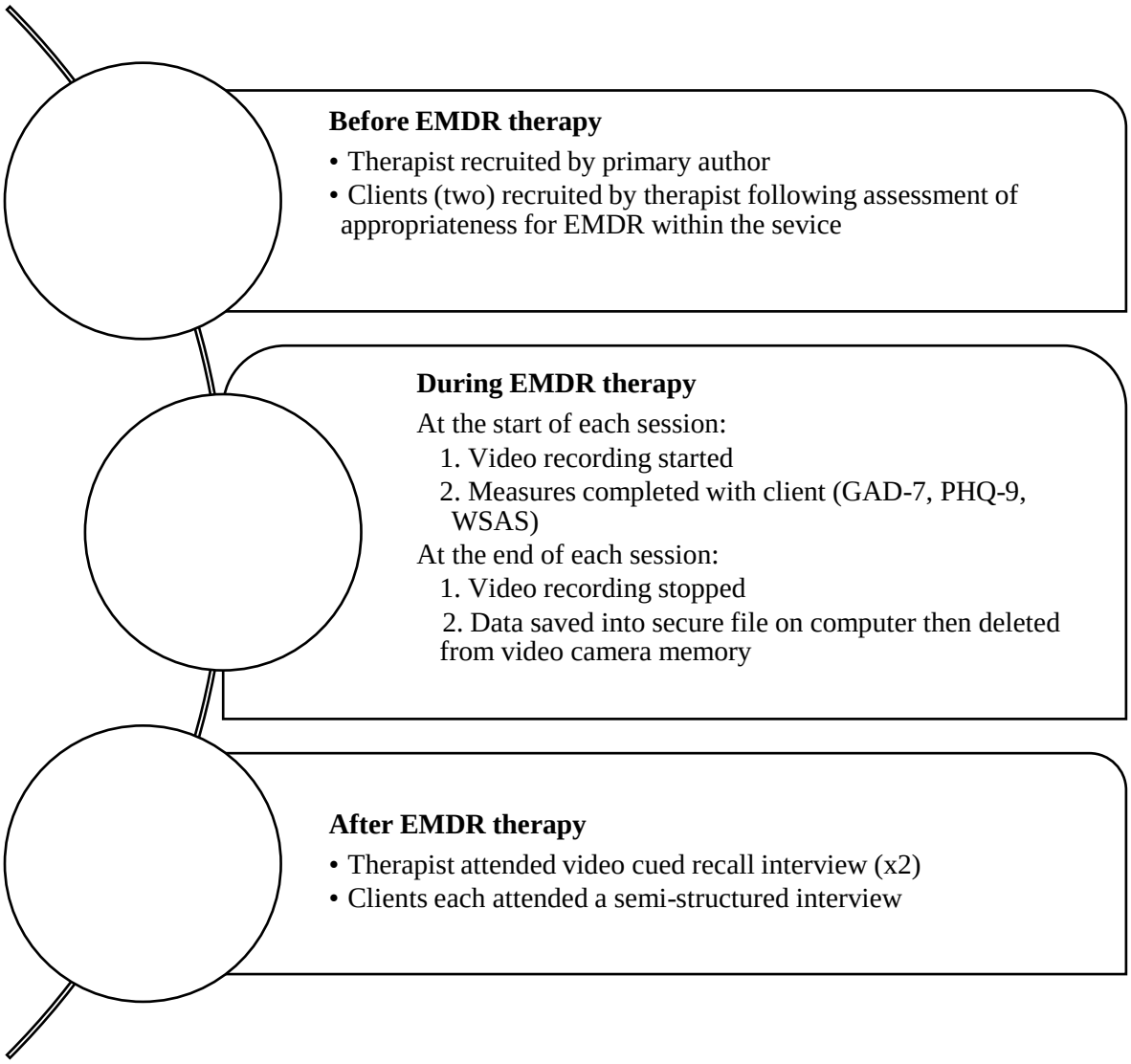

Figure 1. Study Procedure.

Psychometric Measures

Outcome measures.

A number of measures were used during the study. [see extended section 2.0 for further details and critique of the measures used] The clients' levels of distress, and work and social functioning were measured by the therapist at the beginning of each session as is routine practice within the service. This included the Patient Health Questionnaire version nine (PHQ-9; Spitzer, Kroenke, & Williams,1999), the Generalised Anxiety Disorder version seven (GAD-7; Spitzer, Kroenke, Williams & Lowe, 2006) and the Work and Social Adjustment Scale (WSAS; Marks, 1986).

The PHQ-9 is a self-report measure of depression developed by Spitzer et al. (1999). The questionnaire has nine items that are rated for how often the respondent has been

troubled by each item over the last two weeks, for example ‘feeling down, depressed or hopeless’. It is scored on a Likert scale from 0 (not at all) to 3 (nearly every day), with higher scores representing more severe depression, with a possible range of 0 - 27. The psychometric properties have demonstrated good internal consistency (Cronbach’s alpha 0.89) (Kroencke, Spitzer, & Williams, 2001) and test re-test reliability (correlation of 0.84) (Kroencke et al, 2001). It has been widely used within primary mental health services, including to measure fluctuations in depression related to treatment outcome (Löwe, Kroenke, Herzog, & Gräfe, 2004).

The GAD-7 questionnaire was published by Spitzer et al. (2006). It is a seven-item, self-report anxiety questionnaire designed to assess the respondents’ anxiety levels during the previous 2 weeks. Each item, for example ‘feeling nervous, anxious, or on edge’, is rated on a Likert scale from 0 (not at all) to 3 (nearly every day), where higher scores represent more severe anxiety, with a possible range of scores from 0 – 21. The GAD-7 demonstrates high levels of internal consistency (alpha = .98 - .92) and test – retest reliability (r = .83) (Lowe et al., 2008; Spitzer et al., 2006). The GAD-7 has been widely used within primary mental health services, including use as a measurement of fluctuations in anxiety (Dear et al., 2011).

The WSAS was introduced by Marks (1986) and is designed to measure patients’ perceived functional impairments resulting from a given problem (e.g. anxiety and depression). It is a 5 item self-report questionnaire answered on a Likert scale from 0 (not at all) to 8 (very severely), referring to how much the problem has affected the respondent’s ability to carry out the activity, for example ‘Because of my [problem] my ability to work is impaired’. The total scores range from 0 – 40, with higher scores representing greater impairment in work and social adjustment. The WSAS has demonstrated acceptable internal consistency (alpha = .70 - .94) and test-retest reliability (r = .73) (Zahra et al., 2014). It has been used to assess changes in social functioning for patients with anxiety and depression (Zahra et al., 2014).

Process measures.

The video recordings of EMDR sessions were analysed using the Working Alliance Inventory short observer-rated version (WAI–O–S; Tichenor & Hill, 1989; Tracey & Kokotovic, 1989). This is a 12-item observer-rated measure of the quality of the therapeutic alliance with each item rated on a 7-point scale (0 never to 6 always), based on Bordin’s (1979) highly cited tripartite conceptualization of the alliance construct. Higher scores on the WAI represent a stronger alliance whilst lower scores represent momnets when the alliance between therapist and client is considered to be weaker. The WAI is a widely accepted

measurement of the alliance with favourable reliability (Elvins & Green, 2008). Furthermore, it has previously been used to rate recordings of sessions (Startup, Wilding & Startup, 2006) and to track the alliance over the course of therapy (Kivlighan & Shaughnessy, 1995).

In order to capture the pattern and strength of the alliance across therapy, each session was divided into three equal segments, for example a session lasting 60 minutes would be divided into three 20 miunute segments as follows: 0 – 20, 21-40 and 41-60. Each of the segments were then rated individually using the WAI-O-S by the primary author. These are labelled a, b and c in the visual analysis (results section) for each of the video recorded sessions. A random subset (25%) of the segments were independently coded by the second author (Clinical Psychologist), to provide a quality check via Inter-Rater Reliability (IRR), which quantified the degree of agreement between the two coders who made independent ratings of the alliance using the WAI-O-S. Given that the WAI-O-S yields continuous data over a large scoring range (0-84), the Intraclass Correlation Coefficient (ICC) was used to ascertain consistency between the two coders instead of absolute agreement. The larger the magnitude of disagreements, the lower the ICC results.

Interviews

Semi-structured interviews were conducted with each client within a month of therapy termination to maximise recall. The primary author conducted the interviews individually within a private clinical room. An interview schedule was developed by the research team, which involved questions related to the clients' general experience of EMDR followed by specific questions regarding the therapeutic relationship, to capture their experience of the alliance related to the aims of this study (see Figure 2 for the interview schedule).

Semi-Structured Interview Schedule – Clients

1. How did you find the experience of EMDR therapy?

2. What were the most helpful aspects of your therapy?
   - Which sessions stand out
   - Which moments / parts of the session(s) stand out

3. What were the least helpful aspects of your therapy?

4. What was the relationship with your therapist like?

5. Were there any specific moments in therapy which made a difference (positively or negatively) to the relationship with your therapist

6. Was there anything that you didn't like about your therapist or the therapeutic relationship?

7. What did you make of the Bilateral Stimuli (eye movements- part where you follow her finger with your eyes) of the therapy?

   a. Did you notice any changes to the therapeutic relationship with your therapist during this part of the therapy?

Figure 2. Semi-Structured Interview Schedule for Clients.

Two video-cued recall interviews were conducted with the therapist by the primary author (one for each of the therapy cases). During these interviews, lasting between 60 - 90 minutes each, short video clips (range 3 – 7 minutes) from the EMDR sessions were replayed to the therapist, in line with BSR therapist recall instructions (see; Elliott & Shapiro, 1988) This enabled the therapists' unspoken content to be accessed to gain a more in-depth understanding of how the alliance was enacted throughout the therapy (see appendix A for the full instructions). Although both clients initially consented to a video-cued recall interview, they declined to participate at post-therapy and instead consented to a semi-structured interview (described above). All interviews were audio recorded and subsequently transcribed by the primary author. The transcripts were analysed using an inductive and deductive framework analysis (described below).

Analysis

The clients' symptoms (GAD-7, PHQ-9, WSAS) were analysed using the Reliable Change Index (RCI) and Clinically Significant Change (CSC) criteria (Jacobson & Truax, 1991) to evaluate whether reliable change occurred pre, mid and post treatment and if any changes were significant. The pre-therapy scores were taken from the client's intial contact

with the service (point ‘p1’ on Figure 4 and Figure 5). The mid-therapy point was identified for each client by calculating the median of the entire sessions that they engaged in (12 for Lola and 14 for Sarah). The end point for both clients was measurements taken during their last therapeutic session.

For each client, distress and functioning levels (GAD-7, PHQ-9, WSAS scores) were graphed alongside strength of the alliance (WAI-O-S and ARM-5) to enable visual analysis of the data in line with the preferred method of data analysis in single-subject research (Busk & Marascuilo, 1992). The process of visually examining graphical data allowed for interpretation of the level, trend and variability throughout each case of EMDR treatment. This included considering commonalities and differences in TA scores falling below and above the mean within and between the cases. [for further discussion of the analyses used see extended paper, section 2.1]

Framework analysis.

The interviews produced qualitative data regarding the participants’ perception of the alliance during EMDR treatment, which was analysed using a deductive and inductive Framework Analysis (FA; Ritchie & Spencer, 1994). FA was used to reduce and summarise the data in a way that supported answering the research question and draw out explanatory conclusions clustered around pre-determined themes related to the aims of the research. The pre-determined themes (or framework) was developed by the primary author based on an inclusive description of the TA derived from existent literature. This involved reviewing the most common components of the TA within empirical review papers (Ackerman & Hilsenroth, 2003; Elvins & Green, 2008). Therefore, the framework developed was considered to encapsulate the essence of the TA within psychotherapy. Each pre-determined theme within the framework is anchored by descriptions of the components offered in the WAI-O-S to remain consistent with the alliance ratings in this study (see Figure 3 for the framework used). [see extended paper section 2.2 for further description of the FA]

Item / Theme	Therapist enactment	Client enactment
Trust	• Does not interrupt / override client's train of thought • Expresses confidence in client's ability to discuss intimate information	• Openly sharing personal / intimate information • Receptive to therapists' reflections/challenges • Expression of confidence in therapist
Respect	• Completely attends to client's communications • Use of minimal encourages • Verbalisation of respect for what client is trying to do	• Completely attends to therapist's communications • Active participation
Understanding	• insightful and accurate reflections	• answers the therapist's inquiries without much confusion • comment that the therapist truly understands him/her.
Genuine concern	• Direct statements of concern	• Comments about feeling cared for or that the therapist likes her
ADDITIONAL – inductive:		

Figure 3. The Framework used for the Framework Analysis.

Following the interviews, each transcript was read through and all lines relevant to research questions were given a code; some were linked with the existing themes and others were inductive (open and closed coding). Once each transcript was coded, the codes were considered in relation to the pre-determined themes of the framework, whilst considering any emerging unique themes. A matrix was then constructed with a summary of each theme for each participant (see results section), along with quotes from the data which best captured the theme. Further analysis of within and cross-case themes was conducted to consider similarities and differences between therapist and clients, and the two dyads (therapy cases).

Results

Aim 1: Relationship Between the Therapeutic Alliance and Outcome Measures

The RCI and CSC criteria were used to consider clinical outcomes for each case. Both clients demonstrated improvement at post intervention. However, while Sarah's symptoms dropped below clinically significant cut-off by mid-treatment, Lola's symptoms fell below

the cut-off in the second half of the treatment. With regards to depression, Lola had a low score at pre-treatment that increased significantly by mid-treatment. This may be a reflection of Lola having initially gained insight into her distress and revisiting distressing memories within sessions. These symptoms fell below clinical norms by post-treatment. In contrast, Sarah presented with similar symptom levels of anxiety and depression at pre-treatment which declined gradually from pre to post treatment.

The tables below summarise the data for RCI and CSC for each case, displaying the raw scores for each of the measures, followed by the RCI value and whether or not it was clinically significant pre to post treatment, labelled simply as "yes" or "no". [for further information on clinically significant scores see extended paper, section 2.3]

Table 2
Outcome measures, pre, mid and post for Lola.

Measure	Pre	Mid	Post	RCI	CSC
GAD-7	19	13.5	2	3.68	Yes
PHQ-9	3	8.5	1	7.39	No
WSAS	0	5	0	10.78	No

Table 3
Outcome measures, pre, mid and post for Sarah.

Measure	Pre	Mid	Post	RCI	CSC
GAD-7	16	7	0	3.68	Yes
PHQ-9	16	10	0	7.39	Yes
WSAS	18	13	0	10.78	Yes

Inter-Rater Reliability (IRR) was calculated for the observed therapeutic alliance (WAI-O-S), to consider the degree of agreement between the two coders using the Intraclass Correlation Coefficient (ICC) statistic. The average measure was .78 with a 95% confidence interval. According to the literature, this represents a good level of reliability (Koo & Li, 2016). [for further discussion of IRR see extended paper, section 2.4]

Clinical outcomes for each case were compared to the strength of TA via graphical display, see Figure 4 and Figure 5. Visual analysis is the hallmark for interpreting effects of single case designs, offering a clear visual expression from pre to post intervention allowing change over time to be considered as well as identifying particularly salient sessions (Spriggs & Gast, 2010). In this study, clear visuals are presented for each case by graphical representation of the distress and functioning measures plotted alongside the alliance measure. Overall, the alliance has a similar trend and range of scoring within both cases,

representing an overall strong and steady alliance throughout the EMDR intervention. [for more detail of the visual analysis see extended paper, section 2.5]

Aim 2: Exploration of Fluctuations of the Therapeutic Alliance

Each graph was inspected to investigate the direction and degree of trends, the level, and the variability of the data across the intervention to further consider the second aim regarding the fluctuations of the TA across the two therapy cases. This involved considering alliance scores above and below the mean alliance score calculated for each therapy case using the WAI-S-O, as represented in the relevant graphs, labelled 'Average'. The individual items on the WAI-S-O were considered for the scores furthest from the mean line (highest and lowest TA) in each case. The segments in which the highest and lowest alliance scores were rated by the WAI-O-S were reviewed by the principle researcher by re-watching the video recordings of these segments, in order to consider how the TA was being enacted.

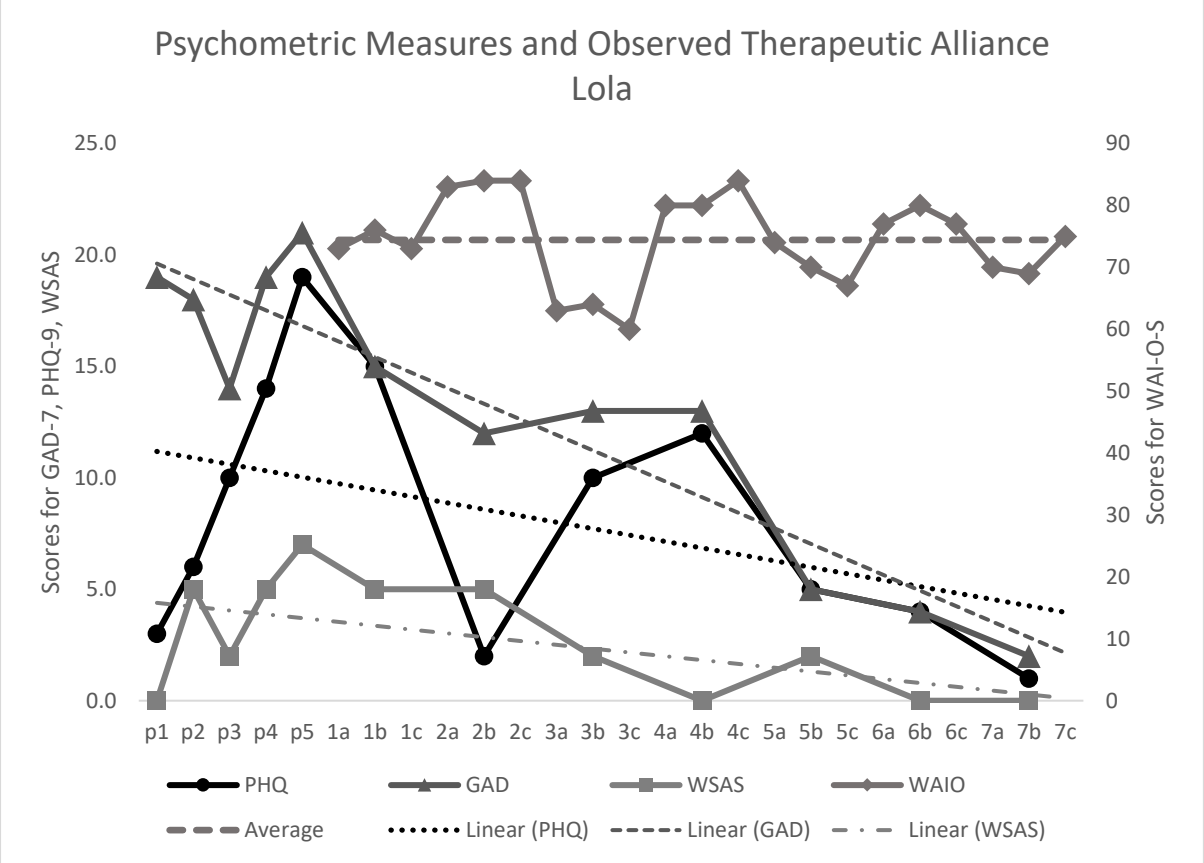

Figure 4. Visual Analysis of Lola's symptoms and TA.

Visual analysis of Lola's results revealed a decline in distress throughout the intervention. Lola's depression scores fluctuate dramatically with a relatively large reduction

in depression at session two, followed by an increase over the following two sessions, before declining until reaching a score of one (within the 'no disturbance' range) at termination of the intervention. Lola's anxiety scores also declined from pre to post treatment however, these follow a more regular trend of decline from the peak at the fifth pre-session (p5) and falling at termination to within the range of 'no disturbance'. Lola's functional abilities as measured by the WSAS are less problematic overall, which can be understood in terms of Lola being retired and therefore not scoring on the items related to work-related difficulties. The alliance during the intervention remained somewhat stable, ranging from the weakest in session three (score of 60) to the peak at 84 in session four representing the strongest alliance. TA scores falling below the mean for Lola reflected segments where the items on the WAI-O-S regarding agreement on goals/tasks were not relevant or not scored highly. Furthermore, these segments reflected a reduced scoring in efficiency of the therapy, for example in one of the segments falling below the mean, the therapist appeared to be attempting to move conversation forwards with some resistance. At other times, efficiency score reduced due to conversations unrelated to the direct goals in the segment. The highest scoring segments for Lola involved a "eureka moment" which is described by the client in interview as a breakthrough in understanding her difficulties.

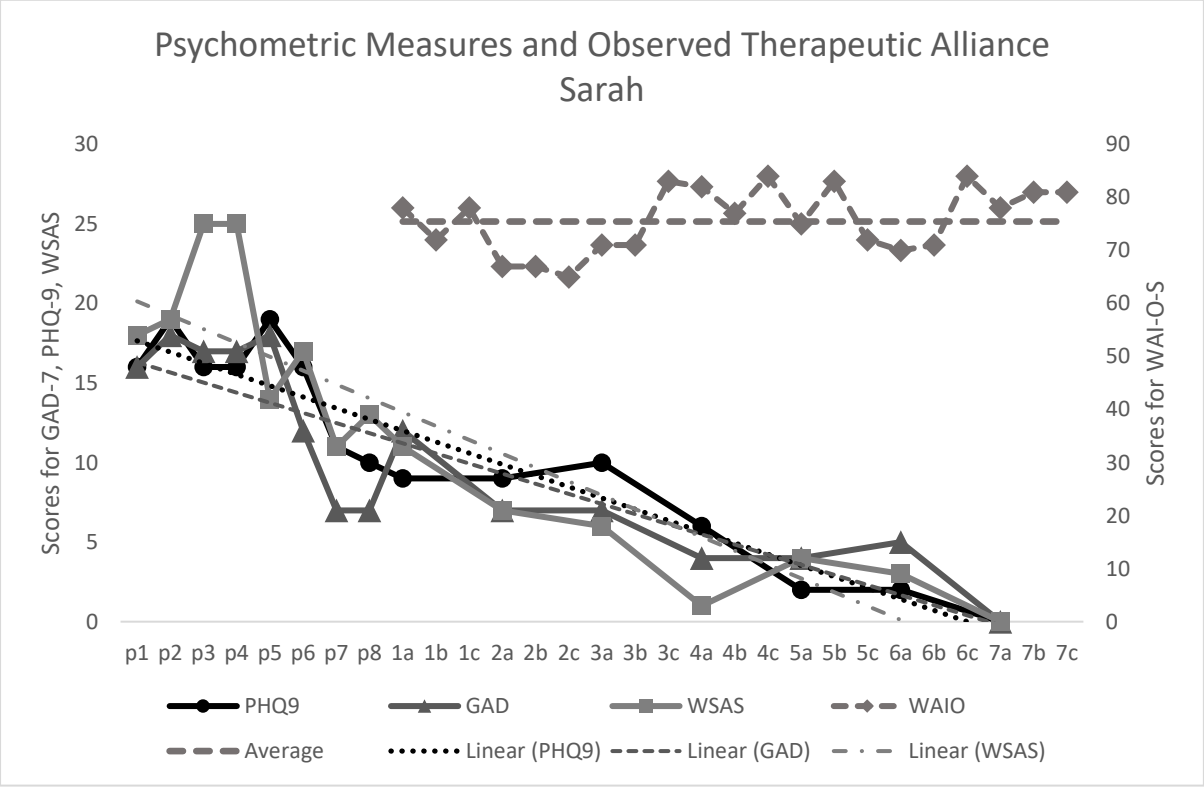

Figure 5. Visual Analysis of Sarah's symptoms and TA.

Visual analysis of Sarah's results shows a steady decline in all of the weekly measures, demonstrating a decrease in distress alongside increased functioning in her work and social life. All scores are zero at post-treatment indicating no disturbance. The alliance remains stable with some mild fluctuations. The weakest alliance occurs in session two (score of 65) and strongest alliance occurs in sessions four and six (score of 84). The TA scores falling below the mean for Sarah predominantly indicated reduced scoring in areas of understanding between client and therapist, an increased level of discomfort between them, and less efficiency of the therapy within the segments observed. Similar to Lola, the items regarding agreement on goals/tasks scored lower at these times however, the scores suggested that this activity was not relevant at this point in therapy. The higher scoring segments involved more in-depth explanations which appeared to increase understanding between therapist and client, and moments of new insight during the processing work.

The qualitative interview data supports the understanding of the fluctuations identified. The understanding of particular moments within the sessions for Sarah appeared to be related to fluctuations in the TA. Sarah reported some initial scepticism about the EMDR rationale and methods, whereas Lola reported being trusting and enthusiastic from the start. This enthusiasm may account for some of the moments of reduced TA strength in terms of efficiency of the therapy slowing down as focus on a particular task may have reduced.

Aim 3: Client and Therapist Perspectives of the Therapeutic Alliance

The FA explored how the TA was experienced by the clients and the therapist during EMDR and supported how and why fluctuations in the TA occurred. Table 4 displays the FA (matrix) representing the therapist's perspectives of the TA for each of the cases, whilst Table 5 displays the framework analysis (matrix) representing Lola's and Sarah's perspectives of the TA. Each table includes an overall summary of the theme related to the individual participant, followed by a quote from the raw data considered by the primary researcher most representative. Following on from this, interpretation of the themes is offered alongside narrative interweaves from the qualitative data that related to the phenomena of interest taken from the interviews to expand on the FA. [for further elaboration of qualitative results see extended paper, section 2.6]

Table 4

Therapist's perspective of the alliance.

	Theme 1: Trust	Theme 2: Respect	Theme 3: Understanding	Theme 4: Genuine Concern
Case 1 Lola	Trust from the start, which increased as client sees positive change in therapy. "I think she's always trusted me but I think it's kind of becoming more like, oh there's things are changing so maybe her trust is getting deeper"	Paying attention to body language to monitor progress and check client's wellbeing. "….and not judge her and not come out looking like I was judging her".	Increased understanding during the therapy. "I think she's much more aware of what this therapy's about probably a lot more understanding...it' s more intuitive with each other"	Wanting to help the client heal and putting herself in the client's shoes to help with this. "I think I was worried about her not being able to put herself in her safe place"
Case 2 Sarah	A building up of trust from some initial guardedness, to increased trust when client sees positive effects of therapy. "I felt like she was beginning to trust….and you know I think that was really helpful". "I mean she was a bit cautious but I think her trust built up as the session went on"	Continually considering what's going through the client's mind in the moment. "not give her false promises that it works for everybody...I think that made her feel important and to be felt heard and felt listened to and not dismissed"	Increased understanding during the therapy enabled an easier, more relaxed relationship. "I think I had to help her to make the connections in the first one" "I think it's nice for (client) to know the theory about it and not just do it and not explain it".	Ensuring that the client feels important and treated as an individual "I think I always try and...remember things about them I think that's really important "

Table 5

Clients' perspective of the alliance

Client	Theme 1: Trust	Theme 2: Respect	Theme 3: Understanding	Theme 4: Genuine Concern
Lola	Feeling safe to disclose intimate information and express distress. "I think it's that thing isn't it, it's 'I feel your pain I'm feeling your sorrow but we're guna get through it'….that's the kind of confidence you got in her".	Strong confidence that the therapist had the capabilities to help. "she made me feel that we could work on it and we could probably find a solution". "you know that's that's the kind of confidence you got in her that she could work through that with you"	Feeling understood via accurate reflections from the therapist. "I never went out once and said well I don't know where it's going". "(therapist) had picked up that I didn't feel a good person".	Warm, kindness and care regularly communicated by the therapist. "even like after the sessions she would, you know I would talk about how cruel people have been with me….and then (therapist) would relay back to me things that people have said to her".
Sarah	Perceiving the therapist as open and capable of managing any disclosure. "she truly makes you feel at ease" "I felt I could say anything to her…I didn't feel as though I had to keep anything back"	Belief in the therapist's knowledge and capabilities from the start, with a non-judgemental stance. "you didn't feel as though she was judging you" "she would never let you go (end the session) until you felt ok"	Increasing understanding about the therapist's approach during the therapy. "you think yeh I can see what she's actually doing there"	Feeling cared for and that the therapist genuinely was interested in helping, beyond her job role, from the start. "she's just a lovely genuine person and you can tell she cares…..you can just see that she really wants to help you and she genuinely cares".

The FA revealed that Lola perceived strong trust with the therapist from the very beginning. Additionally, Lola described her attendance of the EMDR therapy as highly motivated, based on beliefs regarding the privilege of receiving healthcare and consequently being grateful for the therapeutic input. This attitude is likely to have supported enthusiastic engagement within the sessions, including an openness and acceptance of the therapist from the start. When asked specifically about the therapeutic relationship, Lola stated "(Therapist) has the techniques but I don't think those techniques probably would have been erm so useful or so strong had it not been for the relationship". In contrast, Sarah reflected on having had some initial doubts about how EMDR therapy would work to reduce her symptoms and was somewhat more guarded within her interactions, describing her trust as growing stronger throughout the therapy. The therapist also commented on Sarah's initial guardedness and wondered whether this impacted on Sarah's experience of the therapy, in particular describing having to pay more attention to the relationship rather than protocols at the beginning of the therapy with Sarah.

The usefulness of the therapist being adaptable, or flexible, was commented on as a positive from both the clients' perspectives during the interviews. In particular, the therapist's adaptability towards the timing of sessions and the way in which the EMDR phases were facilitated helped build trust and a sense of genuine care within the therapeutic relationship. Furthermore, genuine care was facilitated by the therapist via the use of self-disclosure and a strong belief in the therapist's ability to reduce their difficulties. This was conceptualised by the clients as an informal style. Interestingly, when moving to the 'ships in the night' position (sitting side by side facing the opposite direction; Shapiro, 2001) to begin BLS, the clients considered the therapist's style to become more formal, but were clear that this did not reduce the strength of the alliance. This appeared to be linked to a clear understanding between therapist and client about the goals and tasks of the therapy, developed during preparation phases for the desensitisation. Furthermore, the subtle shift to a more formal therapy style was considered by the clients to remain a warm, open, and supportive approach, with the therapist adapting the length and content of interweaves between sets of BLS.

The moments of therapy reviewed during the BSR interview with the therapist were found to correspond to the lower scoring and higher scoring alliance segments as measured by the WAI-O-S (as oppose to the median alliance score). Therefore, the therapist discussed those moments in which she appeared to have a strong alliance and moments when she had a relatively weak alliance during the EMDR therapy.

The therapist described her enthusiasm and belief in EMDR, commenting that she believes in it "100 percent" during interview. The therapist also highlighted that she held the clients in mind outside the therapy room, thinking about how Lola and Sarah's symptoms can be ameliorated by EMDR. This linked to the therapist's belief that having such an in-depth understanding about her clients enables her to remain adaptable to incorporating new information, for example making changes to the positive cognition and offering varied interweaves to aid clients' processing. Additionally, the therapist described having a positive view of self-disclosure with the clients, in an attempt to develop a genuine relationship based on the mutual sharing of life experiences. Relatedly, the therapist spoke about remembering detailed information shared by the clients to express her respect toward her clients by treating them as "individuals".

Discussion

This study used a single-case design with multiple baselines to investigate the role of the TA in treating anxiety and depression symptoms using EMDR in an IAPT service. Although previous studies investigating EMDR processes have used single-case design (e.g., Gauvreau & Bouchard, 2008), this is the first research study examining the TA during EMDR. The three aims of this study were to firstly investigate the relationship between the TA and clinical outcomes, secondly to investigate the fluctuations of the TA during EMDR, and finally to explore how the TA is experienced by client and therapist.

Aim 1: Relationship of TA to Outcome

Consistent with literature, a strong alliance was present within two successful outcomes cases; the WAI-O revealed a strong alliance throughout both of the therapy cases in which clients reached non-clinical levels post-treatment as measured by the GAD-7, PHQ-9 and WSAS. This appears to support the common factors argument and in particular, previous findings that the alliance is a component commonly found within positive therapeutic outcome cases (Martin et al., 2000; Wampold & Imel, 2015). Nonetheless, this study is unable to demonstrate causality and therefore the strong alliance in this study may be reflective of an unknown third factor variable that may explain both alliance and outcome variance. Positive outcomes may precede a strong alliance and therefore the TA may be secondary to outcomes. Some researchers propose that prior symptom change accounts for positive alliance (Barber et al., 2009). This suggests that, should the TA be related to symptom improvement in Lola's and Sarah's case, then symptom improvement may have been a priori for the positive alliance observed. However, the opposite has also been reported

with early alliance accounting for positive outcomes in other studies (Weiss, Kivity & Huppert, 2014). The consistently strong alliance seen for both EMDR cases here, including moments when clients' symptoms were within clinical levels (higher), suggests that the alliance is not solely a secondary factor to symptom improvement, although, this study can only speculate about the potential existence of a connection between the TA and outcomes. Nonetheless, the qualitative data highlighted the importance of the alliance for the clients, particularly Lola, who stated "I don't think those techniques probably would have been erm so useful or so strong had it not been for the relationship".

Some authors have shown a reciprocal causation in which both symptom improvement and alliance influence each other to produce symptomatic changes (Falkenström, Granström, & Holmqvist, 2013). Unfortunately, early alliance ratings were unavailable in this study, limiting the information regarding the direction of any potential influence of the alliance as measured in these two cases. This could be teased apart further in process research with a larger data set to enable time-series analysis such as simulation modelling to understand the direction of this interaction. Additionally, to further explore the reciprocal influence of alliance on outcomes in EMDR, future studies could investigate the TA in poor EMDR outcomes. [for further discussion see extended paper, section 2.7]

The strength of the TA evident in this study suggests that the successful amelioration of symptoms in EMDR may be based on more than the underlying theory suggests. Although Shapiro recognised the importance of the TA for delivering EMDR (Shapiro & Forrest, 2001), the AIP model prioritises information processing as the change mechanism. The focus on the AIP model in most writings on EMDR emphasises fidelity to the protocols; in fact, Van der Kolk (2002) speculated that positive results are possible with EMDR even in the absence of a therapeutic relationship. The information from these two therapy cases highlight that the TA may be an influencing factor above what is currently acknowledged within the EMDR literature. However, whilst this study was conducted in a structured, time-limited service (IAPT) and fidelity to the EMDR model can be expected, no assessment of fidelity was conducted. Therefore, results may reflect unexplored deviations from EMDR protocols. Similar to concerns regarding EMDR (Dworkin, 2005), professionals have raised concerns about the potential lack of a therapeutic relationship in online and self-help therapies (e.g., MacLeod, Martinez, & Williams, 2009; MacNeil, Hasty, Evans, Redlich, & Berk, 2009). In particular, MacNeil et al. (2009) noted that generic, standardized, internet-based interventions, run counter to developing a therapeutic alliance. Similarly, Leahy (2008) warned against the manualisation of techniques and protocols for therapy such as CBT self-

help, at the expense of the therapeutic relationship. Evidence that such programmes are improved by therapist support (instead of purely self-help) suggests the ongoing importance of the TA in these structured therapies (Palmqvist, Calbring, & Andersson, 2007). However, others have suggested that the alliance is not a requisite in such treatments. (Ormrod, Kennedy, Scott & Cavangh, 2010). [for further discussion see extended paper, section 2.8] Whilst evidence regarding the overall impact of alliance on treatment outcomes is extensive, the exact nature of this relationship remains less clear. As a result, researchers (e.g., Kivlighan & Shaughnessy, 2000) have increasingly turned their attention to determining how the alliance functions to better understand its influence.

Aim 2: Fluctuations in the TA

There is broad consensus within practice and research that fluctuations in the TA are unavoidable and the repair of ruptures arising may form an important change process (e.g., Bordin, 1994; Horvath & Luborsky,1993; Safran & Muran, 2000). The fluctuations in the TA were explored in this study using visual analysis to consider the pattern of the TA within and between each of the cases. Although the TA remained relatively stable throughout both cases (limiting opportunities for in-depth exploration), the fluctuations present were examined via analysis of fluctuations above and below the mean WAI-O-S scores.

Several distinct patterns of alliance development over the course of treatment have previously been identified, including a stable pattern[1] (Eaton, Abeles, & Gutfreund, 1988), a linear pattern[2] (Kivlighan & Shaughnessy, 1995), and a curvilinear/ U-shaped pattern[3] (Golden & Robins, 1990; Horvath & Marx, 1990). The results of this study appear to reflect a stable pattern in which the TA remains strong throughout the intervention. However, previous findings remain inconsistent and the significance of particular patterns to psychotherapy outcomes remains unclear. Furthermore, research is more likely to yield clinically relevant information by focusing on factors that cause particular dyads to develop and maintain a strong alliance rather than global patterns. [for further details see extended paper, section 2.9]

The small amount of within-patient variation in the alliance scores found in this study could reflect a true lack of within-patient variability in the alliance or the insensitivity measurement of the TA (WAI-O-S) in capturing fluctuations.Although the observed fluctuations in this study were not analysed specifically for ruptures or repture repairs, the WAI-O-S scores falling furtherest below (lowest alliance scores) and above (highest alliance

[1] A constant strength of alliance throughout the treatment.
[2] A gradual increase or decrease in the alliance throughout treatment
[3] The alliance begins strong, weakens in the middle of treatment and becomes stronger again at the end

scores) the 'Average' line were considered. Ruptures are defined as tension or breakdown in the relationship between client and therapist and are often divided into 'withdrawal markers' and 'confrontation markers' (Safran & Muran, 2006). The weaker alliance scores in this study predominantly represented moments of reduced understanding between client and therapist, reduced efficiency of the therapeutic process, and lack of agreement on goals for both cases. Therefore, these moments may represent 'withdrawal markers' in which clients are thought to disengage from the therapist and/or disengage in some aspect of the therapy. The alliance scores then rise relatively quickly (within a session), perhaps reflecting repair of the alliance. Research has demonstrated the importance of repairing alliance ruptures, to minimise their negative impact on clinical outcomes (Safran & Muran, 2006). The qualitative data suggest that the therapist was attuned to such moments. The theme of 'Respect' for the therapist was summed up by ongoing consideration of the clients' body language and identifying their point of view. This is likely to enable the therapist to remain flexible in her approach, to attend to any ruptures and repair them. This is further supported by the clients' view of the therapist as being flexible, which related to themes of trust and genuineness.

The strongest alliance (as measured by the WAI-O-S) in both cases occurred during new or powerful moments of insight. This seems to fit with literature on sudden gains (large between session symptom improvements) in which the TA has been observed to improve in sessions following a sudden gain (Tang & DeRubeis, 1999). Sudden gains have been linked to successful therapeutic outcomes, particularly in other protocol driven therapies, such as CBT for depression (Hardy et al., 2005; Lutz et al., 2012; Tang, DeRubeis, Beberman, & Pham, 2005) and anxiety (Hofmann, Schulz, Meuret, Moscovitch, & Suvak, 2006). Hardy et al. (2005) confirmed Tang and DeRubeis (1999) findings along with a more recent study concluding that sudden gains have a significant impact on recovery rates (Wucherpfennig, Rubel, Hollon, & Lutz, 2017). Despite repeated evidence within CBT, research on sudden gains in EMDR is currently lacking. Investigating sudden gains in EMDR could offer further understanding of the mechanisms underlying change during EMDR. Whilst potential moments of sudden gain have been speculated on in these two cases, a future study may focus on particular moments using pre-established criteria for identifying sudden gains alongside TA fluctuations. [for further discussion of sudden gains in psychotherapy see extended paper, section 3.0]

Researchers have also considered therapist and client characteristics that may contribute to alliance quality. Previous research suggests that both therapists (Kazdin et al, 1997), and clients (Johansson & Eklund, 2003) consider the TA as a key determinant of

treatment success. In this study, the therapist was described by both clients as having many attributes that have been identified in the literature as favourable for developing and maintaining TA, for example a warm interpersonal style (Ackerman & Hilsenroth, 2003; Hersoug, Hoglend, Monsen, & Havik, 2001), empathy and respect (Ackerman & Hilsenroth, 2003; Angus & Kagan, 2007; Hilsenroth & Cromer, 2007). Additionally, the importance of client safety before beginning major EMDR work has been noted (Marich, 2010). This was a common theme within this study; the FA revealed that safety was considered vital by both clients and the therapist.

Therapists who consistently form better alliances with their clients generally achieve better outcomes (Baldwin et al., 2007). Given that the therapist is likely to make therapeutic decisions related to their evaluation of the alliance during therapy sessions, the therapist is likely to have influenced the TA and overall successful outcome in the two cases presented here. Despite this, conclusions are offered with caution given the sample of only one therapist; future research would benefit from recruiting a number of therapists and assessing the relevant variables. Furthermore, the alliance-outcome correlation may be due to client characteristics. Studies have shown that patients with secure attachment histories or more adaptive attachment styles report better alliances with their therapists (e.g., Mallinckrodt, Coble, & Gantt, 1995). The client characteristics were not explored in-depth here, limiting conclusions regarding the potential influence of the clients' attributes on TA. [for further consideration of client and therapist characteristic on the TA see extended paper, section 3.1]

Aim 3: Participants' Perspectives on the TA

The importance of therapists' ability to influence the quality of the TA is considered in studies exploring therapists' experience of the TA. The therapist has opportunities to notice and repair ruptures to enhance psychotherapeutic outcome; either via improving the outcome directly (common factors argument) or by enabling the client to engage in specific techniques. The evidence from the FA is consistent with previous research that clinicians (Kazdin et al., 1997) and clients (Johansson & Eklund, 2003) view the therapeutic relationship as a key determinant of treatment success. When examining the theme of safety several qualities of a good EMDR therapist are identified including the ability to empower clients, flexibility (regarding EMDR protocols) and a commitment to demonstrating care (Marich, 2012). These are mirrored in this study, in which safety is given high importance and supported by the therapist's ability to remain flexible as well as demonstrations of deep care. For example, Sarah stated "you can just see that she really wants to help you and she

genuinely cares", which mirrors quotes from clients in Marich's study, "I did not seem just like a number" (2012 p.412).

Additionally, the FA reveals similar data to a recent study exploring clients' perspective of the TA; clients in the study by Noyce and Simpson (2016) described their desire for a therapist to have good clinical knowledge, perceiving young therapists as less effective in therapy. The similarity in age may have aided the trust that appeared to develop readily in both cases, however this was never explicitly acknowledged by the participants but the therapist's knowledge base was considered important for developing trust.

The therapist FA revealed great belief in EMDR. This may help to explain the strong TA and positive outcomes, given findings that therapist's allegiance to a particular intervention is highly predictive of efficacy. Wampold (2001) found this effect is substantially larger than any other effect that has so far been isolated in RCTs, and clinically this finding implies that therapies are likely to be less effective if administered by a therapist who is not convinced of the value of that therapy. This runs counter to the argument that technique is the only change mechanism in psychotherapies (Chambless & Hollon, 1998; Chambless & Ollindick, 2001).

The narrative surrounding specific therapies guides governing of which training programmes are promoted and accredited and how research is regarded. The primary strategy for quality improvement in mental health today is to implement Empirically Supported Treatments (ESTs) in clinical practice (McHugh & Barlow, 2012), which draw heavily on RCTs. EMDR has achieved this status and is recommended by NICE (NICE, 2005). Whilst this approach may be seen to improve accountability given its rigour, the prioritisation of this evidence can be seen to have minimised Practice Based Evidence (PBE). PBE looks to the practice of therapies in real-world settings, drawing on more varied types of research The EST approach proposes that psychotherapeutic treatments contain specific techniques that reduce symptoms of a given mental disorder. The TA has strong PBE but is neglected within the EMDR literature. EMDR literature and training currently provide little detail about the formation of safe, trusting, therapeutic relationships (Dworkin & Errebo, 2010). This study, along with growing interest in the relational aspects of EMDR, promotes the significance of considering EMDR as both a protocol driven and relational psychotherapy. [for further consideration of clinical implications see extended paper, section 3.2]

Conclusion

A single case design investigating the TA in EMDR was conducted within routine clinical practice. The findings that a strong TA was present alongside positive outcomes in

two cases of EMDR treatment suggests the existence of relationship variables within a predominantly protocolised therapy. Whilst the underlying theory (AIP) of EMDR proposes that the techniques utilised act as the mechanisms of change, relational factors can be considered to interplay with the techniques in promoting positive outcomes. The quantitative data presented is further supported by the qualitative data in which the TA was a highly valued aspect by therapist and clients in both cases. Whilst this study is limited by generalisability given the small sample size and correlational design, it draws researchers' and clinicians' attention to the paucity of information guiding the practice of EMDR in terms of the relational imperative. Therefore, EMDR theory and practice may benefit from considering the therapy as both technical and relational to maximise outcomes. [for additional discussion of limitations and future research see extended paper, section 3.3]

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Extended Paper

Extended Background Section

Section 1.1: The Dodo Bird Verdict

In 1936, Saul Rosenzweig published an article that stimulated the conversation about common factors within psychotherapy. The idea that all psychotherapies are equally effective became known as the 'Dodo bird verdict' or 'conclusion'. This referred to a scene from Alice's Adventures in Wonderland in which the Dodo bird announces, "Everybody has won and all must have prizes" (Carroll, 1865), quoted by Rosenzweig in his 1936 article. Only in the 1970s did this become a prominent conversation within the literature as research methods evolved to enable large comparative studies to be conducted.

The first of such studies in 1975 by Luborsky, Singer and Luborsky has since been supported by large meta-analyses (e.g., Smith, Glass & Miller, 1980). These findings were further supported in a rigorous meta-analysis in which only 'bona fide' psychotherapies[4] were included to minimise inflated effect sizes (Wampold et al., 1997). Wampold et al. (1997) proposed that if the Dodo bird verdict is false (specific features produce treatment outcomes), then comparison studies should yield large effect sizes. If there are truly no differences, then the effect sizes will be near zero and the Dodo bird verdict can be considered true, demonstrated in figure 6.

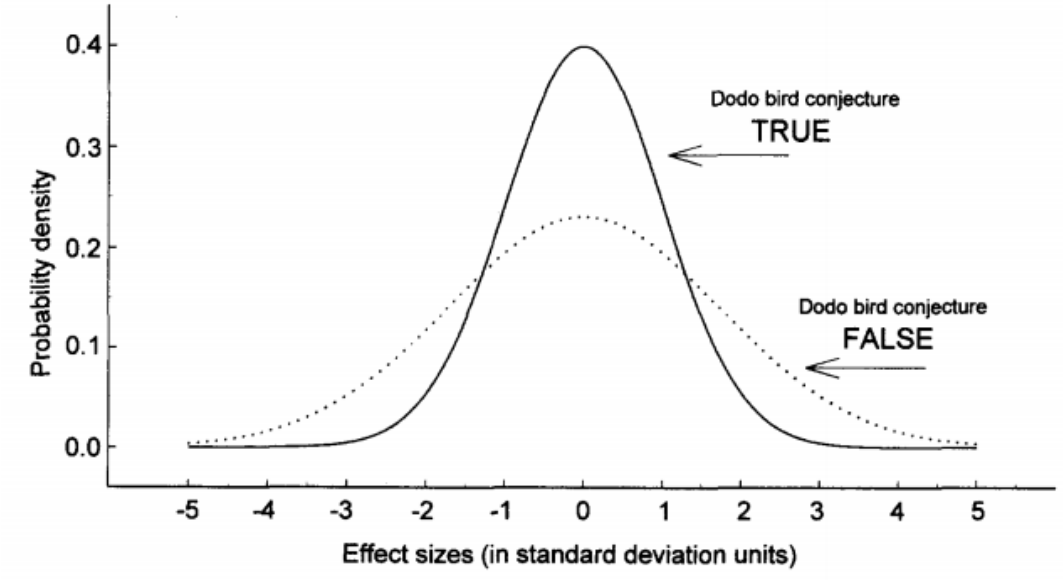

Figure 6. Dodo Bird Effect Size Predictions (from Wampold et al., 1997).

[4] Those demonstrating efficacy in the literature.

These results have been further supported by Luborsky et al. (2002). However, this meta-analysis has been questioned for including poor quality primary studies. For example, in some cases, psychotherapy was compared to pharmacology and therefore cannot inform us about equivalence of different psychotherapies (Chambless, 2002). Furthermore, Chambless (2002) raised concerns about the interpretation of effect sizes and overgeneralisation from a limited population. Nonetheless, Luborksy et al. (2002) make the limitations of their findings explicit in their conclusion. Another criticism aimed at such meta-analyses relates to assumptions of homogeneity; although collapsing treatments can be justified when they share the same underlying theory such as Cognitive Therapy (CT) and Cognitive Behavioural Therapy (CBT), Luborsky et al. (2002) combined a number of divergent treatments (e.g., humanistic, psychodynamic, systemic) with differing underlying theories. Despite the questions raised by some authors, Wampold et al. (2017) continue to advocate for the Dodo bird verdict, stating that, "Evidence for the superiority of CBT is weak and problematic…" (p. 14). They base this on what they describe as, 'Errors in interpretation' of the results from studies demonstrating superiority of CBT, alongside methodological flaws and investigator biases (some of which are explored below).

The finding of equivalence can be thought of as particularly undermining for therapeutic models that prescribe specific techniques based on underlying psychological processes believed to underpin specific mental health conditions. For example, CBT theorises that maladaptive cognitions are responsible for depression and considers the technique of 'cognitive restructuring' as the change mechanism for ameliorating symptoms of depression (Beck, 1987; 1995). This contrasts with therapeutic models with a relational focus (e.g., psychodynamic), which operate on the assumption that the relationship is the change mechanism (Gabbard, 1994; Gabbard & Westen, 2003). The common factors conclusion does not offer a challenge for the therapies which theorise the relationship is a key change mechanism, but does offer a challenge for those with the emphasis on specific techniques. This could partly account for the surge in comparative studies attempting to demonstrate superiority of a particular model and confirm the underlying assumptions regarding the development and remediation of mental health symptoms.

Empirically supported treatments.

In the mid-1990s, researchers began to focus on investigating the efficacy of psychotherapy in terms of Empirically Supported Treatments (ESTs) for particular problems, emphasising Randomized Control Trials (RCTs) as the 'gold standard' of empirical support for a treatment. In 1995, the American Psychological Association's (APA) Division 12

(clinical psychology) formed a task force that developed lists of ESTs for particular problems such as agoraphobia, generalized anxiety disorder, obsessive–compulsive disorder, panic disorder and so on (Chambless et al., 1998). The APA's review was part of a wider movement that arose in the United Kingdom (UK) the drivers for which were outlined by Chambless and Ollendick (2001) as follows:

1. Patient care can be enhanced by acquisition and use of up-to-date empirical knowledge.
2. The difficulties for practicing clinicians in keeping up with newly emerging research findings.
3. If clinicians struggle to keep up-to-date then their knowledge and clinical performance will deteriorate over the years after their training and therefore;
4. Clinicians need summaries of evidence provided by expert reviews and instructions on how to access this information during their routine practice.

The UK published its review of the psychotherapy literature in 1996; 'What Works for Whom' (Roth & Fonagy, 1996). In line with many organisations that have adopted policies that encourage the use of ESTs as first-line treatment options (McHugh & Barlow, 2010), the National Institute of Health and Care Excellence (NICE) recommend psychological treatments within the UK based on such reviews. Currently, CBT is recommended as the first line psychological therapy for anxiety (NICE, 2011) and depression (NICE, 2016) (along with Interpersonal Therapy (IPT)).

There have been criticisms of the reviews attempting to establish ESTs. For example, some have argued that the search for ESTs will restrict practice to a limited number of treatments, therefore, impeding flexibility and clinical innovation (Elliott, 1998). Other authors have questioned the use of diagnostic systems to identify discrete samples within the studies being reviewed (e.g., Henry 1998). This is based on concerns about the validity of diagnostic systems due to overlapping symptoms, the somewhat arbitrary boundary drawn between mental disorder and normality, and the failure to consider the broader context of people's lives. However, some method for describing clients is beneficial to enable clinicians to evaluate the likelihood of generalisation from research samples to clinical practice. Without some categorisation, synthesis of evidence is extremely difficult.

Similarly, some authors have highlighted that unlike for some physical health conditions and treatments, diagnosis and treatment type as independent variables cannot be adequately controlled or operationalised in mental health conditions with large heterogeneity, even within the same diagnostic category. This is acknowledged by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V: APA, 2013) with the

introduction of dimensional assessments to capture the full range of symptoms and severity of a particular diagnosis for individuals. Therefore, meta-analyses of primary RCT studies in psychotherapy research should be interpreted with caution as they may not be capable of successfully partitioning any possible treatment-specific variance in outcome. Thus, the repeated failure to find any clear evidence that any one type of therapy is superior to any other, for any given diagnosis (e.g., Baardseth et al., 2013; Benish et al., 2008), may be a direct consequence of the fact that key assumptions underpinning RCTs, namely that the experimental manipulations are clearly definable and operationalise-able, do not apply to psychological therapy.

These reviews have generally not attempted to determine which treatments are not efficacious. This relates to a more general critique of psychological literature, commonly known as publication bias (see; Song et al., 2010). This refers to the fact that only successful outcome studies tend to be published with those demonstrating no, or harmful effects of psychotherapy, either not being submitted for publication or not being accepted. Therefore, reviews of primary studies may be skewed and unable to gather a holistic view of the effectiveness of psychotherapies.

Another argument against the dissemination of ESTs is a lack of evidence that such treatments are beneficial when applied in clinical settings (Rothwell, 2005). For example, community mental health services such as the IAPT service used in this study. This relates to research with high internal versus high external validity. RCTs, which are considered the gold standard (McGovern, 2001), often have commendable internal validity as they control for a number of variables. However, the settings in which they are conducted tend not to replicate true clinical settings and, as such, lack external validity (Rothwell, 2005). Without establishing external validity, the outcomes may be very different in true therapy settings (Westen & Morrison, 2001). Therefore, effectiveness research is needed alongside efficacy research.

Cognitive behavioural therapy.

CBT has demonstrated efficacy for adults with depression and anxiety in the above-mentioned reviews (Chambless & Ollendick, 2001). Specific questions have been raised regarding the seeming superiority of CBT. As this model of psychotherapy has been researched with RCTs more frequently than any other forms of psychotherapy, there may be an unfair advantage to CBT in demonstrating efficacy over other therapies (Bohart, O'Hara & Leitner, 1998). CBT involves the delivery of observable, structured, techniques in contrast to other less directive therapies, such as psychodynamic, and therefore fits with RCTs much

more comfortably. A further consideration when assessing the outcome literature is how 'outcome' is defined. The surge of CBT therapies established a pervasive tradition of conceptualising treatment outcome in terms of symptom reduction. Whilst this remains an important change criterion, it can be argued that symptom reduction is not the only salient result of treatment. Sceptics may even argue that there are large financial gains at stake here, alongside reputational concerns for authors on either side. The financial gains may be more obvious with those supporting the specific factors argument who can make money from developing specific therapies with discriminate techniques and selling their manualised treatments, such as CBT and EMDR. Despite the reviews finding particular models superior for particular diagnoses (see; Chambless & Ollendick, 2001) and the related critiques of these findings, proponents of the common factors conclusion (e.g., Wampold et al., 1997) consider the search for ESTs as a meaningless quest given the repeated findings of equivalence of psychotherapies.

The findings of equivalence have been interpreted by the proponents of the common factors argument as evidence that factors common to all psychotherapies are responsible for positive outcomes. However, there are a number of alternative conclusions from these findings. One such alternative interpretation is that findings of equivalence represents equivalence in effect of the discrete techniques in differing therapies i.e. the techniques deliver psychological change differently but are equally effective. This interpretation supports the specific factors argument. Nonetheless, more detailed studies are required to discern the impact of specific techniques. The use of dismantling studies encourages researchers to look more closely at the specific elements of psychotherapies, for example, see; Bryant, Moulds, Guthrie, Dang & Nixon, (2003) and Foa et al. (2005). Such studies may improve the ability to identify separate and incremental contributions to treatment efficacy (Hazlett-Stevens & Borkovec, 1998). For example, some researchers have questioned whether the cognitive component of CBT treatment is superior to the behavioural component (Borkovec, Newman, Pincus & Lytle, 2002; Jacobson et al., 1996). Jacobson et al. (1996) found no evidence that the complete treatment package produced better outcomes (at treatment termination or 6-month follow-up) than either component alone. This appears to support the notion that components of therapy may be equally effective. It also raises questions regarding the composition of interventions being delivered; which components are required to produce positive clinical outcomes, and for which individuals? Dismantling studies have also been conducted to investigate some of the key components in EMDR, in particular, the use of Bilateral Stimulation (BS) (e.g., Van Deusen, 2004). However, this

research has not reached a consensus, without a definitive study or meta-analysis demonstrating whether or not each element of EMDR is required to observe beneficial outcomes i.e. symptom improvement / amelioration. Furthermore, not all components of psychotherapy are easily discernible; the TA component within psychotherapy (including EMDR),cannot be separated from the treatment and therefore, dismantling studies are not an appropriate methodology for exploring the influence of the alliance.

Specific and common factors.

There are a growing number of authors who caution against becoming embroiled in the common versus specific factors argument. They have highlighted that the dichotomy is misleading and unproductive, impeding psychotherapists from working together and therefore hindering attempts to develop the most efficacious psychological services (Norcross & Lambert, 2011). In recent years, the research field has become more interested, not in whether it is specific or common therapeutic factors affecting change, but a more nuanced and interactive understanding of treatment factors.

This research interest aligns with the more recent attention given to the potential benefits of personalised mental health treatment (DeRubeis et al., 2014). This involves identification of patient characteristics and symptom constellations that are likely to benefit one treatment over another, and therefore avoids the specific versus common factors dichotomy. An example of this comes from Huibers et al. (2015), who developed a multivariable index to identify a subset of patients with superior outcomes in CBT relative to interpersonal therapy (IPT) for depression by considering patient characteristics prior to the intervention. Although the index used has not yet been empirically evaluated in prospective research, the results were promising for informing decision-making to improve individual patient outcomes in depression.

Section 1.2: Common Factors Literature

Alongside the search for which models of psychotherapy are superior, there was a surge in correlational studies that attempted to delineate which variables accounted for the most variance in successful therapeutic outcome. Common factors shown to correlate with therapeutic outcome include: Therapist effects, such as allegiance to the model being delivered (Benish et al., 2008; Wampold, 2001), and client factors, such as expectations of the therapy (Greenberg, Constantino & Bruce, 2006). Lambert (1992) completed one of the first meta-analyses of the amassed primary correlational studies in this area (see Figure 7 for a summary of the results).

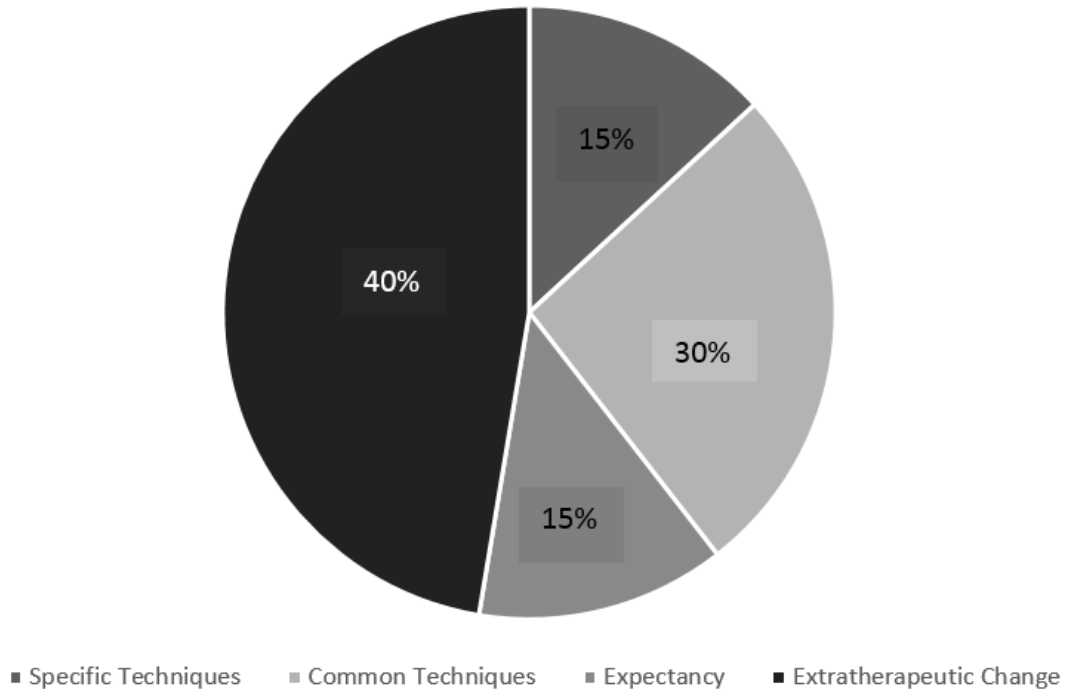

Figure 7. Lambert's (1992) estimates regarding the factors contributing the effectiveness of psychotherapy.

To manage the large amount of data regarding the common therapeutic factors found to correlate with clinical outcomes, authors have categorised common factors in an attempt to offer a clearer understanding of the sources of variation in outcome. In their review of the literature, Grencavage and Norcross (1990) found five groups of common factors: client characteristics, therapist qualities, change processes, treatment structure, and therapeutic relationship. More recently, a factor analysis of 22 common factors identified in the literature resulted in four dimensions: patients' cognitive processing, problem solving, emotional processing, and the building up of a therapeutic alliance (Tschacher, Junghan & Pfammatter, 2014).

Although there are some differences in the grouping of common therapeutic factors, the correlational data consistently report the therapeutic relationship as a meaningful variable, hence the large research interest in this area. In the midst of the argument between common and specific therapeutic factors, a task force was set up in 1999 to specifically consider what elements of the therapeutic relationship correlate positively with outcomes (Norcross, 2001; Norcross 2002). This has since been updated (see; Norcross & Lambert, 2011). However, there was a lack of research specifically considering how the therapeutic relationship may influence particularly models of therapy and for particular clinical problems (mental health difficulties), which would enable a more individualised treatment. This is supported by

findings that the therapeutic relationship exhibits more impact in some disorders and in some therapies than others (Beckner, Vella, Howard, & Mohr, 2007). Norcross and Lambert (2011) concluded that, "As with research on specific treatments, it may no longer suffice to ask, "Does the relationship work?" but "How does the relationship work for this disorder and this treatment?" (p.7). This conclusion supports the rationale for this study in exploring the TA within EMDR, for which there is a paucity of research.

Section 1.3: The Therapeutic Alliance Construct

The therapeutic relationship is one of the most widely researched of the common factors. As a concept, it has its roots in the psychodynamic approach to psychotherapy. In the early 1900s, Freud (1912) emphasised the relationship between client and therapist as a central therapeutic element. The term alliance appears to have been coined by Zetzel (1956) and later elaborated by others. Greenson (1967) emphasised and elaborated the conscious aspects of the alliance. His seminal work reflects a commonly agreed concept of the therapeutic relationship as comprising three distinguishable components: Transference relationship, real relationship, and working alliance. The transference relationship is thought to hold unrealistic and inappropriate reactions experienced between therapists and client. This is in contrast to the real relationship which represent the realistic, appropriate and conscious aspects of the therapeutic relationship. The alliance was considered to represent the cooperation between therapist and client and the capacity to work purposefully within therapy. Alternatively, Luborsky (1976) proposed an extension of Zetzel's (1956) concept of the alliance, suggesting two phases of alliance development. The first phase involved the therapist providing a warm, supporting, caring relationship, and the client's belief that the therapist is a source of help, allowing the work of therapy to begin. The second phase involved the client's investment and faith in the therapeutic process itself and a willing investment of herself or himself to share ownership for the therapy process.

Around the same time, Bordin (1979) proposed a different, pan-theoretical, alliance concept which he named the working alliance. Bordin's concept of the alliance was based on Greenson's (1967) ideas, but departed from the psychodynamic premises even more clearly than Luborsky did by clarifying the distinctions between the unconscious projections of the client (transference) and the conscious relationship between client and therapist (Bordin, 1979). Bordin's definition has been widely embraced, possibly because it does not align to any particular therapeutic model.

Safran, Muran and Samstag (1994) developed a theoretical model of the function of the alliance during therapy. They suggested that the client brings dysfunctional interpersonal

relationship schemas into the therapy relationship. The therapist's response leads to a continuation or a disruption of the cycle therefore assisting the client to gain a better grasp of their difficulties. In support of this, clinical practice and research suggests that therapists can take steps to repair alliance ruptures and that such steps are associated with positive outcomes (Safran, Muran & Eubanks-Carter, 2011). The lack of a precise, agreed upon definition has made it easier for researchers of different theoretical models to embrace the TA within their therapeutic processes. However, this ambiguity led to many alliances measures being developed in parallel, which do not share a common point of reference, creating difficulties for interpreting findings from studies using diverse measures of the TA.

The TA is considered to be a moderate and robust predictor of positive outcome, with studies reporting correlations of 0.26 (Horvath & Symonds, 1991) and 0.22 (Martin et al., 2000) across a variety of psychotherapy approaches. Across 24 studies, Horvath and Symonds (1991) found a correlation of .26 between the therapeutic alliance and symptom improvement; a finding later supported by Martin et al. (2000). It is important to note that many of the constituent studies within these two meta-analyses included therapists who integrated techniques from more than one orientation; thus, the relation of the alliance outcome within a specific form of psychotherapy was not coherently addressed. Additionally, the average effect size (r = .275; Horvath et al, 2011) is small to medium according to established parameters (Cohen, 1988) and as such, accounts for a modest proportion of the total variance in treatment outcome. Nonetheless, the alliance is reported to account for a greater proportion of the outcome than the specific type of therapy (Duncan, Miller, Wampold & Hubble, 2010). Furthermore, drop-out from therapy is more likely with a weaker therapeutic alliance (Hovarth & Bedi, 2002; Sharf, Primavera & Diener, 2010).

From a clinical perspective, these findings indicate that for all therapists, even those who utilise manualised treatments for specific disorders, the quality of the alliance matters. The alliance literature has been criticised because the results are correlational and therefore the alliance may not have a causal relationship to outcomes. It may be that early symptom change creates a stronger alliance (reverse causation). This has been explored and evidence supports the alliance as predictive of patient change by controlling for early symptom change (e.g., Baldwin et al., 2007; Crits-Christoph, Gibbons, Hamilton, Ring-Kurtz & Gallop, 2011; Falkenström, Granström, & Holmqvist, 2013). However, a definitive understanding about how the alliance and symptom change are reciprocally influenced throughout therapy is lacking. The concept of the alliance itself is composed of a number of variables that researchers have attempted to delineate in order to better understand what accounts for the

alliance-outcome correlation. A comprehensive review summarised that the therapist's personal attributes and techniques were reported to be important in the development and maintenance of a strong alliance (see Table 6; Ackerman & Hilsenroth, 2003).

Table 6

Summary of Therapist's Attributes and Techniques Found to Contribute Positively to the Alliance

Personal Attributes	**Technique**
Flexible	Exploration
Experienced	Depth
Honest	Reflection
Respectful	Supportive
Trustworthy	Notes past therapy success
Confident	Accurate interpretation
Interested	Facilitates expression of affect
Alert	Active
Friendly	Affirming
Warm	Understanding
Open	Attends to patient's experience

Some authors have argued that the alliance-outcome correlation is predominantly due to the therapist and those therapists who form better alliances with their clients, generally achieve better outcomes (Baldwin et al., 2007; Dinger, Strack, Leichsenring, Wilmers & Schauenburg, 2008). Similarly, Baldwin et al. (2007) used multilevel modelling to examine the impact of the therapist on the alliance-outcome correlation and found that the therapist contribution to the alliance was a statistically significant predictor of outcome, whereas the patient contribution was not. By understanding the processes involved in moderating and mediating the alliance during therapy, therapists can foster a strong alliance with clients and therefore improve therapeutic success. Clinical practice and research also suggests that therapists can take steps to repair alliance ruptures and that such steps are associated with positive outcomes (Safran et al., 2011). In contrast, some authors have focused on patient contributions. For example, it has been suggested that patients with good attachment histories and well developed social skills might form better alliances and have better prognoses (Mallinckrodt, 1991; Mallinckrodt, Coble, & Gantt, 1995). Therefore, client suitability in

clinical practice would be recommended, alongside therapist training on how to develop a positive alliance.

DeRubeis, Brotman, and Gibbons (2005) argued that the alliance-outcome correlation is likely to be due to contributions of the therapist, contributions of the patient and the interaction of therapist and patient (i.e., the match). In support of this, Castonguay and Beutler (2006) hypothesised that patient factors, relationship quality, specific therapies, and the strategic fit of the intervention to the patient form a distinctive pattern of reciprocal actions that may produce an optimal contribution to clinical improvement. This echoes a number of other authors (e.g., Goldfried, 1980; Norcross, 1992) who have emphasised the need for a comprehensive perspective, instead of the ongoing conflict between different models. Process research has investigated the pattern of the strength of the alliance over the course of psychotherapy, and how particular patterns may influence the outcome(s), i.e. how the alliance functions to foster change. This relates to the third aim of this study, which was to examine fluctuations in the strength of the alliance across two EMDR therapy cases, to explore the interaction between therapist and client(s), and consider this in relation to outcomes (symptom reduction).

Researchers suggested that alliance development goes through a series of changes as patients react to the shifting techniques of the therapist (e.g., Gelso & Carter, 1994; Horvath & Luborsky, 1993, Kivlighan & Shaughnessy, 1995; 2000). Although a number of global alliance patterns have been identified in the literature, the evidence is somewhat inconsistent regarding the patterns that are present and their impact on outcomes. Whilst Kivlighan and Shaughnessy (2000) found three different patterns of alliance: linear growth, stable alliance, and U-shaped (TA begins strong, falls in the middle, and returns to a strong alliance at the end of treatment), Stiles and colleagues (2004), in an attempt to replicate these findings, revealed a fourth pattern with a positive slope and low variability. Unlike Kivlighan and Shaughnessy (2000), who indicated that a U-shaped pattern is a better predictor of positive outcomes, Stiles et al. (2004) found none of the patterns predicted treatment outcome. The U-shaped pattern is thought to reflect the middle phase of treatment in which ruptures occur and cause strain to the alliance. In successful treatment, these ruptures are addressed and the alliance returns to its previously high level during the second half of the therapy.

In 2007, Stevens et al. tested the trends in alliance development using therapist-client dyads in manualised treatments, which may offer relevant understanding of alliance patterns within other manualised treatments such as EMDR. They tested the idea that the rupture–and–repair process is better described as a local, rather than global, phenomenon. There was

no evidence of the U-shaped pattern of alliance and instead, a more localised rupture-repair pattern was revealed. This supports Safran and Muran's (2000) work regarding rupture and repair of the alliance, in which they described as a session-by-session negotiation process within the therapeutic dyad. However, Stevens et al. (2007) found limited relation to improved outcome.

The mixed research regarding the presence of global patterns of the TA during treatment suggests further investigation is needed in this area. A change in focus to considering moment to moment alliance shifts may yield a clearer understanding of what is happening during alliance fluctuations across treatment phases, and the meaning of such fluctuations.

Therapist and Client Experience of the Alliance

Another area of research within the alliance literature focuses on the therapist and client perspective. Given the increasing research interest in this area, a recent review aimed to synthesise qualitative research exploring clients' perspectives of forming a therapeutic relationship. Understanding the client's experience of therapy and forming a therapeutic relationship is considered as fundamental for identifying ways to engage clients in therapy (Eyrich-Garg, 2008) and potentially reduce attrition rates.The meta-synthesis (Noyce & Simpson, 2016) revealed four overarching themes from the literature as follows:

1. Assessing client-therapist match,
2. Facilitating openness,
3. Connecting on a deeper level,
4. Empowerment through respect.

The use of meta-synthesis allows for individual parts of knowledge regarding the same phenomena to be synthesised and become integrated rather than isolationist, allowing for more comprehensive recommendations for clinicians and policymakers (Silverman, 1997). Some authors have questioned the use of meta-synthesis, in particular, questioning the combination of primary studies with divergent philosophical underpinnings (e.g., Sandelowski, Docherty & Emden, 1997). Nevertheless, the synthesis of information allowed the authors to collate primary themes into overarching themes in order to identify the most salient factors as represented in the wider literature.

Noyce and Simpson's (2016) work supports previous research. For example, Luborsky (1976) highlighted that the client's belief that the therapist will be able to provide the required help is an essential part of forming the TA. Noyce and Simpson (2016) highlighted that requests from clients for therapists to disclose both professional and personal

information to demonstrate honesty and openness was evident in a number of studies across the data set. This supports previous research regarding therapist self-disclosure which shows clients tend to view self-disclosure as positive, specifically in terms of perceiving their therapist as warmer and willing to disclose more in therapy (Henretty & Levitt, 2010). The importance of trust was highlighted with some clients suggesting that building trust took place over the first six sessions. In short-term therapy models this may seem an impossible task for therapists. However, the findings from this review highlight the importance of dedicating time at the beginning of therapy to establish an alliance for improved therapeutic progress later on.

In exploring clients' perceptions of EMDR four major themes emerged: the existence of safety as an essential for the EMDR experience, the importance of accessing the emotional core as vital to the recovery experience, the role of perspective shift in lifestyle change, and the use of a combination of factors for successful treatment (Marich, 2010). Marich (2012) explored in greater depth the theme related to safety before beginning fundamental EMDR work and revealed several qualities of a good EMDR therapist. These can be highlighted in order to bolster understanding of what former clients value as important in EMDR treatment. These qualities include: therapist personality, ability to empower clients, flexibility, intuition, a sense of ease, and comfort in working with trauma. However, this work focused solely on females with addiction and therefore may not represent general clinical sample accessing EMDR.

Section 1.4: Overview of the Effectiveness of Eye Movement Desensitisation Reprocessing (EMDR)

The theory behind EMDR developed subsequent to the discovery that bilateral stimulation appears to resolve traumatic memories. The theoretical mechanisms postulated by the AIP have been widely accepted in the treatment of trauma by addressing the traumatic event, for example, via exposure. However, the AIP model theorises that most forms of psychopathology, including anxiety and depression, are based on unprocessed memories and can be resolved by allowing the memories causing the symptom(s) to come to an adaptive resolution (Shapiro, 2007; Shapiro & Forrest, 2001).

After successful treatment, it is posited that the memory is no longer isolated because it appears to be appropriately integrated within the larger memory network. The central mechanisms thought to bring about resolution of the trauma symptomology are: alignment of memory fragments, somatic awareness, cognitive restructuring, and information processing via bilateral stimulation.

The AIP model is consistent with other information-processing models of therapy, particularly the widely used exposure-based treatments for anxiety. The corrective information in exposure based therapies such as prolonged exposure (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991; Rothbaum, Astin, & Marsteller, 2005) is viewed as coming from the therapeutic situation and the effect of habituation (Foa & Kozak, 1986; Rothbaum et al., 2005). However, the shifts that take place in EMDR suggest that clients incorporate information not only from the therapeutic context but also from memories of previous life experiences (Shapiro, 2007; Shapiro & Forrest, 2001).

EMDR and CBT have similarities in that both approaches examine behaviour, cognitions, emotions, and physiological responses. Both approaches also use some of the same techniques e.g. Socratic dialogue and guided discovery. EMDR differs from CBT because of the emphasis on the idea that trauma can be maintained in a memory network that is not available until some aspect of the network is accessed (Shapiro & Forrest, 2001). Initial evidence for the efficacy of EMDR has focused on the treatment of PTSD and more recent studies continue to demonstrate efficacy of EMDR for PTSD (e.g., Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Bradley, Greene, Russ, Duta & Westen, 2005; Watts et al., 2013). Although relatively sparse compared to the literature for PTSD, the evidence base for using EMDR with a broader range of mental health difficulties is growing. This evidence developed from studies demonstrating that participants receiving EMDR for PTSD showed significant improvement on measures of depression and anxiety, alongside posttraumatic stress. In support of this, Cvetek (2008) used an RCT design to test the effectiveness of EMDR with disturbing life events that did not meet the criteria for PTSD, which demonstrated positive results for the broader use of EMDR. Additionally, studies have specifically used EMDR to treat both depression (e.g., Bae, Kim & Park, 2008; Grey, 2011) and anxiety (Gauvreau & Bouchard, 2008; De Roos & De Jongh, 2008), with positive results, including at follow-up (Gauhar & Wajid, 2016; Gauvreau & Bouchard, 2008). Shapiro herself published a book recognising the potential breadth of EMDR, entitled “EMDR solutions II: For depression, eating disorders, performance, and more” (Shapiro, 2009).

Section 1.5: Therapeutic Alliance in EMDR

One of the major differences between therapies with an interpersonal focus and EMDR is that EMDR uses protocols, such as bilateral stimulation, rather than empathetic responses to stimulate the flow of information processing (Bohart, Elliott, Greenberg & Watson, 2002; DiGiorgio, Arnkoff, Glass, Lyhus, & Walter, 2004).

Research by Castonguay et al. (1996) suggested that there may be a negative impact on therapy outcome if there is overuse of cognitive techniques in dealing with alliance issues. This related specifically to clinicians attempting to use cognitive techniques to correct problems in the TA and may represent a broader difficulty for clinicians in the timing of facilitating such techniques. Castonguay et al. (2004) later advocated for improving the efficacy of CBT by having therapists adopt a more humanistic and interpersonal approach in dealing with alliance ruptures. Therefore, the cognitive interweaves utilised within the standard protocol of EMDR may at times hinder the maintenance of the TA, if they are timed inappropriately. This echoes the work of Dworkin (2005), in which he advocates for 'relational interweaves'[5], alongside the specific EMDR cognitive interweave techniques. Currently there is no research investigating specifically how cognitive interweaves are used in EMDR, and therefore, whether such interweaves have an effect on maintaining the alliance during processing. This leaves questions about whether cognitive interweaves are based on blocked processing and/or because of relational cues picked up by the therapist and if, or how, this impacts on EMDR therapy.

Section 1.6: Clinical Relevance

Treatment manuals used in protocol driven therapies, such as EMDR, were developed to explicitly document contents, guide the therapist, and support fidelity to the model. Concerns have emerged that manuals may impede the development of a positive alliance between therapist and client (Addis & Krasnow, 2000; Nelson, Steele & Mize, 2006). Conversely, the opposite has been found by some authors. For example, Langer, McLeod, and Weisz (2011) did not support the contention that using manuals to guide treatment harms the alliance. Although the question is clear, the answer about whether a treatment manual detracts from the alliance is not, especially in newer therapies such as EMDR where there remains little, if any, research specifically investigating the influence of the alliance.

The clinical significance of investigating the TA in EMDR is manifold. The robust finding that a strong alliance relates to positive outcomes in psychotherapy logically leads to central research focus investigating the degree to which the alliance-outcome correlation is a result of direct or indirect causal pathways from the alliance to outcome (i.e., ruling out reverse causation and the influence of other variables). Following on from this, research can aid understanding of how the knowledge of the alliance can improve patient care by taking steps to improve the alliance during treatment. A number of clinical writings have suggested

[5] Interweaves that focus on addressing the alliance

ways for the therapist to enhance the alliance during treatment. Ackerman and Hilsenroth (2003) conclude that when the therapist conveys a sense of being trustworthy, affirming, flexible, interested, alert, relaxed, confident, respectful, and empathic, is more experienced, and communicates clearly, a more positive alliance is present. This concurs with Safran and Muran's (2000) work on understanding how the alliance works by examining in detail the events or characteristics that generate or stress the alliance between therapist and client.

Most writings on EMDR by professionals, including the EMDR founder Shapiro, emphasise fidelity to set protocols that are unique to EMDR as a major factor in ensuring client safety (Shapiro & Forrest, 2001). The information derived from this exploratory, client-centred inquiry has the potential to challenge extant knowledge about what elements of EMDR are the most important to those who receive it. The paucity of empirical focus on the alliance in EMDR currently leaves researchers and clinicians somewhat in the dark about how the protocols and alliance interplay within EMDR therapy. The aims of this article are to further our understanding of the possible function of the alliance in EMDR.Dworkin and Errebo (2010) proposed a process for training EMDR therapists to repair ruptures in the therapeutic alliance, as it is currently an area overlooked during EMDR training but (as for other psychotherapies) is essential to the overall success of treatment. Having a greater understanding of this relationship may lead to better-trained therapists and possibly greater therapeutic successes.

A mixed-methods in-depth case study approach is utilised, offering both quantitative data and the use of qualitative results to assist in explaining and interpreting the findings of a quantitative data. This aids examination of how therapists use TA within sessions, e.g., whether therapists 'front load' the TA to facilitate engagement with EMDR and whether they draw upon TA-facilitating skills at various points during the EMDR sessions.

Extended Methods Section

Section 1.7: Epistemology

The epistemological position adopted within research relates to all aspects of how a particular study is conducted (Willig, 2008) including, aims/hypotheses, design, and interpretation of the findings. Given that every research study makes assumptions, the importance of being explicit about the epistemological position adopted is useful (Hanson et al., 2005). Being clear about the researchers' position allows for transparency and clarity of understanding for the reader and therefore is outlined for this study as follows.

The study utilised a mixed methods case study. Quantitative and qualitative research methods align themselves with different underlying philosophical assumptions and therefore some argue that they cannot be combined appropriately within research. For example, Teddlie and Tashakkoris (2003) highlighted that they make opposing assumptions about reality and what can be claimed from data, which may lead to incoherence. However, pragmatism suggests that qualitative and quantitative approaches can be combined by arguing that methodology is independent of the epistemology it developed from (Patton, 1990). Pragmatists advocate for choosing methods based on those that are best suited to answering the research question but in doing so fail to provide a philosophical justification for their use (Hall, 2013). As noted earlier, the importance of recognising the philosophical underpinnings of the research increases reliability of the findings by being transparent and offering a greater understanding of interpretations being offered by the authors (Hall, 2013).

Quantitative approaches fit within positivist assumptions. Positivism argues that reality is limited to observation of facts (Bechtel, 2009) and is independent from the researcher's frame of reference (Pring, 2000) therefore findings are considered as objective and any potential biases are considered controllable within the research (Howitt, 2010). This approach to research attempts to identify cause and effect relationships and isolate variables that influence such relationships, in order to control for erroneous factors. Therefore, providing results that can be generalised from the use of large study samples to the wider population of interest (Creswell, 2009).

In contrast, qualitative approaches stem from a constructivist stance. The aim of this approach to research is to gather richer data than in quantitative research by gathering in-depth descriptions of the phenomenon of interest. This is facilitated through methods such as interviews to gather understanding of participants' experiences (Harper & Thompson, 2011). This type of data is less easily generalised to the wider population. However, generalisation is not the main aim of qualitative research. Instead it seeks to understand phenomena within the specific context being investigated and is interested in individuals' and sub-sets of individuals' meanings that are brought to their experiences (Denzin & Lincoln, 2011). This allows researchers to study more niche topics and marginalised groups within our society beyond quantitative methods given the in-depth nature of qualitative research approaches. This is both ethical (gathering research representing all populations) and can offer unique insights to areas that may later be generalised to the larger population. Qualitative research would make use of theoretical generalisation, for example, in Grounded Theory (Glaser & Strauss, 1967) the aim is to generate theoretical understanding of particular areas of interest.

The researchers in this study adopted a critical-realist stance. Critical realism embraces the concept that individuals are rarely free from the influence of external factors, addressing one of the main critiques of positivism, which assumes that reality is context-free (Bhaskar, 1975). Although critical realism assumes that there is a real world out there, it also assumes that there is no way that such an assumption can ever be proved or disproved, as social constructivists and pragmatists would argue.

Critical realism has been suggested as a single paradigm for combining qualitative and quantitative methods (Sayer, 2000) with knowledge considered to be influenced by the context, within which interactions beliefs of both researchers and participants and social-cultural factors (De Forge & Shaw, 2012). Critical realism allows qualitative and quantitative data to be combined to explore individual experiences and relate this back to formal measures of underlying processes (Lipscomb, 2011). Critical realism is particularly well suited as a companion to case study research as it justifies the study of any situation, regardless of sample size available, as long as the research process involves thoughtful in-depth research with the objective of understanding why things are as they are. This matches the aims of the current study, which attempts to further understand the TA through a focus on individual experience then relating this back to underlying processes.

A critical realist perspective does not seek to generalise findings or give in-depth accounts of individual experience. It rejects the large claims about knowledge of positivism, admitting that reality may be messy and difficult to know whilst maintaining that reality exists independently from the knowledge of the knower. Its flexibility is particularly well suited to case study research as it justifies the study of any situation, regardless of the numbers of research units involved. Therefore, critical realism avoids the hazards of large claims about knowledge but then risks being non-specific and therefore may struggle to offer meaningful recommendations in applied settings.

This study utilised Framework Analysis, which borrows principles from different epistemological traditions. Its eclecticism has been seen as a strength throughout its development (Ritchie, Spencer & O'Connor, 2003). This fits with a critical-realist stance which maintains that the social world exists independently of individual subjective understanding, but is only accessible in qualitative research via participants' interpretations which are further interpreted by the researcher.

The psychometric measures used throughout this study formed a large part of the data. Measures generally assume that the data collected is a true representation of reality and therefore tend to be aligned with positivist epistemology. Positivism suggests that within the

world, regularities or law-like generalisations exist, which provide the basis for explanation and prediction. This allows a positivist stance to make causal statements. As critical realists, the researchers assume that reality exists, however the measurement of it is imperfect given that individuals make varied interpretations. Therefore, participants' responses to the self-reported measures are considered to be influenced by individual differences rather than offering an accurate reflection of one true reality. The findings are not considered to reflect a true reality but are interpreted in the knowledge that data was co-constructed by both participants and researchers.

Likewise, the analysis of the TA in this study utilised an observational method, recognising that measurement of the strength of the alliance at various points during EMDR can be captured. Although the measure used (WAI-O-S) suggests that there is true reality regarding the measurement of the TA which fits with positivism, the researchers critiqued the measure in acknowledgement that many factors impact on the strength of the TA and that no one measurement of it is necessarily representative of the truth.

For more information about the Critical Realism adopted in this study see Sayer (1992; 2000) who sets out what he regards as the 8 key assumptions of critical realism, as shown in Table 7.

Table 7

The eight key assumptions of critical realism, according to Sayer (1992; 2000).

Critical Realist Assumptions	
Assumption 1	The world exists independently of our knowledge of it.
Assumption 2	Our knowledge of the world is fallible and theory-laden. Concepts of truth and falsity fail to provide a coherent view of the relationship between knowledge and its object. Nevertheless, knowledge is not immune to empirical check and its effectiveness in informing and explaining successful material practice is not mere accident.
Assumption 3	Knowledge develops neither wholly continuously, as the steady accumulation of facts within a stable conceptual framework, nor discontinuously, through simultaneous and universal changes in concepts.
Assumption 4	There is necessity in the world; objects—whether natural or social—necessarily have particular powers or ways of acting and particular susceptibilities.
Assumption 5	The world is differentiated and stratified, consisting not only of events, but objects, including structures, which have powers and liabilities capable of generating events. These structures may be present even where, as in the social world and much of the natural world, they do not generate regular patterns of events.
Assumption 6	Social phenomena such as actions, texts and institutions are concept dependent. We not only have to explain their production and material effects but to understand, read or interpret what they mean. Although they have to be interpreted by starting from the researcher's own frames of meaning, by and large they exist regardless of researchers' interpretation of them. A qualified version of 1 therefore applies to the social world. In view of 4–6, the methods of social science and natural science have both differences and similarities.
Assumption 7	Science or the production of any kind of knowledge is a social practice. For better or worse (not just worse) the conditions and social relations of the production of knowledge influence its content. Knowledge is also largely—though not exclusively— linguistic, and the nature of language

	and the way we communicate are not incidental to what is known and communicated. Awareness of these relationships is vital in evaluating knowledge.
Assumption 8	Social science must be critical of its object. In order to be able to explain and understand social phenomena we have to evaluate them critically

Section 1.8: Extra Information on Participants

Lola was referred via her General Practitioner (GP) where she had presented initially with physical ailments related to stress. She was classified within the Mental Health Clustering Tool (MHCT); a version of the Health of the Nation Outcome Scale (HoNOS) adapted for Payment by Rresults (PbR) (HoNOS-PbR; DoH, 2009) based on her presenting symptoms, as cluster 3. This cluster represents those individuals presenting with non-psychotic symptoms of moderate severity, involving depressed mood and anxiety. During the initial assessment within the service, Lola disclosed distress regarding a childhood traumatic incident which she had never had the opportunity to explore.

Sarah was referred to the service due to presenting with mild to moderate common mental health difficulties and was identified within cluster 1 of the MHCT (DoH, 2009). This group has definite but minor problems of depressed mood, anxiety, or other disorder but they do not present with any distressing psychotic symptoms. During the initial assessment within the service, Sarah disclosed some disturbing memories which were considered by the therapist to be functionally linked to her distress and reduced work and social functioning.

Both clients were referred to the service targeted to conduct this study within. The service was an 'Improving Access to Psychological Therapies' (IAPT) Service. IAPT services were designed in an attempt to make CBT and other evidence based therapies, that have been recommended by NICE, more readily available to the general population and to support people returning to work. The implementation of these services was based on delivering short-term, manualised, structured therapies within the community. The manualised and structured approach of IAPT services has been criticised for focusing on targets, outcomes and protocols, over attention to the patient's psychological needs (Rizq, 2012). However, for this research, EMDR delivered within such strict protocols and timeframes is of benefit as it allows exploration of a pure form of EMDR, as oppose to an integrative approach with other psychotherapeutic approaches more likely to be facilitated in longer-term services, such as Step Four Psychological Services offered to individuals with more complex and enduring mental

health difficulties. The general criteria to be met to be offered therapy within the service was as follows:

1. Primary Diagnosis of Anxiety and Depression.
2. Low risk behaviour to self and others.
3. The client has an ability to emotionally process / and resilience to tolerate therapy.
4. The client is capable of utilising therapy.
5. Readiness / willingness / capability.
6. Suitability according to the service's remit i.e. mild to moderate complexity / severity and chronicity.
7. The client has a stable degree of bio psychosocial and environmental stability.
8. The patient can tolerant therapeutic risk taking without significant risk of relapse when engaging within psychological therapy.
9. A referral will be accepted if the criteria(above points) can be demonstrated with limited contraindications.

Although the IAPT service offered a range of psychological treatments in line with NICE guidelines for 'mild to moderate' anxiety and depression (CBT and IPT), this study targeted clients assessed within the service as most likely to benefit from EMDR to ameliorate their symptoms. The assessment process within the service considers NICE recommended CBT and IPT for anxiety and depression but recommends EMDR if trauma memories are central to the client's presenting symptoms. If trauma is identified in the formulation and etiology of the presentation, clients are given the opportunity to consider EMDR, CBT, or a combination of both (see figure 8 for the referral pathway).

Specific consideration is given to EMDR within the Service when:

1. previous CBT therapy has been unsuccessful.
2. exposure has been difficult or is linked to re-experiencing of trauma memories.
3. Re-living has been difficult or the patient does not want to do this verbally.
4. there is a presentation of a trauma timeline.
5. the person living with mental health problems expressed the treatment preference.
6. if early childhood trauma is present it is followed by a period of stabilization.

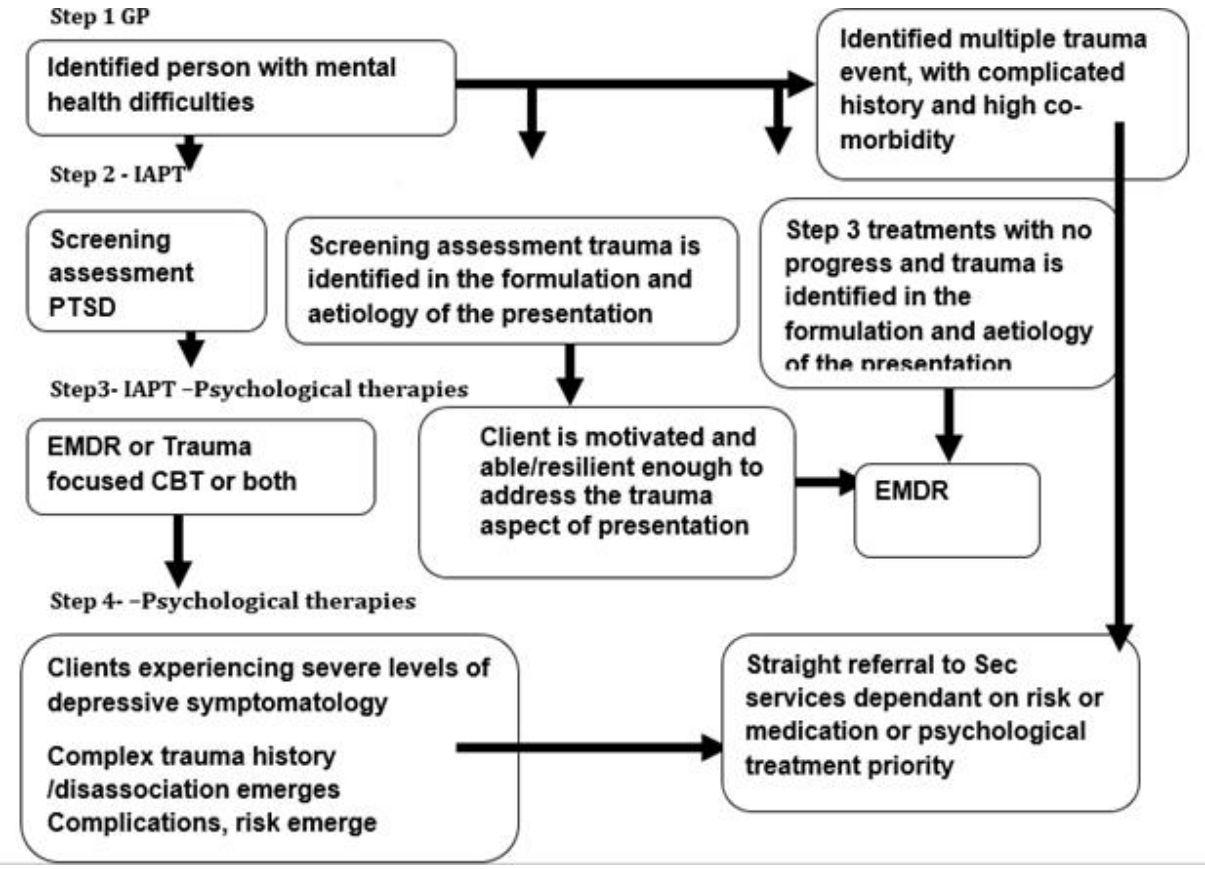

Figure 8. A diagrammatic representation of the referral pathway for the service.

Section 1.9: Extra Information on Procedure

Ethical approval was gained from Leicester South ethics committee (see Appendix B for correspondence).

A single case refers to the participant or cluster of participants under investigation. In contrast to an experimental group design in which one group is compared with another, participants in a single-subject experiment research provide their own control data for the purpose of comparison in a within-subject rather than a between-subjects design (Cooper, Heron & Heward, 2007).

Although group designs, in particular RCTs, have become the 'Gold Standard' for producing evidence of efficacy for psychological interventions, sceptics have called into question the clinical utility of such designs (Wachtel, 2010; Western, Novotny, & Thompson-Brenner, 2004). Between-group designs (including RCTs and non-randomised trials) are typically based on finding meaningful differences among two or more levels of an intervention across at least two measurement intervals, which is well suited for illustrating the broad-level effectiveness of a treatment among a population sample. To conduct such a study investigating

the impact of the TA within EMDR, a group of participants would need to be given the therapeutic intervention without an alliance being present. Clearly this is impractical and perhaps more importantly, unethical, given the strong literature indicating the importance of an alliance for positive outcomes. Furthermore, it would not offer a richness of data, such as exploring fluctuations across therapy, or participants' interpretations of the phenomenon being investigated.

The design in this study bears some resemblance to Single Case Experimental Designs (SCEDs), as it involved repeated and systematic assessment of Independent Variables (IVs; anxiety, depression, and functioning). However, in an experimental design, IVs are manipulated by the experimenter. Furthermore, SCEDs typically involve comparison between two experimental time periods (phases), the first being a baseline phase which serves as a comparison with subsequent phases (Smith, 2012). Therefore, the design better reflects a naturalistic single-case design, which has been used to assess dyadic relationship dynamics between therapists and clients (e.g., Tschacher & Ramseyer, 2009) as they are in applied settings such as therapeutic services. Case studies represent a bottom-up approach to promoting evidence-based practice (Fishman, 2005) and can bridge the research practice gap by providing more clinically relevant information about findings from randomized clinical trials (RCTs) and other process research methods by testing theories and hypotheses in a detailed and contextualized manner (Stiles, 2005).

This single-case design used mixed-methods, gathering both quantitative and qualitative data. It is argued that quantitative and qualitative approaches make unique contributions to studying a particular phenomenon (e.g., the alliance in EMDR) and that combining approaches can improve understanding of more complex issues than either approach alone can achieve (Sale, Lohfeld & Brazil, 2002). Some authors have expressed concerns about mixed-methods approaches, predominantly arguing that differing paradigms cannot be appropriately combined due to contradictory epistemological and ontological viewpoints (Bazeley, 2009). However, other authors highlight that the two approaches share a common goal of understanding the world (Haase & Meyers, 1988) and of disseminating knowledge for practical use, as well as a shared commitment for rigour and critique in the research process (Casebeer & Verhoef, 1997; Reichardt & Rallis, 1994). Furthermore, combining research methods is particularly useful in areas such as psychological interventions because of the complexity of the phenomena, which requires varied data sources for a more comprehensive understanding. Kazdin (2007) suggests that multi methodologies are likely to be needed when considering not only the outcome, but identifying mediators and moderators of change.

Applied research.

Whilst there are advantages to conducting applied research (see analysis section below), there are a number of challenges for carrying out research in clinical settings. Such difficulties are evident in this study. In particular, given the high workload of clinicians, taking time out to participate in research limited the number of participants recruited. Furthermore, the design of the study was impacted by both ethical and practical considerations in regards to the time and effort that the participants were required to offer in order to participate. For example, the service (as all therapeutic services in the NHS) had existing routine outcome measures that are required by service managers, often to demonstrate the effectiveness of therapeutic services to the commissioners. Therefore, the PHQ-9, GAD-7 and WSAS were used in this study (see measures section below for critique) as a matter of service requirement. There were also difficulties in terms of using videoing equipment within the research, which are reflected on further in the 'critical reflection' section below.

Alternative approaches.

Alternative approaches to answering the same research questions were considered. For example, in-depth interviews with a number of therapists and clients post-EMDR treatment followed by an analysis that builds from individual experiential accounts, such as Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009), would have offered more in-depth qualitative data, offering further insights into how each participant made sense of the TA during EMDR therefore, potentially informing researchers about how aspects of alliance interacted with particular tasks of EMDR, since the method is more appropriate for capturing contextualised manifestations of TA in EMDR. However, an approach such as IPA would be limited by the extent to which participants can report on the processes involved, which may be outside of awareness and/or subject to self-presentation or memory biases.

The framework analysis utilised focused on pre-determined (from theory and literature) elements of the TA in a primarily deductive approach, focusing specifically on answering the research questions. Although inductive information was allowed for during the framework analysis, this remained focused on the TA. Whilst a more in-depth qualitative approach could have offered a more detailed interpretation of the therapist and client perspective, the approach would not have enabled exploration of the TA from an observer's perspective to consider the fluctuations in the strength of the TA throughout the EMDR treatment. Notwithstanding potential benefits of using a more inductive, in-depth analysis, the

applied mixed-methods approach yielded a more holistic understanding of the role of the TA in EMDR and therefore can be seen to have offered more in terms of clinical utility. Another approach which was considered was the use of functional analysis on moments of interest to the TA within the EMDR therapy (as used for the therapists' Brief Structured Recall; BSR interview), alongside asking therapists and clients to comment on the same moments. This would have involved exploring the function of in-session behaviours by both therapist and client in terms of possible alliance-building and moments of alliance rupture. Additionally, a functional analysis by one of the authors would have offered an observer perspective of the function of such behaviours. This would have allowed triangulation of the data from therapist, client and observer perspective. Whilst the current study explores fluctuations within the TA across the course of EMDR therapy, functional analysis would have allowed comment on the enactment of the TA and therefore offered a more nuanced understanding of decisions regarding the use of techniques alongside relational consideration during EMDR. The initial design involved both therapist and client completing BSR interviews which would have allowed for triangulation however, the clients declined a BSR interview given concerns about how they may react to watching themselves within therapy. However, interviews are important to get beyond the topography of in-session behaviours and elicit the actual (and/or intended) functions (e.g., behaviours that look like alliance ruptures may actually function to strengthen alliance).

A further method of attempting to examine the relationship between TA and symptom improvement in EMDR would have been to use Simulation Modelling Analysis (SMA) (Borckardt et al., 2008), an approach increasingly used in the single-case literature (Smith et al., 2010). SMA can analyse cross-lagged correlations (within individuals) which could help to explore both the presence and temporal direction of any individual-level association between alliance and outcome i.e. do current alliance scores lead/predict future outcome scores, or do current outcome scores lead/predict future alliance scores? This could help to strengthen causal inferences; whether changes in alliance drive changes in outcome, or changes in outcome drive changes in alliance, or they change simultaneously. Although visual inspection is regularly used to analyse single case data, it cannot account for the fact that single-case data are auto-correlated (i.e., non-independence of sequential ratings by the same informant). The use of SMA may be a useful follow on study once the TA is better understood within EMDR, as the relationship between TA and outcomes has not yet been empirically established. The current study supports the wider literature that a strong alliance

correlates with successful outcomes but cannot confirm the effect of the alliance on outcome given that the data is correlational and relates to a small study sample.

Recruitment.

The therapist was recruited via her employment as a therapist delivering EMDR in the target service, within the study's timeframe. The clients were recruited by the therapist, based on the inclusion and exclusion criteria, within the study's timeframe.

An email advertising the research was circulated via the NHS email system to all potential therapist-participants (Appendix C). The information sheet (Appendix D) was attached to this email and the contact details for the principal investigator (primary author) for anyone interested in taking part. All eligible participants (approximately twelve) were given equal opportunity to take part. One therapist within the targeted service expressed an interest and attended a meeting with the principal investigator to talk through the information sheet and answers questions / clarify details of the research procedure. Following this meeting, the therapist took time (>24 hours) to consider their participation and later gave her fully informed consent (Appendix E). Although two other therapists expressed interest in participating, ultimately they declined due to concerns surrounding competing demands on their time. All participants also signed a separate form of consent to the video recording of interviews (Appendix F).

Interviews.

The primary author has experience of conducting semi-structured research interviews previously, therefore increasing the validity of data collected. A semi-structured interview schedule was developed (seefigure 2) by the primary and secondary authors by reflecting on questions that would most directly address the aims of the research, whilst allowing for inductive information to be gathered surrounding the theme of the TA within EMDR. The schedule began relatively broad (general experience of EMDR) to consider whether the TA would be offered as a factor of the therapy prior to being specifically asked to comment on their experience of the TA. The subsequent questions became more specific about how they experienced the TA during the EMDR therapy that they received, including questions about positive and negative experiences in an attempt to draw out a holistic understanding.

This interview schedule was utilised during the client interviews, allowing the interviewer to engage with what the participants said, and explore any interesting related areas that arose. This method is expected to facilitate rapport building and encourage participants to talk in depth about their experiences (Reid, Flowers & Larkin, 2005). Smith and Osborn (2008)

further propose that this method of data collection allows the exploration of new areas which might come up, enriching the data.

The therapist interviews used (BSR (Elliott & Shapiro, 1988); a video cued-recall method, used for identifying significant moments within therapy sessions related to the alliance and to obtain the therapists' moment-to-moment experiencing during these significant events (see appendix A for interview schedule). The BSR interviews with the therapist involved playing back moments from the videos of the therapy sessions, in order for the therapist to comment on unspoken thoughts and feelings at the time. These moments (video clips) were chosen by the principal author, informed by previous literature regarding ruptures and repair of the alliance. This was a somewhat subjective process however, the moments chosen were supported by consideration of the literature and my own clinical experience in noticing moments of fluctuation in the alliance. The process of selecting particular moments involved the video recordings being viewed fully from start to finish and then being watched a second time, in which moments of alliance fluctuations were noted. The moments initially chosen were then compared to the description of alliance strength using the WAI-O-S items to further consider whether there appeared to be strengthening or weakening of the alliance within the clips selected for use in BSR.

The original study design involved clients also completing BSR interviews and therefore capturing the moment-to-moment experiences. However, following completion of therapy the clients declined a BSR interview but consented to a semi-structured interview.

Section 2.0: Extended Measures [See appendix G for the measures used]

The measures used in this study each specify cut-off scores representing severity of the symptoms that the individual questionnaires measure, as follows:

- PHQ-9 scores of 5, 10, 15, and 20 represent mild, moderate, moderately severe, and severe depression, respectively.
- GAD-7 scores of 5, 10 and 15 represent mild, moderate and severe anxiety, respectively.
- A WSAS score above 20 suggests moderately severe psychopathology, scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology, and scores below 10 appear to be associated with subclinical populations.

The distress measures used during this study were considered by the researchers during the study design despite not being specifically chosen for the purposes of the research (the service

routinely used these measures as required by commissioners of the service to support demonstration of the value of the service). The PHQ-9 demonstrates good validity and reliability (see; Spitzer, Kroenke & Williams, 1999). Although there have been questions regarding the diagnostic ability of the PHQ-9 in discriminating between diagnoses for example, bipolar disorder patients have been misdiagnosed with major depressive disorder (Inoue et al., 2012), such concerns are not applicable for this study given that the PHQ-9 was not used diagnostically as the client's presenting symptoms had already been classified. Additionally, the use of a further two symptom measures supported a more nuanced understanding of the clients' symptoms than a single diagnostic tool allows.

The GAD-7 has been shown to distinguish between patients with different degrees of anxiety (Spitzer et al., 2006; Swinson, 2006). Whilst other anxiety measures are likely to capture a more comprehensive picture of an individuals anxiety symptoms for example, the Beck Anxiety Inventory (BAI; Beck & Steer, 1990), given this is a 21-item measure, the utility of longer measures within time-limited clinical practice is lacking.

The WSAS has been used to assess changes in social functioning for patients with anxiety and depression. The WSAS is widely used because it fits well with the aims of the IAPT programme in supporting individuals to return to and stay in work, which is not relevant to this research. However, it complements symptom measures (PHQ-9 and GAD-7) in further considering the impact of therapeutic input on client's daily functioning. Furthermore, Mundt et al. (2002) report good internal (0.70 to 0.94) and test–retest (0.84) reliability of the WSAS in patients being treated for depression and good convergent validity with depression severity (0.86). Although the WSAS has been used as an outcome measure (e.g., Nelis et al. 2011), it has not been directly compared to other measures (e.g., PHQ-9 or GAD-7) regarding reliability or sensitivity to time or treatment effects (Zahra et al., 2014).

Two additional measures were administered by the therapist at the end of each session for the purposes of this research. One was an alliance measure; the Agnew Relationship Measure five item form (ARM-5; Agnew-Davies, Stiles, Hardy, Barkham & Shapiro, 1998), which both the therapist and the client(s) completed in order to consider both viewpoints of the alliance and explore discrepancies. The second was the Helpful Aspects of Therapy (HAT) form (Llewelyn, 1988). This is a post-session questionnaire that asks the client to identify helpful or hindering events in the session. The events are then further reflected upon in written comments by the client, which are made immediately after the session.

Agnew Relationship Measure-Five (ARM-5).

The TA was assessed by the client and therapist each session using the respective version of the five item Agnew Relationship Measure (ARM-5; Agnew-Davies, et al, 1998). The ARM-5 assesses five dimensions of the therapeutic alliance: bond, partnership, confidence, openness, and client initiative; for example, "My therapist and I agree about how to work together/My client and I agree about how to work together". The measure uses a seven-point scale anchored 'strongly disagree' to 'strongly agree' with a range of scores from 0 – 35. The ARM-5 is a short form of the 28-item ARM, developed to track alliance in busy practice settings as a clinical decision tool. The psychometric properties of the ARM-5 are acceptable with a relevant comparison sample, internal consistency reported as (alpha = .88) (Cahill, et al, 2012). Although the dyads completed the ARM-5 after each session, the data was not used because it lacked utility due to continuous ceiling effects leading to each session being scored as 35 and almost no variation between therapist and client in their scores of the alliance.

Helpful Aspects of Therapy form (HAT).

The HAT form was modified to focus participants' evaluations of the session on aspects of the therapy related to the therapeutic alliance. The HAT form (see appendix G) was completed by the clients at the end of each of their EMDR sessions however, the data collected offered very little, if any, utility due to ceiling effects, and limited and vague comments. Therefore, this data was excluded from the main study.

Working Alliance Inventory – Observer Short Form (WAI-O-S).

Given the lack of a single agreed definition of the TA, the measurement of the TA also varies, with many alliance measures to choose from when conducting research. The different tools for measuring the alliance are based on somewhat divergent theoretical conceptualisations of the alliance. Some measures attempt to capture specific conceptualisations of the alliance, such as the Penn Helping Alliance Scale (PENN; Morgan, Luborsky, Crits-Christoph, Curtis & Solomon, 1982), the California Psychotherapy Alliance Scale (CALPAS; Gatson, 1991), and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), whereas other measures attempt to capture a blend of alliance constructs, such as the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983) and the Therapeutic Alliance Rating Scales (TARS) (Marziali, Marmar & Krupnick, 1981). The consequence of this is that the measure used will lead researchers to focus on different aspects of the alliance in data collection and interpretation. See figure 9 for the genealogy of the most commonly used alliance measures.

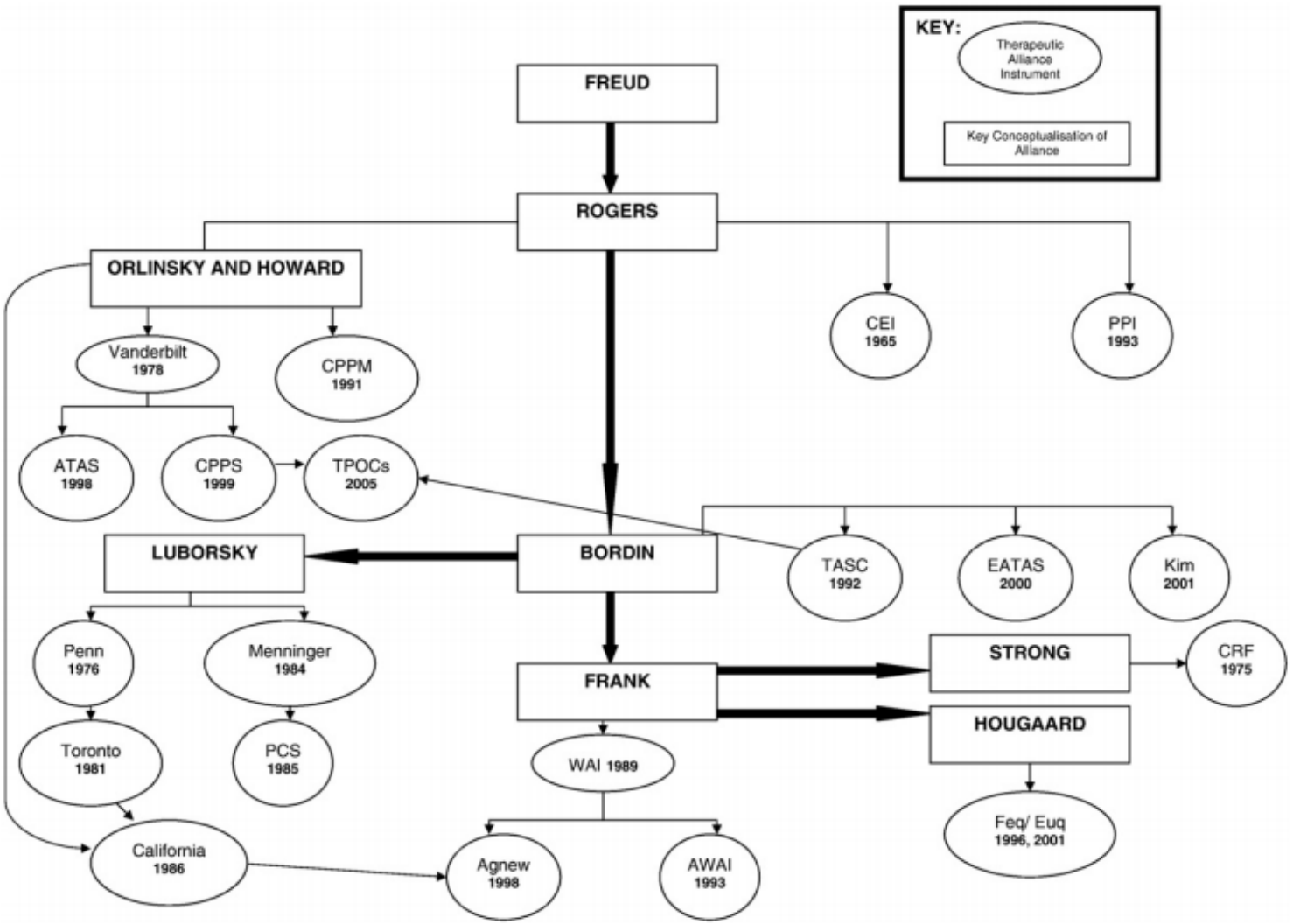

Figure 9. The development of the construct of the therapeutic alliance (Elvins & Green, 2008).

In a comprehensive review of alliance measures, Elvins and Green (2008) concluded that the WAI, VTAS, and CALPAS have received more empirical scrutiny and support in the literature than other scales. The WAI (Horvath & Greenberg, 1989) has conceptual roots in the first generic synthesis of an alliance construct by Bordin (1979). A meta-analysis of substantive alliance studies in the adult literature (Martin et al., 2000) included comparison of the alliance instruments used in different studies. The WAI was used most often (n= 22), followed by CALPAS (n= 16), Penn (n= 12), Vanderbilt scales (n= 9) and TARS (n= 5); of these, the WAI showed the best interrater reliability (r= 0.92 overall).

The WAI scales were shortened from 36 items to 12 items by Tracey and Kokotovic (1989), and Tichenor and Hill (1989) adapted the WAI to be rated by observers (WAI-O) by adapting the pronouns from the client and therapist forms. The observer version of the WAI was utilised because our study's sample consisted of videotaped sessions of EMDR. Tichenor and Hill (1989) found the WAI-O to be internally consistent (r=.98) and to have high inter-rater reliability (ICC=.92).

The selection of the WAI-O-S in this study meant that the research focused on the conscious features of the TA and did not consider unconscious processes, i.e. transference and counter-transference (see; Freud, 1912; 1935). An additional focus on the unconscious may have been useful in considering the fluctuations in the alliance during EMDR as the WAI is not capable of scoring when non-verbal events were observed during therapy (e.g., bilateral stimulation in EMDR). The BSR method allowed for consideration of potentially unconscious aspects of the alliance to be brought into the consciousness as the therapist reflected on moments within the sessions. However, the focus of this study was on a pan-theoretical concept of the alliance which applies to diverse psychotherapeutic models and therefore transference was not the intended focus.

The use of the WAI-O-S for scoring sessions in thirds (approximately 20 minute segments) was decided during a number of research meetings. The rationale was to capture the alliance during each session; the three segments captured the beginning, middle and end and offered enough therapeutic process in each segment (20 minutes) to be meaningfully scored on the 12 items.

Section 2.1: Extended Analysis

In 1991, Jacobson and Truax offered a methodology by which a client's change on an outcome measure can be classified in the following categories: recovered; reliably improved; no change; deteriorated. There are two pieces of information necessary in order to make these

client's outcome classifications: Reliable Change Index (RCI) and a functioning (symptom level) cut-off score called Clinically Significant Change (CSC).

Reliable change index.

Reliable change was a concept introduced by Jacobson, Follette and Revenstorf in 1984. The RCI is a statistic that we can use to work out whether a change in an individual's score (e.g., before and after some intervention) is statistically significant or not (based on how reliable the measure is). It is defined as the change in a client's score divided by the standard error of the difference for the test(s) being used. It is a standardized score representing the change in a client's score on a test. The RCI is equal to the individual's score before the intervention minus their score after the intervention then divided by the standard error of the difference of the test (Jacobson & Truax 1991).

Clinically significant change.

If an individual has achieved reliable change, then their post-treatment score can be investigated to determine whether this change is also clinically significant. Clinically Significant Change (CSC) was introduced in the same paper by Jacobson, Follette and Revenstorf (1984). However, CSC is different; this considers whether a change in an individual's scores has taken the person from a score typical of a problematic, dysfunctional client group (those scoring in the clinical range for anxiety and depression in this study) to a score typical of the "normal" population.

Inter-rater reliability.

Inter-Rater Reliability (IRR) analyses aim to determine how much of the variance in the observed scores is due to variance in the true scores after the variance due to measurement error between coders has been removed (Hallgren, 2012), often seen simplified to: observed score = true score + measurement error, abbreviated to symbols X=T+E with the corresponding equation Var(X)=Var(T)+Var(E).

Whilst Cohen's (1960) Kappa is readily used, this statistic quantifies IRR based on an all-or-nothing agreement. Instead, ICCs incorporate the magnitude of disagreement and therefore quantifying the consistency between raters rather than absolute agreement. This approach was considered more appropriate for this study given that the WAI-O-S measure has a large scoring range for each of the 12 items of 0-84 and therefore it would be unlikely to yield exact correlation.

A subset of the segments of the EMDR sessions were rated by multiple (two) coders with the remainder coded by single coder, rather than all sessions being rated by both coders. The percentage of segments coded by both raters was 25% so for each case i.e., 21 segments =

5.25 segments (5 rated by second rater). The ICC was calculated in SPSS (see table 8 for the SPSS results). The ICC was found to equal 0.78, which is considered an excellent correlation (Cicchetti, 1994); approximately 78% of observed variance was therefore considered to be due to true score (similarity between coders) and 22% due to error variance. However, a criticism of using percentages is that they do not correct for agreements that would be expected by chance and therefore overestimate the level of agreement. Despite this, the ICC scores demonstrated in this study are similar to acceptable scores reported in the wider literature (Strunk, Brotman & DeRubeis, 2010; Webb, et al., 2011).

Visual analysis.

The use of statistical methods alongside visual analysis is generally debated, but supported whenever it is appropriate to do so (Kratochwill, Levin, Horner, & Swoboda, 2011). The predominance of visual analysis as the preferred method of data analysis in the single-subject research literature was first empirically demonstrated by Kratochwill and Brody (1978), and later supported by Busk and Marascuilo (1992). Visual analysis remains the standard by which SCED data are most commonly analysed (Parker, Cryer, & Byrns, 2006). Visual analysis methods are especially adept at determining intervention effects and can be of particular relevance in real-world applications (e.g., Borckardt et al., 2008; Kratochwill, et al., 2011). However, some have shown visual analysis can be inconsistent (Matyas & Greenwood, 1990), which may stem from a lack of formal decision rules to guide inferences. Visual analysis can also make it difficult to compare results to the effect sizes generated by other statistical methods which may be important for considering the effect of the alliance in EMDR therapy. The focus of this study is predominantly investigative rather than evaluative, with limited empirical evidence regarding the impact of the alliance in EMDR currently. Visual analysis encourages the researcher and reader to fully examine every aspect of the data to determine sources of variability rather than just overall effects and easily identifies extremes within the data on all measures.

- Level refers to the mean performance during the study.
- Trend references the rate of increase or decrease of the best-fit straight line for the dependent variable within a condition (i.e., slope).
- Variability refers to the degree to which performance fluctuates around a mean or slope during a phase.

In visual analysis, the reader also judges the magnitude of changes in the measures and the consistency of data patterns across the intervention. All scientific research can be conceptualised as attempting to account for variability in the phenomenon of interest. The

single-participant design both methodologically and epistemologically distinguishes itself from group designs in psychology, in the treatment of variability. Individual differences make no contribution to the variance in single-participant designs because no comparisons are made across participants unlike in group (within-participant) designs. A participant's behaviour at one point of the experiment, or therapy, is compared with their own behaviour at another time, not with the behaviour of other participants. This is viewed as the only relevant comparison because in most natural settings, the question will be whether an individual's behaviour has changed relative to his or her own baseline, not relative to that of another person.

This study can be conceptualised as applied research given it was conducted within a clinical setting (mental health service) which is a natural environment. It can be argued that in the 'real world', treatment objectives do not centre on how group averages respond to manipulated variables and interventions but instead change is captured through multiple measures taken over prolonged observational periods. This more refined assessment of the data can reveal extraneous factors e.g. deviations from a steady pattern in the absence of manipulating variables. Such deviations are considered a positive as they are informative about functional relationships and can, in applied settings, prove especially useful in the development and modification of a treatment program.

Techniques for analysis and interpretation of single-subject data fall into two main categories; visual analysis and statistical analysis. The presentation of data in this study displayed individual participants' measures rather than summarising aggregate measures. The hallmark features of multi-phase, single-subject designs are the repeated observations of the dependent variable and the presentation of the raw data record, which is usually represented graphically and readily lends itself to visual analysis (Perdices & Tate, 2009). Although little consensus has emerged regarding the appropriate method of analysing single-participant data, many single-participant researchers continue to justify the graphic display and visual analysis of such data (Hopkins, Cole, & Mason, 1998). Single-participant researchers argue that meaningful effects of an independent variable ought to be noticeable on visual inspection (Morgan & Morgan, 2001).

Section 2.2: Extended Framework Analysis

Framework Analysis (FA) was developed as a pragmatic approach for real-world investigations within social policy research in the UK (Ritchie & Spencer 1994, Ritchie et al., 2003). The approach is now increasingly used in healthcare including psychological research settings (Swallow, Lambert, Santacrose & Macfadyen, 2011; Tierney, et al., 2011). It was developed for addressing specific questions within an applied research approach and

therefore is useful for informing practice, such as guidance for therapists. FA gives applied researchers a structured process for managing data whilst allowing for the flexibility associated with qualitative enquiry (Swallow, et al., 2011). It provides transparent results and offers conclusions that can be related back to original data (Johnston, Milligan, Foster & Kearney, 2011). Similar to other qualitative methods, FA involves a number of stages that allow for theme-based analysis, including data immersion and reduction and a comparison of emerging themes (Ward, Furber, Tierney & Swallow, 2013). FA has been criticised for lacking the same theoretical underpinnings as other qualitative approaches such as grounded theory and ethnography (Smith & Bekker 2011), though this can have advantages.

The framework for the analysis in this study was developed by the primary author based on theoretical understandings of the TA from a broad perspective. This involved the primary researcher identifying the core components of the TA common to the most widely used definitions within the literature, as described below.The three domains of Bordin's (1979) trans-theoretical definition of the TA were initially explored given that this study primarily utilises Bordin's definition. Individual alliance items from other dominant models were then considered in order to further delineate these three categories (agreement on tasks, agreement on goals, bond), in order to extrapolate nuanced information from the qualitative data using the FA approach.

The individual alliance items were taken from reviews of the literature regarding the elements of the alliance to include a broad range of empirical evidence in particular; Akerman and Hilsenroth (2003), and Elvins and Green (2008). Both indications and contraindications for the strength of the alliance were considered. For example, the CALPAS measure was used to consider the presence of negative aspects (contraindications) as it includes items that support exploration of potential ruptures in the TA alongside identification of positive indications of the alliance. A table of the deductive themes was created from this in order to guide the coding phase; the table labelled each of the deductive themes and described evidence for and against, for each of the themes (see Figure 3). The theme titles (items) and descriptions of each of these seen in Figure 3, were taken from the scoring manual of the WAI-O-S in order to develop a framework with a clear description for each of the items. The framework developed was used to code each relevant line of the transcribed interviews. Lines without any data relevant to the framework were open coded to enable new themes to emerge from the interview data. The primary author transcribed each of the interviews, documenting verbal communication verbatim, from the password protected USB memory stick onto a password protected computer and Word document.

The transcripts were read a number of times and the margins were used to annotate anything that the participants said related to the aims of this study. The transcripts were then considered in respect to the pre-identified themes in line with deductive framework analysis, whilst allowing any new themes to emerge (inductive).

The purpose of the FA in this study was to support understanding of the fluctuations in the alliance over the course of the two EMDR therapy cases, as well as further understand client and therapist perspectives of the role of the TA in EMDR therapy.

Extended Results Section

Section 2.3: Reliable Change Index and Clinically Significant Change

The RCI criterion was used for the distress (GAD-7 and PHQ-9) and functioning (WSAS) measures, using a reliability coefficient (Cronbach's Alpha) and the standard deviation (SD) of the sample at pre-treatment assessment for each of the measures. The PHQ-9 alpha was .83, clinical norm mean score = 12.7 (SD = 6.47), comparison norm mean score = 6.25 (SD = 6.01) (Cameron, Crawford, Lawton & Reid, 2008). The GAD-7 alpha was .92, clinical norm mean score = 14.4 (SD = 4.7), comparison norm mean score = 4.9 (SD = 4.8) (Spitzer, Kroenke, Williams, and Lowe, 2006). The WSAS alpha was .82, clinical norm mean score = 18.81 (SD = 9.17), comparison norm mean score = 13.75 (SD = 9.59) (Zahra, et al, 2014). The reliable change criterion was calculated as 3.68 for the GAD-7, 7.39 for the PHQ-9, and 10.78 for the WSAS. Therefore, the participant's score had to improve by the respective calculations from pre- to post-therapy to be able to demonstrate that they have made reliable improvement. If the RCI is 1.96 or greater, then the difference is said to be statistically significant (1.96 equates to the 95% confidence interval). The CSC offers three different criteria (see Figure 10). This study used criterion C to consider whether each client had moved from clinical to non-clinical ranges on each of the measures (Morley & Dowzer, 2014).

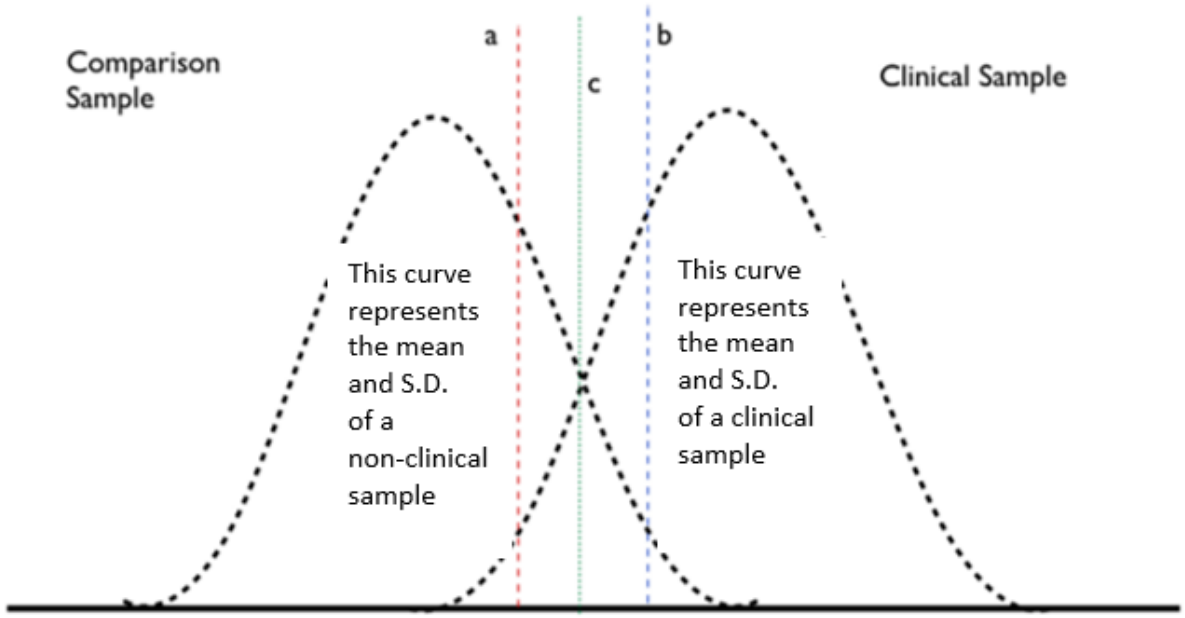

Figure 10. Three criteria for considering CSC (Morley & Dowzer, 2014).

The cut-off points were calculated at 9.7 for the GAD-7, 9.36 for the PHQ-9, and 16.34 for the WSAS based on existant literature regarding the mean and S.D. for clinical and non-clinical populations. . Refer to Figures 11, 12 and 13 for the cut-off score for each measure plotted onto bar charts for each of visual interpretation; the black line represents the score that each client must fall below for each of the measures,to be said to have achieved CSC

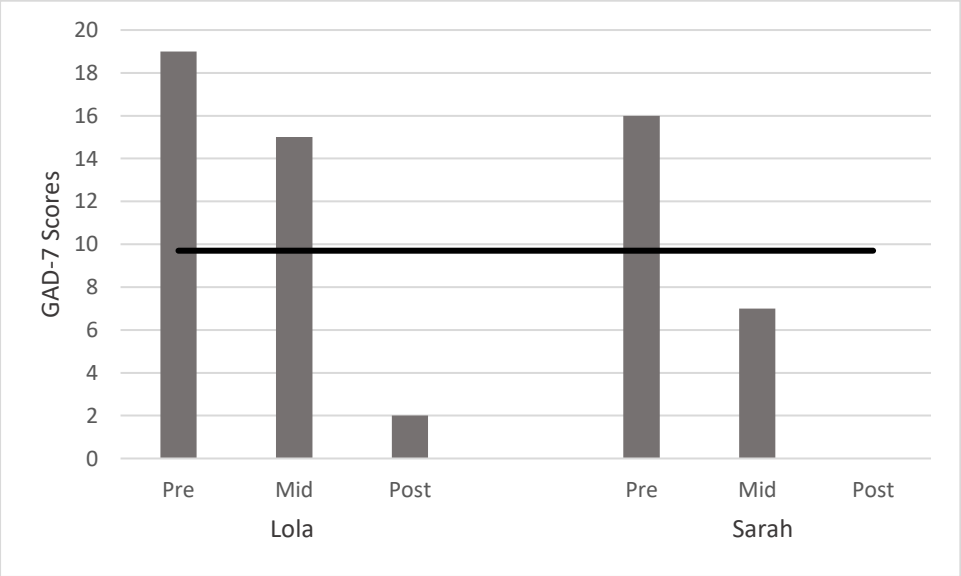

Figure 11. Clinically Significant Change for the GAD-7.

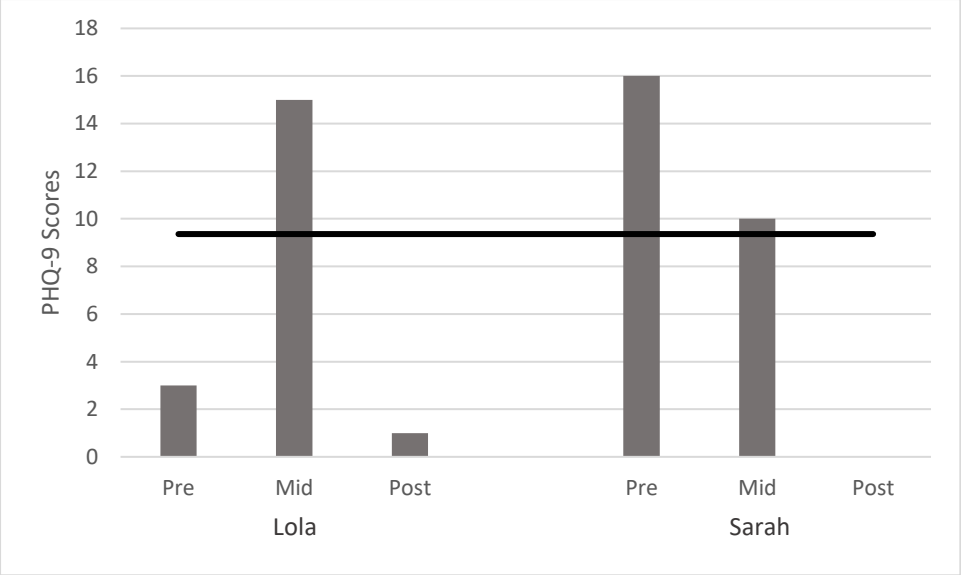

Figure 12. Clinically Significant Change for the PHQ-9.

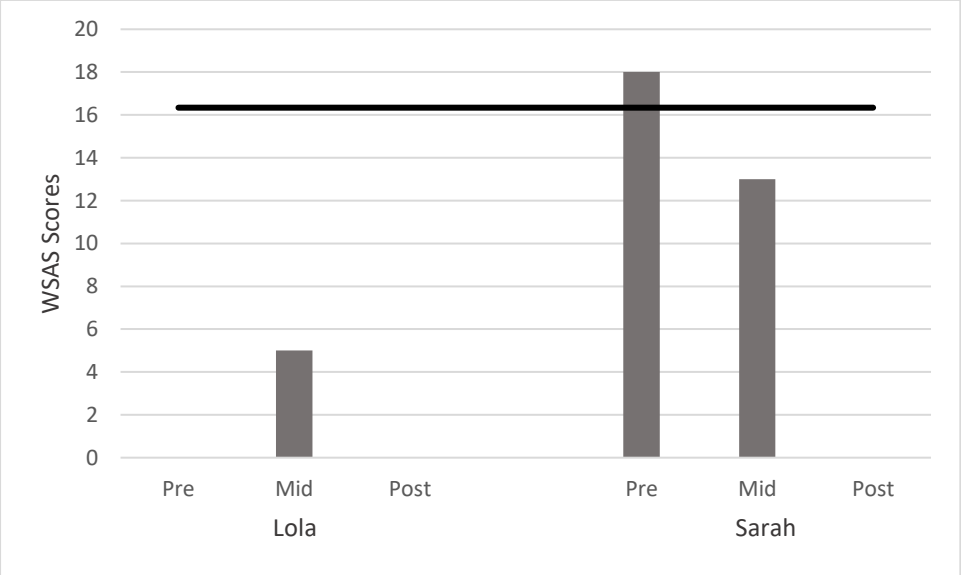

Figure 13. Clinically Significant Change for the WSAS.

Lola was retired which helped explain a lack of scoring on the WSAS however, interestingly her functioning difficulties increased mid-therapy, perhaps due to the strain/ emotional effort that therapy requires given a lack of change in her social context during the treatment. An alternative measure may have been chosen to measure Lola's functioning given that half of the items on the WSAS refer to employment. However, this was not persued given the burden of completing further measures above those required within the service. Furthermore, ther was likely to be limited value to the research aims of an additional functioning measure given Lola's primary symptoms were represented by the GAD-7 and

PHQ-9. Sarah, in line with the other measures, experienced reduced difficulties in functioning incrementally during the treatment, reaching significant change by post-treatment.

Section 2.4: Inter-Rater Reliability

The ICC statistic was used instead of the more commonly used coefficient alpha. The ICC more accurately represents data that has been coded by researchers, rather than original data itself as would be extracted for example from participants' answers to a survey. Given the ranked data that the WAI-O-S generated with each video recorded session segment scoring on a range of 0 – 84, absolute agreement was deemed less appropriate than a measure of consistency between the two raters. A two-way mixed effects model where people effects are random and measures effects are fixed was calculated in SPSS; results can be seen in Table 8.

Table 8

ICC Results in SPSS.

Intraclass Correlation Coefficient							
	Intraclass Correlation[b]	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df1	df2	Sig
Single Measures	.775[a]	.325	.939	7.904	9	9	.003
Average Measures	.873[c]	.491	.969	7.904	9	9	.003

Section 2.5: Visual Analysis

The visual analysis in this study reveals a potential criticism of the WAI-O-S measure as it appears to remain relatively constant throughout the EMDR treatment and therefore correlation is less obvious as both variables require variance (alliance and distress). This is likely to be an issue of the sensitivity of the WAI-O-S given that the alliance reaches the highest score (84) and therefore ceiling effects appear to have occurred. However, given that the alliance was not measured during the preparatory/assessment sessions, it may be that any variation in the alliance was missed. Whilst measuring the alliance during preparatory sessions could have offered further information regarding the development of the alliance, this study only measured the alliance during EMDR specific sessions which did not begin until after the preparatory (assessment) sessions.Furthermore, it could be considered that if floor effects were found then the outcome of the treatment would be different given the

literature regarding the importance of a strong alliance to psychotherapeutic outcomes. Therefore, the alliance scores remain informative within the two cases presented.

Section 2.6: **Qualitative Data**

Initially an additional theme appeared to emerge inductively from the data, which was labelled 'flexibility'. Flexibility was eventually subsumed into 'Genuineness' as the participants described the importance of the therapist remaining flexible in timings of the session related to feeling cared for.

The deductive themes chosen may have prevented unique themes emerging due to their broadness. The use of sub-themes could have aided a more nuanced understanding; future qualitative research in this area may benefit from a more in-depth analysis of client and therapist perspectives to further consider whether this corresponds with previous research or unique perspectives of the TA within EMDR emerge, and what this means within therapeutic contexts. [See appendix H for an exerpt of the transcript with coding]

Extended Discussion Section

Section 2.7: Relationship Between TA and Outcomes

Similar to other correlational research, this study can be criticised as the alliance may not be causal to the observed clinical outcomes (GAD-7, PHQ-9, WSAS). It may be that the clients' contributions (Lola and Sarah) to the alliance were salient; individuals with better prognoses are able to form better alliances and have better outcomes (Garfield, 1994). However, if this was the case then we would expect Lola to have formed a better alliance and achieve superior outcomes than Sarah whose symptoms were more severe pre-treatment. Nonetheless, the individual client characteristics, including symptom severity, were not investigated within this study and therefore cannot be meaningfully commented upon. Although demographic data were gathered by the primary author, documenting in-depth information would have been inappropriate for confidentiality reasons given the small sample size (two clients). Future research in EMDR may therefore benefit from using a larger sample and assessing client characteristics in order to further understand the potential influence on these within the TA in EMDR. In contrast to these findings, other authors have found that the therapists' contributions to the alliance predict outcome rather than the clients' contribution (e.g., Baldwin, et al, 2007) (see section on therapist and client characteristics below for more information). Recognising the criticisms of correlational data, a number of studies have controlled for early symptom change to explore the relationship between alliance and outcome. These studies offer evidence that the alliance is predictive of client change (e.g.,

Baldwin et al., 2007; Crits-Christoph et al., 2011; Falkenström, et al, 2013; Webb et al., 2011).

The mechanisms of change within EMDR, although not fully agreed upon, are thought to be related to the information processing systems within the brain (see previous section on the AIP for further explanation). According to Chambless and Crits-Christoph, (2006): "Of all the aspects of psychotherapy that influence outcome, the treatment method is the only aspect in which psychotherapists can be trained, it is the only aspect that can be manipulated in a clinical experiment to test its worth, and, if proven valuable, it is the only aspect that can be disseminated to other psychotherapists" p.199. Although common factors are less easily measured in a recognised scientific approach, such as RCTs, it is naive to dismiss them given the convincing evidence of its impact on outcomes (e.g. Martin et al, 2000; Horvath et al, 2011). Excluding common factors from the evidence base restricts the manner in which findings are interpreted and limits a holistic understanding of psychotherapeutic processes. Substantial evidence from the common factors approach can be thought of as having been given low evidentiary prioritisation with RCTs being deemed the gold standard for scientific research. However, this limits our ability to maximise clinical outcomes. Therefore, ongoing exploratory research, such as the current study, is required to continue developing an in-depth understanding of how and why particular ESTs, such as EMDR, can be maximised within clinical settings i.e. therapeutic services such as IAPT.

The EST approach proposes that psychotherapeutic treatments contain specific techniques that are purported to remediate identifiable deficits that form the diathesis of a given mental disorder (Barlow, 2004; Chambless & Hollon, 1998). Component studies can help to further understand particular aspects of therapeutic approaches that account for therapeutic outcomes. A comprehensive meta-analysis concluded that there was minimal impact with differing amounts of components in the psychotherapies being practiced, concluding that added specific ingredients appear to modestly contribute to outcomes (Bell, Marcus & Goodlad, 2013). This suggests the role of common factors is present. Currently, dismantling studies of EMDR have focused on populations presenting with PTSD for example, De Jongh, Ernst, Marques and Hornsveld (2013) looked at the impact of BLS (whether this particular component influences outcomes). Future research may benefit from a component study which identifies both specific EMDR techniques and common factors to consider both their presence and their interaction within the therapy to consider the association with outcomes. This would be useful in EMDR for a variety of mental health difficulties, given the influence of symptomology on outcomes (Garfield, 1994), although the

underlying theory of EMDR (AIP theory) suggests the same mechanisms of change within the divergent diagnoses for which it has been applied.

The common factors argument does not dismiss the need for ESTs, including techniques based on theories regarding development and amelioration of mental health symptoms; it does not suggest that a relationship with a therapist is sufficient, as some have misinterpreted (Laska, Gurman & Wampold, 2014).

Section 2.8: Influence of TA in Protocol Driven Therapies

A number of concerns regarding the manualisation of psychotherapy have driven researchers to consider the role of the TA specifically in these more structured therapies. With the increasing influence of technology from which the therapeutic world is not immune, this is of growing importance for the future of psychotherapy delivery. Currently, the alliance in this area is mixed, with some studies suggesting that the alliance remains significant within disorder-specific manualised treatments (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012) whilst others have suggested that the alliance is not as salient in such therapies (Ormrod, Kennedy, Scott & Cavangh, 2010). The aim of manualised treatments is to reduce individual therapist factors by diminishing variability with the use of instructions for delivering sessions. However, this runs counter to the evidence that individual therapists can have a substantial impact on client outcome (e.g., Crits-Christoph & Mintz, 1991).

Another area in which the TA has been questioned is self-help therapies. The importance of paying attention to common factors for effective CBT in self-help materials has been highlighted (Peck, 2010; Richardson & Richards, 2006). However, this research is hampered by the varying definitions of what self-help is, particularly how much support is available within a particular package/programme (Lewis, et al, 2003). The drive for offering self-help interventions, similar to some of the impetus to offer time-limited therapies (such as in IAPT services), is primarily financial. This is especially true for the common mental health difficulties such as depression and anxiety, given the relatively large percentage of people that will suffer from such symptoms at some stage in their life (McManus, Bebbington, Jenkins & Brugha, 2016; NICE, 2011).

Section 2.9: Alliance Patterns

In previous studies, clients have described the importance of therapists being flexible and allowing the client to pace the therapeutic process themselves (Noyce & Simpson, 2016). The concept of pace is particularly interesting in therapies such as EMDR, which adhere to strict protocols, especially when being delivered in a time-limited service. The framework

analysis revealed that the clients in this study did not feel rushed and that the therapist thought carefully about the balance of material to cover in order to achieve this.

Another similarity to the Noyce and Simpson (2016) review was a sense of empowerment that seemed to propel the clients towards taking control and implementing positive action independently to support their emotional well-being. Both clients in this study clearly took positive action. For example, they both utilised the skills outside the therapy room (in-between sessions) e.g. practicing the safe place technique. This may be due to feeling empowered, it may also relate to general self-motivation (as expressed by Lola in interview), and/or early positive results (reduction in symptoms) reinforcing further implementation of techniques.

A rupture in the therapeutic alliance can be defined as a tension or breakdown in the collaborative relationship between patient and therapist (Safran & Muran, 2006); which have been defined in terms of two specific types of markers[6], labelled 'withdrawal' and 'confrontation'. A withdrawal marker is a patient behaviour indicating disengagement from an emotional state, from the therapist, or from some aspect of the treatment. It includes patient movements away from the therapist (away from the other); examples include silences, minimal responses, topic shifts, abstract talk, and storytelling; these are movements toward autonomy and isolation. Withdrawal also includes patient movements toward the therapist (away from self); examples include begrudgingly or too readily complying with a therapist, doing something with great anxiety or cynicism; these are movements marked by compliance or appeasement. A confrontation marker is most commonly a direct expression of anger or dissatisfaction by the patient about the therapist or some aspect of the treatment. It essentially involves patient movements against the therapist; these are movements marked by aggression and control; examples can also include coercions like being overly friendly or seductive.

An alternative research direction would involve, rather than training therapists, the provision of ongoing feedback to therapists on the quality of their alliances with patients. The framework analysis conducted offers qualitative data in support ofthe presence of smaller moments of rupture and repair with the therapist describing being aware of potential ruptures, for example she described paying more attention to the TA at the beginning with Sarah to strengthen the alliance due to potential ruptures. Conversely, the clients did not report any ruptures within their therapeutic relationship.

[6] patient behaviours and/or communications

Authors have emphasized the importance of alliance rupture-repair sequences that are repaired through interpersonal exploration between client and therapist. These authors have argued that working through alliance ruptures may be a key pantheoretical change mechanism in its own right (Smith-Hansen, 2010). In these cases, if the therapist's potential recognition of alliance ruptures would likely to have minimised or prevented any negative effects of ruptures on the client's symptom ratings in the following session. This fits with previous studies highlightinged the importance of therapists' recognition of deterioration in the alliance for a repair process to take place that may eventually lead to an improved relationship and outcome (Chen, Atzil-Slonim, Bar-Kalifa, Hasson-Ohayon & Refaeli, 2016). Furthermore, when therapists accurately assess their clients' progress throughout treatment, they can become better attuned to the client's needs from session to session and, if needed, renegotiate the therapeutic contract (Lambert & Shimokawa, 2011).

Section 3.0: Sudden Gains

The framework known as 'sudden gains' was developed by Tang and DeRubeis (1999) and can be used for fine-grained analysis of individual change patterns in psychotherapy. The majority if the literature focuses on sudden gains in CBT for depression, as was the initial focus of Tang and DeRubeis (1999). Findings from the initial study on sudden gains in CBT for depression suggested that cognitive changes may result from a strong therapeutic alliance and consistent application of CBT techniques in the early stages of therapy (Tang & DeRubeis, 1999). Tang and DeRubeis (1999) findings have since been supported by Hardy et al (2005). The evidence from Hardy et al. (2005) suggested that sudden gains occur across a range of treatment approaches (not just CBT) that do not work specifically on client cognitive change, then perhaps a more transtheoretical model should be developed to explain sudden gains.

Sudden gains experienced early in treatment tend to yield stronger effects than sudden gains experienced in later treatment sessions (Busch, Kanter, Landes, & Kohlenberg, 2006; Kelly, Roberts & Ciesla, 2005; Stiles et al., 2003). Therefore, the literature on sudden gains might be helpful in determining the optimal number of sessions for a particular client. However, the majority of sudden gains literature is from RCTs rather than routine clinical practice. In this study the use of the HAT form could have helped identify sudden gains, should they exist, within EMDR. The sudden gains framework has not currently been utilised to assess EMDR and therefore future research may consider sudden gains to further understand how and when symptom change occurs in EMDR.

Section 3.1: Therapist and Client Characteristics Influencing the TA

Increasing evidence has highlighted the variability in therapist factors associated with clinical outcomes, for example, Okiishi, Lambert, Nielsen and Ogles (2003) conducted a large study involving 91 therapists. The outcome showed considerable variability, with the most effective therapists' clients showing both rapid and substantial treatment response, whereas the least effective therapists' clients showed an average worsening in functioning. Variability attributable to individual therapists provides an opportunity to directly manage and improve outcomes in specific services.

Several recent studies have investigated the impact of therapist versus patient variability in the alliance, suggesting that the therapist contribution is more critical than the patient contribution to the alliance-outcome correlation (Baldwin, et al., 2007; Dinger et al., 2008). However, studies have shown that the patient's quality of past and present relationships is positively related to the alliance (Kokotovic & Tracey, 1990; Mallinckrodt, 1991; Piper et al., 1991). Friendly submissive interpersonal styles, the ability to trust, and comfort with intimacy have been positively related to the alliance (Kivlighan, Patton, & Foote, 1998; Muran, Segal, Samstag, & Crawford, 1994; Satterfield & Lyddon, 1995), whilst hostility, fear of abandonment, defensiveness, and perfectionism have been found to be negatively related to the alliance (Gaston, Marmar, Thompson & Gallagher, 1988; Kivilighan et al., 1998; Kokotovic & Tracey, 1990; Zuroff et al., 2000). This runs counter to the drug metaphor of psychological therapy, which suggests that therapeutic effectiveness rests mainly on ensuring that therapists only use ESTs and closely adhere to the related treatment manuals.

In the case of clients and therapists, therapists have experienced the alliance with other clients and may rate their alliances with current clients relative to those with previous clients. Clients may have had little prior experience in therapy and, therefore, have minimal comparison therapy experience against which to judge their current alliances. Clients however, may have had experience with other health service professionals and may rate the alliance in terms of this perspective.

In the review by Noyce and Simpson (2016), note-taking was highlighted as a barrier to the formation of the TA. They suggest that as note-taking is more prevalent at the beginning of therapy (need for gathering information) this could impact on the newly forming relationship. Subsequently, the study recommends that clinicians consider more creative ways of gaining this information e.g. audio-record sessions instead of writing notes (Noyce & Simpson, 2016). In EMDR, note-taking is present in a number of the phases, including the assessment and ongoing preparation phases prior to desensitisation and installation phases

using BLS. This highlights a potential tension within more protocol driven therapies, such as EMDR, to remain faithful to the model, whilst recognising how this may impact on the TA. This study somewhat contradicts the findings by Noyce and Simpson (2016) as the clients did not comment on the therapists' use of writing notes in the sessions (although this was not specifically asked about during interviews). In contrast, the therapist commented on her use of note-taking as potentially a barrier to the relationship, stating that at these times "I'm not giving her eye contact". Nevertheless, the therapist's overall sense was that this did not hamper her alliance with the clients, however, the therapist suggested alternatives ways that she may use when taking notes in her future therapeutic work (e.g., "I'm wondering whether I should have sat over the other side to do this protocol writing…might have been a way to give her that eye contact").

Section 3.2: Clinical Implications

This study supports the conclusion that the TA is present within EMDR therapy as would be predicted from the wider literature (e.g., Martin et al., 2000). The paucity of empirical evidence regarding the TA in EMDR offers little information regarding its role within EMDR; these findings support the various clinical writings highlighting the relationship as a factor that would benefit from further investigation in EMDR practice (e.g., Dworkin, 2005; Leeds, 2009; Parnell, 2007). Currently, within the EMDR literature and training little detail is provided about the formation of a safe, trusting, therapeutic relationship (Dworkin & Errebo, 2010). An increased focus on the relational aspects of EMDR, including encouraging clinicians to notice and repair ruptures, may increase positive outcomes and reduce the likelihood of individuals dropping out of EMDR. If this is the case then EMDR may be better understood and disseminated as both a protocol driven and relational psychotherapy.

This study offers further evidence regarding the effectiveness of EMDR. In particular, the findings suggest that a sense of safety is a pertinent aspect of the alliance; which appears to be related to the distinctive techniques (e.g., bilateral stimulation) used in EMDR, as described by Sarah; "at first I thought this is a bit bonkers when she's waving her hand". This supports previous findings (Marich, 2010; 2012), suggesting that EMDR therapists are more likely to engage clients in the protocols if a strong trusting alliance is developed and maintained during the treatment. Whilst a TA is marginalised within traditional EMDR writings (e.g., Shapiro, 2001), the findings here indicate it has a substantial role in successful treatment.

The efficacy of EMDR has been evidenced within controlled studies (e.g., Bisson et al., 2013) and therefore, is recognised as an EST and included in NICE guidelines; however, this evidence is questioned for a lack of external validity (applicability to clinical settings; Rothwell, 2005). This study builds on PBE, which offers high external validity and therefore develops understanding of not only whether a treatment is efficacious but also its effectiveness within real-life clinical contexts. Whilst publication of ESTs can help clinicians differentiate between scientifically supported treatments and those based on pseudo-science (e.g. clinical judgement), the criteria for establishing that a treatment is scientifically supported is far from agreed upon and therefore lists of ESTs must be considered as one part of a larger evidence base influencing clinical practice. Therefore, PBE also has value in guiding which treatments are recommended and how they are practiced in routine clinical settings. This study proposes the role of the TA is influential for successful delivery of EMDR in primary care and therefore advocates for a greater understanding of how the protocols interplay with the alliance during EMDR to optimise practice. Whilst the conclusion that services should consider how offering EMDR interventions with a more relational focus is premature based on these findings, this is an area of future research. In particular, further research focusing on the interaction is needed to further understand the impact of the alliance in EMDR.

Section 3.3: Limitations and Future Research

Whilst this study has some clear strengths and offers much to both the literature and practice of EMDR, a number of limitations have been considered. The use of treatment fidelity checks, which are recognised as important within outcome studies to ensure that interpretations of the data are based on treatment delivery as expected (Moncher & Prinz, 1991), may have strengthened this study treatment, Therefore, fidelity checks could have supported conclusions based on the premise that protocols delivered to both clients during the therapy, were delivered using a pure model of EMDR. However, the main focus of this study was not assessment of outcomes, where the importance of fidelity is high, in order to interpret the efficacy of a (new) treatment. Furthermore, the service chosen (IAPT) is a time-limited service offering manualised treatments to individuals in which protocols must be adhered to, instead of other services such as a Step-Four psychological service in which therapies are more likely to be delivered in an integrative manner to more complex presentations. Nonetheless, there may have been occasions when the therapist in this study utilised EMDR protocols in a flexible manner that would not be considered as pure EMDR techniques (e.g., use of non-cognitive interweaves). Future studies would benefit from utilising a fidelity

check although this would have to be balanced against the burden on participants in completing several measures for the purposes of research. It is well recognised that applied research within routine clinical settings cannot maintain the same methodological rigour given high case-load limiting time to complete additional measures for the purposes of research (Schoenwald & Hoagwood, 2001).

There was no clear measurement of a baseline period for the cases presented. The principal focus of the study was to better understand the trajectory of symptoms and how this correlated with the TA, rather than solely on symptom reduction.Hence, capturing a stable baseline period of symptom stability was not of primary importance. Nonetheless, baseline measures could have supported the interpretation of symptom amelioration despite both cases meeting pre-determined criteria (clinical cut-offs) for receiving therapy within the service. Measures of the TA pre-treatment (at the initial service assessment) would have allowed further consideration of when the alliance levelled out, or whether it was strong from the very first meeting with the therapist. However, ethical and practical restraints did not allow for this because each client attending the service is initially assessed prior to deciding on their treatment pathway. Theethical approval gained for this study did not allow for researchers to approach potential participants (clients) until they had been assessed as suitable for EMDR within the service. Additionally, technology difficulties with recording the sessions interrupted optimum data collection, for example, a power-cut occurred during one of the earliest sessions for Lola and therefore only 90 seconds of recording was collected. Future studies would benefit from capturing TA measures from the first meeting with the therapist in order to further consider alliance patterns, for example, was the TA high from the beginning or did it increase over the course of the first few sessions before levelling out.

As with any interviews, those conducted with the therapist and clients may be limited by demand characteristics (e.g., attempting to please the researcher). The interviewing researcher is experienced in research and clinical interviewing and allowed time at the beginning of the interviews to build rapport with the participants to encourage an open interaction. Furthermore, this research was not conducted within a positivist paradigm but critical realism and therefore the potential influence of the researcher is accepted and no one truth is sought.

As with all small N study, the sample is limited to a small demographic. In this study the two participants were females, 46 and 63-years-old. Whilst females are more likely to present with mental health difficulties, this study does not consider how the alliance may be with males, or for younger clients. Therefore, more research is required in this domain to

strengthen inferences that EMDR delivered in primary mental health care especially when considering the treatment of males and children /young people.

Critical Reflection

A reflective diary was kept throughout the research process to ensure quality and transparency with decisions regarding data collection and analysis. The reflective diary also supported the reliability of this study by managing researcher bias and being explicit about the assumptions made by the researchers through collection and interpretation of the data. This is in line with the critical realist stance assumed as the researcher's construction of reality is key to data interpretations (Morrow, 2005).

During the initial design phase of this research there was a tension between what could be achieved within the time-frame, what would be of interest to the research team, what would be meaningful to clinical psychology, and what is possible from an ethical standpoint. As is often the case at the beginning of new projects, there was hope and enthusiasm from the primary researcher. This mimics the hope that I often feel as a therapist at the beginning of therapy and the importance of instilling hope in clients seeking therapy (Cooper, 2009). Snyder (2000) asserted that agency, or self-belief, and willpower to reach the envisioned goal is essential in the face of challenges. Therefore, the belief that the project could be achieved was essential, which links to my initial high levels of hope.

Along with hope came my expectations for how I would complete the project. I found my expectations difficult to manage at times when the challenges increased, such as difficulties with recruitment. This taught me the importance of holding on to hope whilst being flexible in the pathways to achieve my goals, which I believe involves being able to adapt expectations as situations unfold within live research projects in applied settings that are not as controlled as quantitative experiments.

The first step in this project was to gain ethical approval from the appropriate boards. My initial focus on conducting research was contemplating the ethics board viewpoint which I considered thoroughly in preparing to submit the application for ethical approval. The initial considerations involved careful thought about how to conduct a clinically meaningful research project within an applied setting. The area chosen, the TA, is a complex concept and therefore quantitative approaches are less suitable for understanding the complexities of the phenomenon. It is not a variable that can be manipulated in the true form of an experiment i.e. offering therapy with an alliance to one group and offering therapy without an alliance to another. Despite being unethical given the literature demonstrating its importance for positive outcomes (e.g., Martin et al, 2000), it is also not possible, or very difficult, to offer therapy

without an alliance being present at all. Some computer based therapies may come close, but EMDR is a face-to-face therapeutic approach.

Having never completed such a large project previously, I was less prepared for ongoing ethical decisions that came up during the research process. I looked to the values of clinical psychology and of the NHS to guide my decision making, for example, respect, compassion and integrity. Whilst rules are absolute, values are flexible within any given context and therefore support ethical decision making. There were a number of occasions which involved changes to the project that required consultation with the ethics board;this created frustration due to time pressures for me to complete the project and overall doctoral course. Looking back, some of these delays may have been foreseen and a more comprehensive proposal to the ethics board would have supported the project by accounting for difficulties with data collection, which required some amendments. For example, due to technological problems, a second interview was required with one of the clients but I only had initial ethical approval to interview this participant once.

The practicalities of data collection within this study became a large obstacle. The use of a video camera to record therapy sessions and to secure this data onto an NHS computer took a vast amount of time. In particular, the video recordings from the camera transferred very slowly onto NHS computers due to processing speeds of the operating system, which are less advanced than current technology is capable of. Additionally, not all NHS computers had the ability to play the video recordings and this led to difficulties with the BSR interviews in terms of time and location. Having a more thorough understanding of the challenge may not have changed the design of this study, given the rich data that was collected via video recording however, being more prepared by consulting thoroughly with the IT Department prior to data collection may have supported this study.

The use of technology in research allows for both in-depth and accurate information to be gathered, as oppose to post-hoc evaluations gathered via post intervention interviews. Therefore, potentially increases the validity of the findings in this study, triangulation was possible therefore increasing the quality of the results. However, triangulation was not within the initial design of this study which started as a group design, relying on interviews post EMDR. I wonder now if I could have further developed the triangulation of the data gathered by exploring specific moments from the interviews with ratings of the alliance observed (WAI-O). This would allow for a more nuanced understanding of the fluctuations that occurred during the EMDR sessions. This was not necessarily possible as the client-participants declined a BSR interview and therefore the interview data was general.

The use of the ARM-5 and the HAT was initially a large aspect of this study. The aim was to gather the participants' experiences of the TA throughout the therapy, alongside the observation from the video recording, and to highlight salient moments using the HAT. I now think about how I could have encouraged the participants to better utilise the HAT form to indicate particular moments in the therapy which indicated fluctuations in the alliance.

I remained critical of quantitative measures which can miss individual experiences and neglect context and interpretation of symptoms for the individual. However, I recognise the usefulness that the structure of the psychometric measures used in this study allowed routine data collection throughout the EMDR therapy, rather than relying on post-hoc gathered data which can be susceptible to memory biases. However, I may have decided on different measures if I had had the flexibility to choose rather than relying on measures already used within the service, based on the commissioning of the service.

During the interviews I was aware of the clients generously offering their time to my research project and being willing to be open about the personal experience of having therapy. The clients had some very interesting views about mental health care and therapy in general, although these were not always relevant to the research aims and therefore required re-directing focus several times to the interview questions. This highlights the balance between being a pragmatic researcher and also a clinician with a passion for supporting individuals' wellbeing. My previous experiences of research interviews supported my confidence in being able to recognise when I was becoming more of a clinician than a researcher, and being able to re-focus whilst maintaining rapport.

The semi-structured interviews with participants was an aspect of the study that I felt more comfortable, with having completed research interviews previously, and having experience of interviewing clients regularly within my job role. This led me to consider the inevitable power dynamic that is created between myself and the participants. Having few participants (three in total) I was able to carefully consider how the relationship dynamics may influence the data collected. For example, I had regular meetings with the therapist involved in the project to support the video data collection and therefore I developed a relationship. I believe that this allowed the therapist to enter into a more balanced conversation with me during the research interviews, in which she felt able to discuss more authentically the questions and probes without fear of judgement.

Prior to the client-participant interviews I had watched each of them in their EMDR sessions and began to develop an understanding of their relational style. I particularly considered their general attachment style to consider how I may support them in feeling able

to be honest and open with me, despite the power imbalance which existed. For example, one of the clients appeared to have a strategy of compliance within her therapy sessions. This indicated that she may also be keen to comply with what she believed I wanted within the interview. Therefore, at the beginning of the interview I spent some time building a rapport with a specific focus on demonstrating a non-judgemental attitude and genuineness, in order to support her view of me as an equal. It is hard to comment on how well I achieved this but my opinion immediately following the interview was that she felt able to be at least somewhat open; she explicitly stated at one point that she would tell me if there were things that she thought could be improved in the therapy.

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Appendices

Appendix A:

Therapist Interview Schedule

BSR interview procedure

A. ***Orient Participant to Recall Procedure:***

In a couple of minutes, I will be playing back parts of the tape of the session. I'll do this to help you remember what was going on during particular moments in the session. Clients and therapists often have many unspoken experiences during sessions, including thoughts, feelings, images, memories, and evaluations; we find it extremely interesting to learn about those unspoken experiences. In particular, we are interested in things that seem helpful or unhelpful for the therapeutic relationship (already agreed definition with participant prior to interview starting) during EMDR protocols.

B. ***Locate Event:***

Wind tape to the beginning of the identified moment of interest.

C. ***Surveying the Event:***

Instructions: We will play through the event and then I will then ask you to tell me about your experiences during the event. As I play the tape back for you, I would like you to try to put yourself back into the event as much as you can. Try to remember what was going on for you then, as opposed to what you might think about it now. Try to remember exactly what you were working toward or trying to do in giving the responses you did in the event; that is, your therapeutic intentions.

I will play the event twice and on the second play-through, please let me know when you would like to stop it to note something that is happening that seems helpful or hindering with regards to your relationship with your client/ therapist.

Begin playing the event through; keep an eye on the participant, looking for nonverbal signs that s/he has something to note or say. When this happens, stop the tape, and ask the participant if s/he wants to say anything.

D. ***Describe Your Experience During Event***:

Non-leading probes (tell me more, could you elaborate, is there anything else)

What was happening for you during the event we just watched?

a. What were you feeling?

b. What was going through your mind? (What were you thinking?)

c. What were you doing or trying to do?

d. How did this event affect your relationship with your client at the time?

e. The most and least helpful things you said / did for the therapeutic relationship.

Anything else you noticed or were aware of that you would like to tell me?

Appendix B:

Ethical Approval Letter

NHS
Health Research Authority
East Midlands - Leicester South Research Ethics Committee
Royal Standard Place
Nottingham
NG1 6FS

04 May 2016

Dr Thomas Schroder
Division of Psychiatry and Applied Psychology
University of Nottingham
YANG Fujia Building
NG8 1BB

Dear Dr Schroder,

Study title:	Analysing the Therapeutic Alliance in Eye Movement Desensitisation Reprocessing (EMDR) Therapy.
REC reference:	16/EM/0130
Protocol number:	16024
IRAS project ID:	195063

Thank you for your letter of 28 April 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Rebecca Morledge, NRESCommittee.EastMidlands-LeicesterSouth@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University of Nottingham Clinical Trials Insurance]		
Interview schedules or topic guides for participants [Therapist]	1.1	04 April 2016
Interview schedules or topic guides for participants [Client]	1.1	04 April 2016
IRAS Checklist XML [Checklist_03032016]		03 March 2016
Letter from funder		
Letter from sponsor [Sponsor Letter NHS REC]		
Non-validated questionnaire [ARM5 for therapist The Therapeutic Alliance in EMDR v1.0 date 220316]	1.0	22 February 2016
Other [GAD-7]		
Other [IES-R]		
Other [PHQ-9]		
Other [clarification email from DS]		03 March 2016
Other [Modified HAT form Clients]	1.1	04 April 2016
Other [Modified HAT form Therapist]	1.1	04 April 2016
Other [Therapist Email]	1.1	04 April 2016
Participant consent form [Client]	1.1	04 April 2016
Participant consent form [Therapist]	1.1	04 April 2016
Participant information sheet (PIS) [Client]	1.1	04 April 2016
Participant information sheet (PIS) [Therapist]	1.1	04 April 2016
REC Application Form		04 April 2016
Research protocol or project proposal [PROTOCOL The Therapeutic Alliance in EMDR v1.0 date 220216]	1.0	22 February 2016
Response to Request for Further Information		28 April 2016
Summary CV for Chief Investigator (CI) [Staff - CV Thomas Schroder 1510 IRAS Oct15]		
Summary CV for student [Student - CV Deborah Skinner IRAS Feb16]		
Summary CV for supervisor (student research) [Staff - CV Rachel Sabin-Farrell 150420 IRAS Apr15]		
Validated questionnaire [ARM5 for clients The Therapeutic Alliance in EMDR v1.0 date 220316]	1.0	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

16/EM/0130	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely,

pp

Mr John Aldridge
Chair

Email:NRESCommittee.EastMidlands-LeicesterSouth@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Ms Angela Shone*
Mrs Shirley Mitchell, Nottinghamshire Healthcare Trust

Appendix C:

Recruitment Email

Therapist-Participant Email

Dear Colleagues,

I am a second year student currently completing my Doctorate in Clinical Psychology at the University of Nottingham and working within Nottinghamshire NHS as a Trainee Clinical Psychologist.

As part of my qualification it is necessary to complete a research study of relevance to clinical psychology. I am passionate about investigating EMDR therapy to discover new knowledge and/or confirm current ideas surrounding its effectiveness.

An area I am particularly interested in is the therapeutic alliance between EMDR therapists and their clients. Therefore, I would like to invite you to participate in my doctoral thesis study.

Please find attached an information sheet and consent form related to my research study. You are likely to already be aware of this study via Margo Brock van der Zanden (EMDR Consultant). I hope that you are enthusiastic about the potential outcomes of the study as I am. If you have any questions, please do not hesitate to contact me or one of the other researchers via email or telephone (contact details are on the information sheet).

I look forward to hearing from you.

Yours Sincerely,
Deborah Skinner.

Appendix D:

Information Sheet(s)

Participant Information Sheet - Client

(Final version 1.1. Date: 04.04.2016)

Title of Study: Analysing the Therapeutic Alliance in Eye Movement Desensitisation Reprocessing (EMDR) Therapy.

Name of Researcher(s): Ms Deborah Skinner, Dr Rachel Sabin-Farrell and Dr Thomas Schroder.

We would like to invite you to take part in our research study. Before you decide, we would like you to understand why the research is being done and what it would involve for you. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The aim of the study is to better understand how the relationship between therapist and client is developed and maintained during EMDR therapy. EMDR is a relatively new therapy and the reasons why it works are not currently clear. It is important to understand how both therapists and clients experience the therapy, including what they value most and what may be less important about EMDR sessions.

The study is also part of a Doctoral programme in Clinical Psychology.

Why have I been invited?

You have been invited to take part in this study as you have been assessed as being suitable to have EMDR therapy within Nottinghamshire's Let's Talk Wellbeing IAPT Service.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. It is completely your choice whether to take part or not. If you decide not to take part, this will not affect the standard of care that you receive in any way.

What will happen to me if I take part?

If you decide to take part, you will be asked to consent to your EMDR therapy sessions being video recorded by your EMDR therapist. This will be done discreetly so that your session is not disrupted in any way.

In addition, you will be asked to complete two questionnaires following each of your EMDR sessions (once a week), for this research. This is in addition to any that your EMDR therapist may ask you to fill in. These two questionnaires will take you approximately 15-20 minutes to complete all together. You will be given a unique code (a few letters and numbers) to write

on these questionnaires. This is so that only the researchers will know to whom they belong and nobody else will know your answers to the questions. You will also be asked to consent to the results of other questionnaires, which your EMDR therapist asks you to complete, being shared with the researchers in this study.

There is a second part to this study that some participants will be asked to take part in at the end of their complete EMDR therapy. If you are asked to participate in the second part of the study, you will be asked to attend an informal interview lasting 60-90 minutes, which aims to provide you with the opportunity to share your experience and opinions. This interview will be with Deborah Skinner who is the Principle Researcher and a Trainee Clinical Psychologist. The interview will be audio recorded. There are no right or wrong answers. This interview might involve you looking at parts of the video from your EMDR sessions ad discussing this with the researcher

All of your travel costs for the purposes of participating in this study will be reimbursed to you. You will also be entered into a prize draw with the chance to win £50 of high-street vouchers as a thank you for participating.

What are the possible disadvantages and risks of taking part?
It is very unlikely that any harm will come to any of the people participating in this study. It can be uncomfortable to be video recorded, however this will be conducted as discreetly as possible and no one else but you, your therapist, and the Principle Researcher (Deborah Skinner) will see any of these video recordings unless you say it is ok.

Completing the two questionnaires after each session (as described above) may be inconvenient. However, these will take around 15-20 minutes a week to do, which we hope is acceptable. The researchers are keen to make it as easy as possible for you to participate and therefore will provide you will an envelope that is addressed and stamped all ready for you to put your completed questionnaires into and put into any letterbox.

If you are asked to participate in the second part of this study and chose to do so, it may be more difficult for you to offer 60-90 minutes of your time to attend an interview. However, this will be done on a day and time to suit you.

The value of being able to better understanding the processes that happen during EMDR therapy is far reaching. In particular, it is extremely important to understand the experiences of those who have received the therapy in order to help therapists improve how they deliver the therapy to other people. It is hoped that the results of this research will be shared with others and be able to make a positive impact on mental health care.

What are the possible benefits of taking part?
We cannot promise that the study will help you, but the information we get from this study may help with understanding how to deliver EMDR in the best way possible. This could then help people with similar difficulties to you benefit from improved therapy practice.

In addition, having the opportunity to reflect on your therapy may be helpful for remembering the usefulness of the therapy for you.

What happens when the research study stops?
At the end of the entire study, it will be written up as part of an overall thesis project as a requirement for completion of the Trent Doctorate in Clinical Psychology programme. It is also hoped that the study will be sent for publication, which means it will be published in a psychological journal for others to read. It will not have your name on so you will never be identified as having taken part.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet.
If you remain unhappy and wish to complain formally, you can do this by contacting the Patient Advice and Liaison Service (PALS); phone number: 0800 015 3367 or email:PALS@nottshc.nhs.uk.

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled confidentially.

If you join the study, the data collected for the study will be looked at by authorised persons from The University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All of these people have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept strictly confidential, stored in a secure and locked office, and on password protected electronic computers. This includes the video recordings of your EMDR therapy sessions and audio recordings, if you have taken part in an interview.

Your personal data (address, telephone number) will be kept for a number of months after the end of the study so that we are able to contact you about the findings of the study if you request this. All other data collected during the study (video and audio recordings), will be kept securely for 7 years. After this time, your data will be disposed of securely. During this time, all precautions will be taken by all those involved to maintain your confidentiality and only members of the research team will have access to your personal data.

Should you give us any information which we feel puts you or anyone else at any risk of harm, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your rights being affected. Your current EMDR therapy and any future care will **NOT** be affected if you withdraw from the study at any time.

If you withdraw then you have a choice about the information collected so far. Before the stage of analysis (which happens after all data is collected and the study has finished), you can request that all of your data is erased. Alternatively, you can give permission for the data collected so far to be used in the study but have no further participation in the study yourself.

What will happen to the results of the research study?
The results of the study will be sent for publication and may be presented at conferences. If you would like a copy of the paper or a summary of the results, you can email one of the researchers who will be able to supply you will a copy.

You will NOT be identified in any report/publication.

Who is organising and funding the research?
This research is being organised and funded by The University of Nottingham.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The Leicester South Research Ethics Committee.

Contact details:

Principle Investigator:
Deborah Skinner
Email: msxdjs@nottingham.students.ac.uk
or
Deborah.skinner@nottshc.nhs.uk

Chief Investigator:
Thomas Schroder
Email: Thomas.schroder@nottingham.ac.uk
Phone: 0115 846 8181

Co-investigator:
Rachel Sabin-Farrell
Email:Rachel.sabin-farrell@nottingham.ac.uk
Phone: 0115 846 6734

Participant Information Sheet - Therapist

(Final version 1.0. Date: 22.02.2016)

Title of Study: Analysing the Therapeutic Alliance in Eye Movement Desensitisation Reprocessing (EMDR) Therapy.

Name of Researcher(s): Ms Deborah Skinner, Dr Rachel Sabin-Farrell and Dr Thomas Schroder.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The aim of the study is to explore therapist's and client's experiences of the therapeutic alliance during EMDR therapy. As you will be aware, understanding of this relatively new therapy is lacking in literature, in which quantitative outcome studies predominate. As not much research has explored this area in depth to date it may open up a new area of information.

The study is also part of the requirement of a Doctoral programme in Clinical Psychology for Deborah Skinner.

Why have I been invited?

You have been invited to take in this study due to your employment as a therapist practicing EMDR, within Nottinghamshire's Let's Talk Wellbeing IAPT Service.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to participate will be given this information sheet to keep and be asked to sign a consent form. If you decide to participate you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights. It is important that you feel no pressure to participate in this study and we would like to reiterate that declining to participate will NOT affect your employment in anyway.

What will happen to me if I take part?

If you decided to take part,

You will be asked to recruit client-participants by offering those suitable for a discrete EMDR therapy (standalone 6-10 sessions) the 'client information sheet' (provided to you by researchers), at the end of the assessment session. Should they choose to participate, you will be required to take written consent (consent forms provided to you by researchers).

Once you and one of your clients deemed suitable to receive EMDR therapy have both consented to participate in this study, you will be required to video record all of the EMDR

therapy sessions (once a week for the complete therapy; 6-10 weeks). The video recordings of each session should be transferred onto an NHS computer and saved in a restricted and password protected shared folder created by the Principle Research (PI), Deborah Skinner, following each session and then deleted from the video camera.

You will also be asked to complete a questionnaire after each EMDR session with the client(s) participating in the study. This is the Agnew Relationship Measure-5 (ARM-5), which consists of only five questions which are answered on a Likert scale and should take a few minutes to complete. Please keep these in a locked draw/cabinet at your Service. You may wish to scan them onto a computer and save them in the shared folder referred to above, however, the PI is able to scan them onto the computer when she attends the Service if you would prefer. The hard-copies will be collected from you and archived at The University of Nottingham by the research team.

Following completion of the EMDR therapy, a second stage of the study will commence should you continue to consent to participate. The second stage involves attending a one-off interview with the PI, lasting approximately 60-90 minutes. This interview will involve video cued-recall in which certain sections of the video recordings of the EMDR therapy (based on your and the clients answers to process measures) will be played back and your experiences at these moments will be explored. There are no right or wrong answers; I am interested to hear your experience. The interview will be audio recorded. No identifiable details will be shared and your participation will remain confidential.

Any travel costs incurred solely for the purposes of participating in this study will be reimbursed to you

The PI, Deborah Skinner, will be readily available to answer any queries and solve practical issues throughout the study to ensure the procedure is as simple and time-efficient as possible for all participants.

What are the possible disadvantages and risks of taking part?

It is not anticipated that any harm will come to any of the people participating in this study. However, it may be somewhat inconvenient to recruit client-participants, record therapy sessions and complete the ARM-5 on a weekly basis. Furthermore, it can be uncomfortable to be video recorded, however only sections of the video recordings relevant to the study will be reviewed. This research only requires you and the PI to view the video recordings during the one-off video cued recall interview. It may be difficult to offer 60-90 minutes during working hours and therefore you may be required to participate outside of your standard working hours which may create an inconvenience for you.

The value of being able to further understanding about therapeutic processes, particularly with a relatively young therapy such as EMDR, is far reaching. It is hoped that this research will be published and go on to impact positively on theory and practice within mental health care.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help with understanding therapeutic processes and therefore potentially allow more individualistic treatment packages to be offered, as well as adding to a growing body of literature suggesting that EMDR may be beneficial for various mental health difficulties. Furthermore, having the opportunity to reflect on your practice of EMDR therapy may provide a useful opportunity for reflective practice and CPD.

What happens when the research study stops?
Following the completion of the study, it will be written/reported as part of an overall thesis project as a requirement for completion of the Trent Doctorate in Clinical Psychology programme. It is also hoped that the study will be sent for publication (anonymised) which means it will be published in a psychological journal for others to view.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting the Head of Division of Psychiatry and Applied Psychology, Faculty of Medicine & Health Sciences; Cris Glazebroook at cris.glazebrook@nottingham.ac.uk or telephone 0115 823 0420.

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept strictly confidential, stored in a secure and locked office, and on a password protected database.

Your personal data will be kept for a number of months after the end of the study so that we are able to contact you about the findings of the study. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?
Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far will be erased, up until the stage of analysis at which point this information may still be used in the project analysis.

What will happen to the results of the research study?
As mentioned above, the results of the study will be sent for publication and should the results be published, you can obtain a copy via the journal that they become published in directly or by emailing one of the researchers who will be able to supply you will a copy.

You will not be identified in any report/publication.

Who is organising and funding the research?
This research is being organised and funded by the University of Nottingham.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Leicester South Research Ethics Committee.

Contact details:

Principle Investigator:
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Chief Investigator:
Rachel Sabin-Farrell
Email: Rachel.sabin-farrell@nottingham.ac.uk
Phone: 0115 846 6734

Co-investigator:
Thomas Schroder
Email: Thomas.shroder@nottingham.ac.uk
Phone: 0115 846 8181

Appendix E:

Consent Form(s)

CONSENT FORM - Client

(Final version 1.1. Date: 04.04.2016)

Title of Study: The Therapeutic Alliance in EMDR.

REC ref: ***(to be added after approval given)***

Name of Researcher: Ms Deborah Skinner, Dr Rachel Sabin-Farrell & Dr Thomas Schroder.

Name of Participant: **Please initial box**

1. I agree to be video recorded ☐

2. I confirm that I have read and understand the information sheet version number 1.1 dated 04.04.2016 for the above study and have had the opportunity to ask questions. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

4. I understand that relevant demographic information, routine service measures and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

5. I understand that the interview will be audio recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

6. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes

CONSENT FORM - Therapist

(Final version 1.1. Date: 04.04.2016)

Title of Study: The Therapeutic Alliance in EMDR.

REC ref: ***(to be added after approval given)***

Name of Researcher: Ms Deborah Skinner, Dr Rachel Sabin-Farrell & Dr Thomas Schroder.

Name of Participant: **Please initial box**

1. I agree to be video recorded. ☐

2. I confirm that I have read and understand the information sheet version number 1.1 dated 04.04.2016 for the above study and have had the opportunity to ask questions. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights or employment being affected. I understand that should I withdraw then the information ☐

collected so far cannot be erased and that this information may still be used in the project analysis.

4. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

5. I understand that the interview will be audio recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

6. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

2 copies: 1 for participant and 1 for the project notes.

Appendix F:

Video Consent Form

Use of Audio & Visual Recording for Clinical and Research Purposes

NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

AUDIO/VIDEO RECORDING FOR RESEARCH, TEACHING OR TRAINING: CONSENT FORM

My Name: ……..

My Therapist: ……..

Date: ……...

- I consent to be recorded by:

Audio (sound) ☐ TICK IF APPLIES

Video Camera (pictures) ☐ TICK IF APPLIES

- I understand that the recording is for:

Research ☐
Name of project: 'Therapeutic Alliance in EMDR'

Supervision ☐
Type of supervision

Other purpose ☐
Specify ……..

The recordings will only be seen by (TICK ALL THAT APPLY):

Staff involved in the recording ☐

Research staff involved in the project ☐

Supervisors of staff involved in the recording ☐

Other ☐

Use of Audio & Visual Recording for Clinical Purposes

- I understand that my name will not be on the recording.
- I understand that I can change my mind at any time and the recording can be erased at my request, up until the time at which the data has been analysed for inclusion in the doctoral research project.

- I understand that Deborah Skinner (Principle Investigator) is responsible for the recording, and where it is stored it will be stored securely.

Signed ……
(Patient)

Signed
(Member of staff responsible for recording) ……

Date:

Appendix G:

Psychometric Measures

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer"*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column totals: ___ + ___ + ___ + ___

= ***Total Score*** _____

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer"*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.....……	0	1	2	3
2. Feeling down, depressed, or hopeless..……..……	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....……..……..	0	1	2	3
4. Feeling tired or having little energy.....……..……	0	1	2	3
5. Poor appetite or overeating.....……	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down……..	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television……..	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual.....……..	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....……	0	1	2	3
Column totals	___	**+** ___	**+** ____	**+** ___

= *Total Score* _____

Work and Social Adjustment Scale (WSAS)

Identifier | Date

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

If you're retired or choose not to have a job for reasons unrelated to your problem, tick here ☐

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

1	Because of my [problem] my **ability to work** is impaired. '0' means 'not at all impaired' and '8' means very severely impaired to the point I can't work.	
2	Because of my [problem] my **home management** (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired.	
3	Because of my [problem] my **social leisure activities** (with other people e.g. parties, bars, clubs, outings, visits, dating, home entertaining) are impaired.	
4	Because of my [problem], my **private leisure activities** (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired.	
5	Because of my [problem], my ability to form and maintain **close relationships** with others, including those I live with, is impaired.	

Print Form | Clear Form | Total WSAS score =

WAI-S-O

The 12 items with defined anchors.

1. Within this segment*, there is agreement about the steps taken to help improve the client's situation.*

1. = Client directly states that tasks and goals are not appropriate, and does not generally agree on homework or in-session tasks. The client argues with the therapist over the steps that should be taken. The client refuses to participate in the tasks.
2. = Client is hesitant to explore and does not follow therapist guidance. The client withdraws from the therapist and appears to merely "go through the motions", without being engaged or attentive to the therapist or the task.
3. = The client appears to be unsure as to how the tasks pertain to his/her goals, even after some clarification by the therapist. The client seems either ambivalent or unenthusiastic about the tasks in this segment, and is passively resistant to the tasks (e.g., limited participation).
4. *= No evidence or equal evidence regarding agreement and/or disagreement.*
5. = Client follows exploration willingly with few or no therapist clarifications needed. The client becomes invested in the process, and is an active participant in the task. There is a sense that both parties have an implicit understanding of the rationale behind the tasks in this segment.
6. = Client openly agrees on tasks and is enthusiastic about participating in tasks. Both participants are acutely aware of the purpose of the tasks and how the tasks will benefit the client. To this end, the client uses the task to address relevant concerns and issues.
7. = Repeated communication of approval and agreement, both before and after the task is completed. The client responds enthusiastically to interventions, gains insight, and appears extremely confident that the task and goal are appropriate.

2. Within this segment*, there is agreement about the usefulness of the current activity in therapy (i.e., the client is seeing new ways to look at his/her problem).*

1. = Participants repeatedly argue over the task. The client refuses to participate in the task, claiming that it is of no use to his/her goals. There is tension between the therapist and the client, and issues are not explored.
2. = Client does not engage or invest in the task, though he/she may not openly dispute the usefulness of the task. The client fails to explore issues with openness.
3. = Client is hesitant to participate, but eventually becomes invested in the task. The therapist is able to accurately convey the rationale behind the activity so that the client is then able to understand how the task is relevant to his/her current concerns.
4. *= No evidence or equal evidence regarding agreement and/or disagreement.*
5. = Client does not question the usefulness of the task and engages in the task almost immediately.
6. = Participants engage in a meaningful task that addresses a primary concern of the client. The client may remark, "I never thought of that before" or something to this effect.
7. = Participants remark how important/useful the task is. There is openness to exploration of the task and enthusiastic collaboration between the participants.

3. Within this segment, *There is a perception that the time spent in therapy is not spent efficiently.*

1. = Participants work well together. The client seems open to all subjects, focuses on the task at hand with little to no redirection by the therapist, and clear progress is made.
2. = Client works at discussing all subjects, focuses well, and makes general progress. There may be some hesitancy or resistance on the part of the client, even though client is trying his/her best.

3. = Client attempts to discuss most subjects, but may need redirection from therapist. Slow progress is made.
4. *= No evidence or equal evidence regarding time efficiency and/or inefficiency.*
5. = Client has trouble discussing a few topics, and also may require redirection. The client's trouble with the task at hand may be obvious, and the participants seem to have trouble complementing one another's roles.
6. = Client avoids several topics and has trouble focusing. Little progress is made. The participants' attempts to improve the situation are mostly unsuccessful. The segment gives the impression that there is a lack of focus; participants seem to be meandering from topic to topic, without clear direction or commitment to a plan.
7. = Client continually avoids or resists subjects. Focus is often redirected by the therapist, and no productive gains are made. The participants do not work well together.

4. Within this segment, *the therapy process does not make sense to the client.*

1. = Client has a strong understanding of the therapy process. The client actively collaborates with the therapist and seems to have a thorough understanding of why in-session and homework tasks are necessary. This may not always be spoken. The client is almost a co-facilitator of his/her own therapy.
2. = Client has a considerable understanding of the therapy process. The client rarely expresses a doubt openly nor does he/she attempt to implement a different strategy.
3. = Client has some understanding of the therapy process. The client does not often try to change tasks or express doubts.
4. *= No evidence or equal evidence regarding confusion and/or understanding.*
5. = Client shows signs that he/she is uncertain about what to do or that what he/she is doing will be beneficial. Signs may include topic shifts, awkward pauses, and/or frustrated expressions, bodily movements or vocalizations.
6. = Client verbally expresses doubt and confusion and may attempt to shift to a different topic or task.
7. = Client voices strong doubts persistently: challenging the therapist, suggesting other techniques and/or using different strategies (e.g., the therapist wants to use cognitive techniques while the client prefers a psychodynamic approach).

5. Within this segment, There is agreement about what client's roles and responsibilities are in this segment.

1. = Participants do not agree on what the client's responsibilities are in this segment. The client may refuse the therapist's direction, verbally disagree about homework, and seems reluctant to participate.
2. = Client has clear trouble accepting what the therapist wants him/her to do. The client may challenge or disregard the direction provided by the therapist, and may complain about a number of homework issues.
3. = Client seems reluctant about therapist's ideas. The therapist may attempt to be directive, but the client may not understand or accept the direction. The therapist may expend a lot of effort to encourage client participation.
4. *= No evidence or equal evidence regarding agreement and/or disagreement.*
5. = Client may have some hesitation but largely agrees with the therapist. The client offers little resistance to the therapist's ideas, and the session improves as time progresses. The client may also appear to be overly compliant, perhaps in order to avoid confrontation.
6. = Client generally acquiesces to therapist's suggestions, and is relatively enthusiastic about participating. For instance, the therapist may make a suggestion to the client that the client will acknowledge, but not seem excited about.
7. = Client is eager and willing to do what the therapist suggests in session and as homework. The client may also comment on the usefulness or how well the session appears to be going.

6. Within this segment, *The client is frustrated with what he/she is being asked to do in the therapy.*

1. = Client is excited about all tasks in this segment. This enthusiasm may be verbalized or displayed through participation. The client may say things such as, "that was helpful," or even make suggestions about how to improve performance on in-session tasks.
2. = Client seems pleased and generally interested in most tasks and is able to perform most of the tasks well.
3. = Client seems cooperative. Although the client may not be able to perform all tasks perfectly, the client retains a positive attitude towards therapy.
4. *= No evidence or equal evidence regarding frustration and/or satisfaction.*
5. = Client shows minor frustration or shift tasks. The client may not understand tasks perfectly or may not need a re-explanation. May not be able to perform some tasks well. The client may have a good idea of the steps necessary for change but does not seem to be prepared to take action.
6. = Client spends considerable time resisting the task or is unable to do task. The client may require re-explanation of tasks and may still have difficulties after clarification. The client may show considerable annoyance, and may use sighs, body language, facial expressions or statements to display frustration.
7. = Client is unable or unwilling to perform most tasks. The client may not have the patience to wait for re-explanation. The client openly voices frustration in addition to frowning and sighing.

7. Within this segment, *there is a sense of discomfort in the relationship.*

1. = Participants appear extremely comfortable in this segment. The client approaches difficult topics very openly. The client and/or therapist may comment on how comfortable or relaxed the other is. Behavioral cues such as relaxed posture and smooth voice are evident.
2. = Client shows no apprehension toward topics in this segment. The client seems to approach and explore topics without hesitation, is not defensive, and appears to be relaxed during most of the segment. Behavioral cues suggest that the client is comfortable.
3. = Client discusses difficult topics with limited hesitancy, and appears to be relaxed (e.g., relaxed posture, little fidgeting, smooth speaking). The client may become hesitant during parts of the segment, but the therapist and client work through it appropriately.
4. *= No evidence or equal evidence regarding client comfort and/or discomfort.*
5. = Client is fidgety (only during part of the segment) and is generally hesitant to discuss deeply personal topics. The client appears to be unwilling to explore some specific content areas. The therapist may also show some physical signs of discomfort (e.g., fidgeting, shaky voice, frequent posture changes) during part of the segment.
6. = Client and/or therapist show(s) physical signs of discomfort. The client does not appear to become more comfortable as the segment progresses and/or may seem defensive throughout. Communication between the client and therapist may seem forced or uneasy.
7. = Client seems uncomfortable throughout the segment. The client appears extremely defensive and actively avoids difficult topics. Client may even state on multiple occasions that he/she is uncomfortable.

8. Within this segment, *there is good understanding between the client and therapist.*

1. = There is consistent need for clarification of ideas. The therapist makes inaccurate reflections and/or interpretations most of the time. The client becomes outwardly irritated or annoyed by the miscommunication. The tone of the therapist is very cold and mechanical. The therapist does not express warmth toward the client.
2. = Therapist makes several inaccurate reflections, and the client must correct them and ask for clarification at several points in the segment. The client appears to become mildly agitated as a result of the miscommunication.

3. = Therapist makes a few poor reflections. Occasionally, the therapist has a mechanical tone of voice. The client may ask for clarification of ideas on a few occasions.
4. *= No evidence or equal evidence regarding good and/or poor understanding.*
5. = Therapist is generally warm toward the client. There are few/no inaccurate reflections by the therapist. The client answers the therapist's inquiries without much confusion. Understanding improves over the course of the segment.
6. = Participants generally have efficient and warm communication with each other. The therapist makes accurate reflections during the segment.
7. = Therapist makes consistently empathic, insightful, and accurate reflections throughout the segment. The client rarely/never asks for clarification. The client may comment that the therapist truly understands him/her.

9. Within this segment, *the client and the therapist respect each other.*

1. = Participants show a great amount of dislike, disdain, and/or spite for each other.
2. = Participants show some disregard for each other, or one of the participants demonstrates a great amount of dislike, disdain, and/or spite for the other. One or both consistently interrupt and/or demonstrate a lack of effort in trying to understand the other, which could be exhibited by negative nonverbal behaviors including closed posture, and wandering eyes. The therapist could end the segment abruptly, without regard to the client's state.
3. = Participant actions include one or more of the following at times: interrupting each other, employing derogatory/supercilious statements or mechanical reflections, and/or not paying attention. This may cause an inaccurate therapist reflection and/ or the need to ask the client to repeat some content, or induce a client tendency to dismiss therapist ideas or persuasiveness.
4. *= No evidence or equal evidence regarding respect and/or disrespect.*
5. = Participants show some evidence that they are really paying attention to each other. The therapist may exhibit some notable acceptance of client problems.
6. = Participants show frequent signs that they are really paying attention to each other throughout the segment, such as by nodding or other minimal encouragers, insightful reflections by the therapist, and active participation by the client.
7. = Strong evidence that participants consistently and completely attend to the other's communications throughout the entire segment. The client voices strong confidence in the therapist's competence in some way. The therapist voices some note of encouragement that indicates respect for what the client is trying to do.

10. Within this segment, *there is mutual trust between the client and therapist.*

1. = Client states outright that he/she does not trust the therapist at all. The client does not openly discuss any significant issues. The therapist demonstrates a complete lack of confidence in the client's ability to discuss significant issues.
2. = Participants are considerably distrustful of each other. The client is very guarded in disclosing any intimate content, while the therapist also shows a lack of comfort. Questions concerning trust may arise.
3. = Participants are somewhat distrustful of each other. Client is a bit guarded in terms of content disclosed. Therapist may show a few signs of lack of comfort about the therapy situation.
4. *= No evidence or equal evidence regarding mutual trust between the participants.*
5. = Some willingness by the client to disclose personal concerns and some therapist acceptance of the client's statements at face value. The therapist does not override or interrupt a client's train of thought by redirecting focus.
6. = Client is receptive to therapist reflections, challenges, and/or suggestions, and discloses a considerable amount of more intimate/relevant information regarding his/her problem(s). The therapist

seems comfortable with the overall situation and is not defensive at all. The client may express confidence in the therapist.

7. = Participants have complete faith in each other. The client is very comfortable about disclosing extremely intimate details or problems, and the therapist feels extremely comfortable.

11. Within this segment, The client is aware that the therapist is genuinely concerned for his/her welfare.

1. = No concern is shown in therapy. The therapist is non-attentive, cold, and statements are hostile and/or inappropriate. The client seems to not feel genuine concern from the therapist.
2. = Client seems to feel little concern from the therapist. The therapist may give a few statements of concern, but mostly acts in a mechanical and uncaring fashion, despite repeated attempts for responses from the client.
3. = Client seems to feel like therapist is listening, but does not care about the client. The therapist may pay attention, but only give some signs of emotion in response to the client.
4. *= No evidence or equal evidence regarding therapist concern and/or disinterest.*
5. = Client feels some concern from the therapist. The therapist is mostly attentive, shows some warmth using reflection, and may give a few statements of concern.
6. = Client feels like therapist is concerned and invested in this segment. The therapist is attentive and warm, demonstrates empathetic listening, and offers statements of concern.
7. = Client is confident that the therapist is genuinely concerned. The therapist is attentive, shows empathy using a variety of techniques, delivers statements in a warm and caring manner, and uses direct statements of concern.

12. Within this segment, *Both the client and therapist see their relationship as important to the client.*

1. = Client does not respect the therapist. The therapist may make frequent interruptions or seem uninterested indicating that he/she is not fully invested in the relationship. The client may frequently make derisive remarks towards the therapist. If the client opens up at all it is most likely a negative comment (e.g., “I feel that I am not getting what I need from you”). The client may be considering leaving therapy or is being forced to attend.
2. = Client puts little effort into the relationship. The client does not fully participate and rarely opens up. If the client does open up, it may be with a negative comment (e.g., “I feel that I am not getting what I need from you”). The client has little respect for the therapist. The client may not respect the therapy hour, arriving late or missing sessions.
3. = Client is not fully invested in the relationship. The client does not open up a great deal. The client may express a negative comment about the relationship.
4. *= No evidence or equal evidence regarding importance and/or unimportance.*
5. = Client puts some effort into the relationship, task participation and speaking about relevant topics.
6. = Client believes in the process and speaks freely about relevant topics. The client believes in therapist as the facilitator of change. The client looks forward to future sessions and may show concern about any breaks in therapy, such as a therapist or client vacation, etc.
7. = Participants believe that this relationship and the process of therapy will bring about change. This client is highly invested in therapy, and it is evident that he/she spends considerable time working on therapy homework or contemplating therapy outside of the therapy hour. Any breaks in therapy would be taken seriously by the client and could cause discomfort.

Agnew Relationship Measure- 5 (ARM-5)

Date: _____

Thinking about today's meeting, please indicate how strongly you **agreed** or **disagreed** with each statement by circling the appropriate number.

	1. strongly disagree	2. moderately disagree	3. slightly disagree	4. neutral	5. slightly agree	6. moderately agree	7. strongly agree
1. My therapist is supportive	1	2	3	4	5	6	7
2. My therapist and I agree about how to work together	1	2	3	4	5	6	7
3. My therapist and I have difficulty working jointly as a partnership	1	2	3	4	5	6	7
4. I have confidence in my therapist and his / her techniques	1	2	3	4	5	6	7
5. My therapist is confident in him / herself and his/ her techniques	1	2	3	4	5	6	7

Agnew Relationship Measure- 5 (ARM-5)

Date: _____

Thinking about today's meeting, please indicate how strongly you **agreed** or **disagreed** with each statement by circling the appropriate number.

	1. strongly disagree	2. moderately disagree	3. slightly disagree	4. neutral	5. slightly agree	6. moderately agree	7. strongly agree
1. I feel supportive towards my client	1	2	3	4	5	6	7
2. My client and I agree about how to work together	1	2	3	4	5	6	7
3. My client and I have difficulty working jointly as a partnership	1	2	3	4	5	6	7
4. My client has confidence in my techniques	1	2	3	4	5	6	7
5. I am confident in myself and my techniques	1	2	3	4	5	6	7

Helpful Aspects of Therapy Form (HAT)

1. Of the events which occurred in this session, which one do you feel was the most **helpful** or **important** for developing or maintaining **your relationship** with your therapist / client? (It might be something you said or did, or something your therapist said or did.)

2. Please describe **what made this event helpful/important** for your relationship with your therapist / client.

3. **How helpful** was this particular event for developing or maintaining a good relationship with your therapist / client?

Rate it on the following scale. (Put an "X" at the appropriate point; half-point ratings are OK; e.g., 7.5.)

```
HINDERING <--------------    Neutral    ---------------->  HELPFUL
 1       2       3       4       5       6       7       8       9
 |---+---|---+---|---+---|---+---|---+---|---+---|---+---|---+---|
 E       G       M       S               S       M       G       E
 X       R       O       L               L       O       R       X
 T       E       D       I               I       D       E       T
 R       A       E       G               G       E       A       R
 E       T       R       H               H       R       T       E
 M       L       A       T               T       A       L       M
 E       Y       T       L               L       T       Y       E
 L               E       Y               Y       E               L
 Y               L                               L               Y
                 Y                               Y
```

4. About **where** in the session did this event occur?

5. About **how long** did the event last?

6. Did anything happen during the session which might have been **hindering** to the development or maintenance of your relationship with your therapist / client?

YES NO (*please circle)*

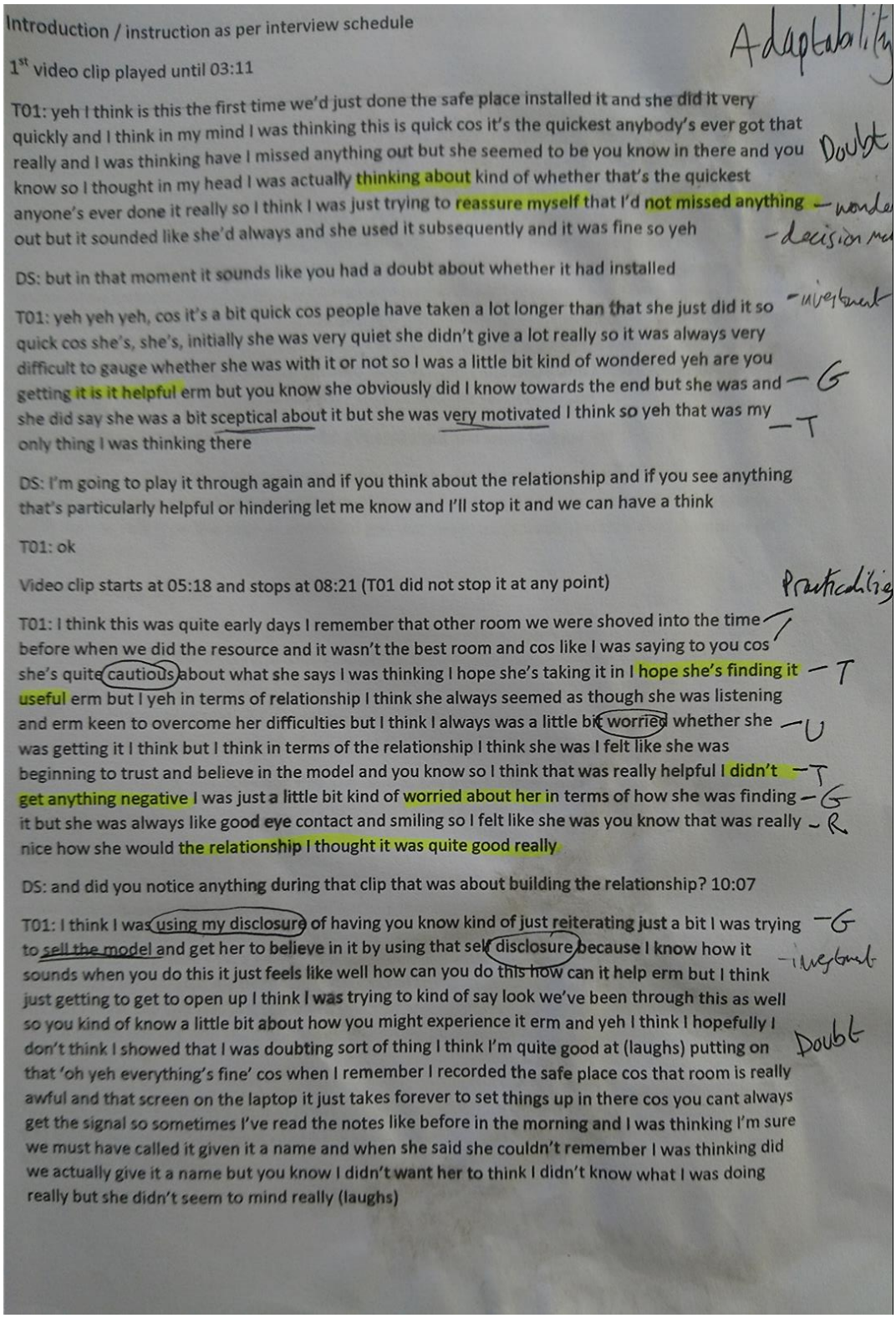
(a. If yes, please rate **how hindering** the event was on the scale of 1-4 below:___ ____

1. Extremely hindering
2. Greatly hindering
3. Moderately hindering
4. Slightly hindering

(b. Please **describe** this event briefly:

Appendix H:

Excerpt from Framework Analysis



Introduction / instruction as per interview schedule

1st video clip played until 03:11

T01: yeh I think is this the first time we'd just done the safe place installed it and she did it very quickly and I think in my mind I was thinking this is quick cos it's the quickest anybody's ever got that really and I was thinking have I missed anything out but she seemed to be you know in there and you know so I thought in my head I was actually thinking about kind of whether that's the quickest anyone's ever done it really so I think I was just trying to reassure myself that I'd not missed anything out but it sounded like she'd always and she used it subsequently and it was fine so yeh

DS: but in that moment it sounds like you had a doubt about whether it had installed

T01: yeh yeh yeh, cos it's a bit quick cos people have taken a lot longer than that she just did it so quick cos she's, she's, initially she was very quiet she didn't give a lot really so it was always very difficult to gauge whether she was with it or not so I was a little bit kind of wondered yeh are you getting it is it helpful erm but you know she obviously did I know towards the end but she was and she did say she was a bit sceptical about it but she was very motivated I think so yeh that was my only thing I was thinking there

DS: I'm going to play it through again and if you think about the relationship and if you see anything that's particularly helpful or hindering let me know and I'll stop it and we can have a think

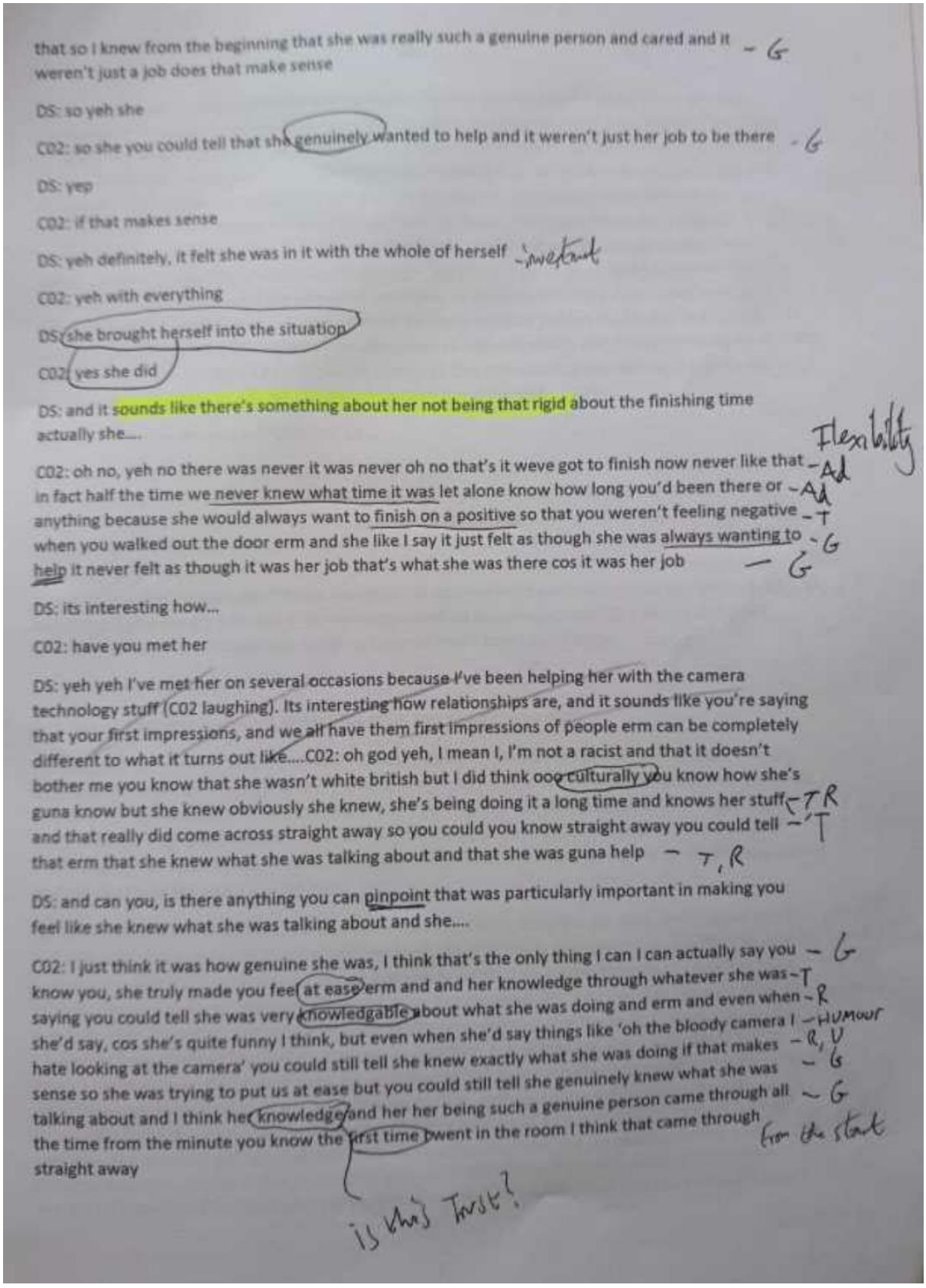
T01: ok

Video clip starts at 05:18 and stops at 08:21 (T01 did not stop it at any point)

T01: I think this was quite early days I remember that other room we were shoved into the time before when we did the resource and it wasn't the best room and cos like I was saying to you cos she's quite cautious about what she says I was thinking I hope she's taking it in I hope she's finding it useful erm but I yeh in terms of relationship I think she always seemed as though she was listening and erm keen to overcome her difficulties but I think I always was a little bit worried whether she was getting it I think but I think in terms of the relationship I think she was I felt like she was beginning to trust and believe in the model and you know so I think that was really helpful I didn't get anything negative I was just a little bit kind of worried about her in terms of how she was finding it but she was always like good eye contact and smiling so I felt like she was you know that was really nice how she would the relationship I thought it was quite good really

DS: and did you notice anything during that clip that was about building the relationship? 10:07

T01: I think I was using my disclosure of having you know kind of just reiterating just a bit I was trying to sell the model and get her to believe in it by using that self disclosure because I know how it sounds when you do this it just feels like well how can you do this how can it help erm but I think just getting to get to open up I think I was trying to kind of say look we've been through this as well so you kind of know a little bit about how you might experience it erm and yeh I think I hopefully I don't think I showed that I was doubting sort of thing I think I'm quite good at (laughs) putting on that 'oh yeh everything's fine' cos when I remember I recorded the safe place cos that room is really awful and that screen on the laptop it just takes forever to set things up in there cos you cant always get the signal so sometimes I've read the notes like before in the morning and I was thinking I'm sure we must have called it given it a name and when she said she couldn't remember I was thinking did we actually give it a name but you know I didn't want her to think I didn't know what I was doing really but she didn't seem to mind really (laughs)



that so I knew from the beginning that she was really such a genuine person and cared and it weren't just a job does that make sense

DS: so yeh she

C02: so she you could tell that she genuinely wanted to help and it weren't just her job to be there

DS: yep

C02: if that makes sense

DS: yeh definitely, it felt she was in it with the whole of herself

C02: yeh with everything

DS: she brought herself into the situation

C02: yes she did

DS: and it sounds like there's something about her not being that rigid about the finishing time actually she....

C02: oh no, yeh no there was never it was never oh no that's it weve got to finish now never like that in fact half the time we never knew what time it was let alone know how long you'd been there or anything because she would always want to finish on a positive so that you weren't feeling negative when you walked out the door erm and she like I say it just felt as though she was always wanting to help it never felt as though it was her job that's what she was there cos it was her job

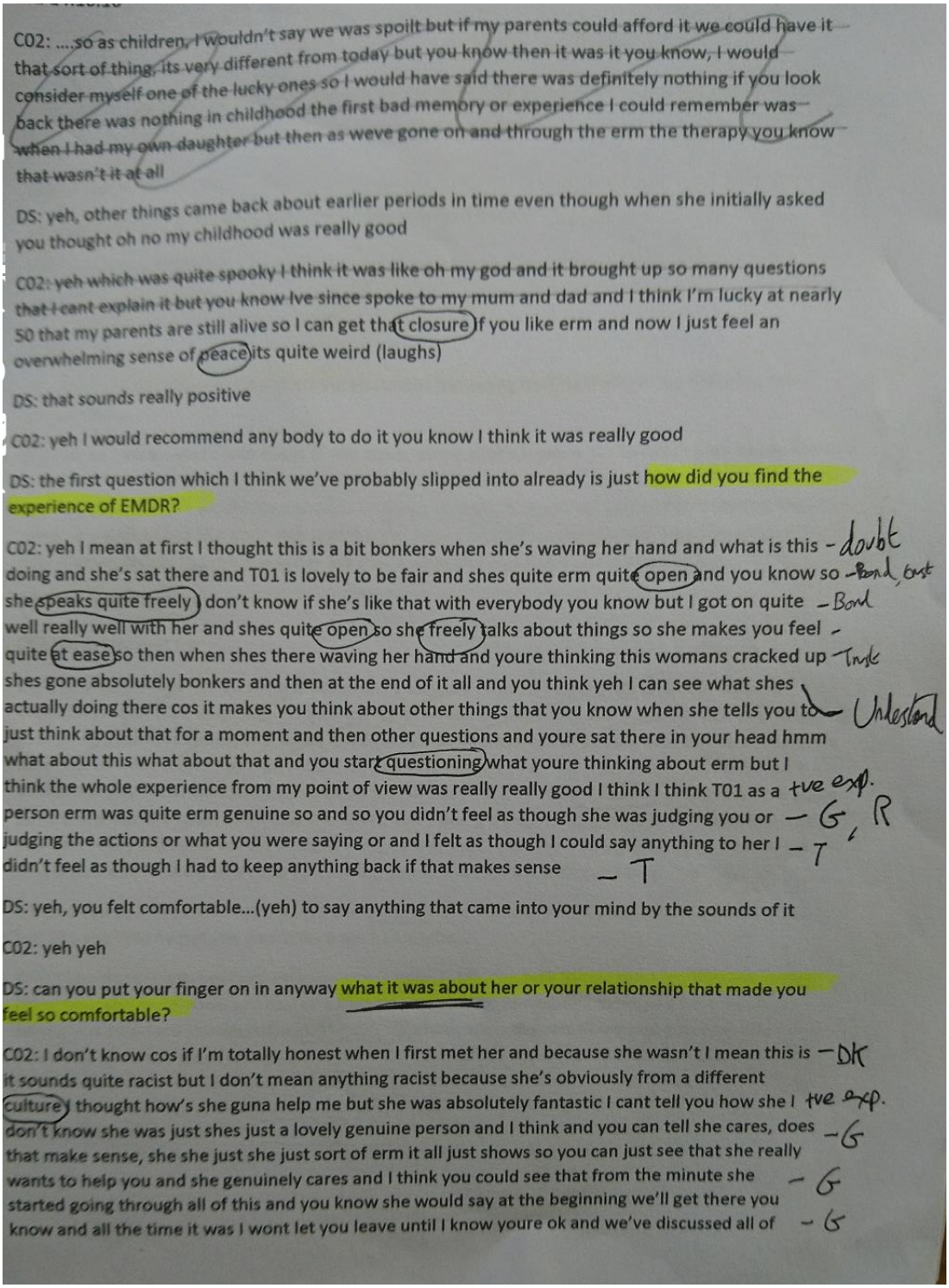
DS: its interesting how...

C02: have you met her

DS: yeh yeh I've met her on several occasions because I've been helping her with the camera technology stuff (C02 laughing). Its interesting how relationships are, and it sounds like you're saying that your first impressions, and we all have them first impressions of people erm can be completely different to what it turns out like....C02: oh god yeh, I mean I, I'm not a racist and that it doesn't bother me you know that she wasn't white british but I did think ooo culturally you know how she's guna know but she knew obviously she knew, she's being doing it a long time and knows her stuff and that really did come across straight away so you could you know straight away you could tell that erm that she knew what she was talking about and that she was guna help

DS: and can you, is there anything you can pinpoint that was particularly important in making you feel like she knew what she was talking about and she....

C02: I just think it was how genuine she was, I think that's the only thing I can I can actually say you know you, she truly made you feel at ease erm and and her knowledge through whatever she was saying you could tell she was very knowledgable about what she was doing and erm and even when she'd say, cos she's quite funny I think, but even when she'd say things like 'oh the bloody camera I hate looking at the camera' you could still tell she knew exactly what she was doing if that makes sense so she was trying to put us at ease but you could still tell she genuinely knew what she was talking about and I think her knowledge and her her being such a genuine person came through all the time from the minute you know the first time I went in the room I think that came through straight away



C02: ....so as children, I wouldn't say we was spoilt but if my parents could afford it we could have it that sort of thing, its very different from today but you know then it was it you know, I would consider myself one of the lucky ones so I would have said there was definitely nothing if you look back there was nothing in childhood the first bad memory or experience I could remember was when I had my own daughter but then as weve gone on and through the erm the therapy you know that wasn't it at all

DS: yeh, other things came back about earlier periods in time even though when she initially asked you thought oh no my childhood was really good

C02: yeh which was quite spooky I think it was like oh my god and it brought up so many questions that I cant explain it but you know Ive since spoke to my mum and dad and I think I'm lucky at nearly 50 that my parents are still alive so I can get that closure if you like erm and now I just feel an overwhelming sense of peace its quite weird (laughs)

DS: that sounds really positive

C02: yeh I would recommend any body to do it you know I think it was really good

DS: the first question which I think we've probably slipped into already is just how did you find the experience of EMDR?

C02: yeh I mean at first I thought this is a bit bonkers when she's waving her hand and what is this doing and she's sat there and T01 is lovely to be fair and shes quite erm quite open and you know so she speaks quite freely I don't know if she's like that with everybody you know but I got on quite well really well with her and shes quite open so she freely talks about things so she makes you feel quite at ease so then when shes there waving her hand and youre thinking this womans cracked up shes gone absolutely bonkers and then at the end of it all and you think yeh I can see what shes actually doing there cos it makes you think about other things that you know when she tells you to just think about that for a moment and then other questions and youre sat there in your head hmm what about this what about that and you start questioning what youre thinking about erm but I think the whole experience from my point of view was really really good I think I think T01 as a person erm was quite erm genuine so and so you didn't feel as though she was judging you or judging the actions or what you were saying or and I felt as though I could say anything to her I didn't feel as though I had to keep anything back if that makes sense

DS: yeh, you felt comfortable...(yeh) to say anything that came into your mind by the sounds of it

C02: yeh yeh

DS: can you put your finger on in anyway what it was about her or your relationship that made you feel so comfortable?

C02: I don't know cos if I'm totally honest when I first met her and because she wasn't I mean this is it sounds quite racist but I don't mean anything racist because she's obviously from a different culture I thought how's she guna help me but she was absolutely fantastic I cant tell you how she I don't know she was just shes just a lovely genuine person and I think and you can tell she cares, does that make sense, she she just she just sort of erm it all just shows so you can just see that she really wants to help you and she genuinely cares and I think you could see that from the minute she started going through all of this and you know she would say at the beginning we'll get there you know and all the time it was I wont let you leave until I know youre ok and we've discussed all of

What influence does the Therapeutic Alliance (TA) have during EMDR therapy?

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Background

- Research supports the benefits of EMDR for mental health difficulties[1]
- The TA is linked to successful outcomes in psychotherapy[2]
- EMDR uses protocols, such as bilateral stimulation, rather than the therapeutic relationship to stimulate the flow of information processing[3]
- Currently, the TA has not been empirically investigated in EMDR.

Method

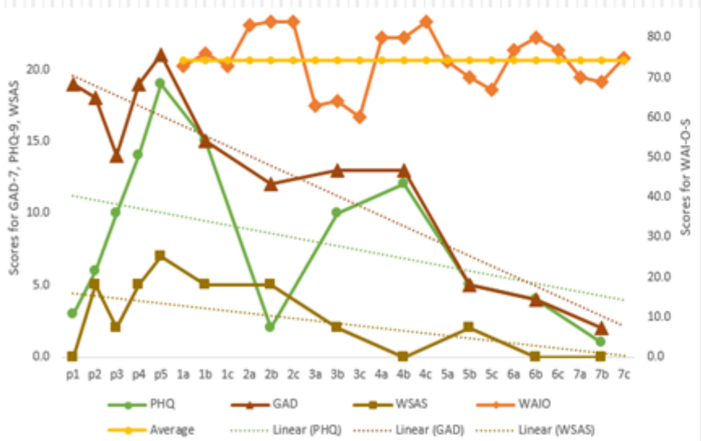
- Participants: 2 therapist-client dyads.
- Measures: GAD-7, PHQ-9, WSAS, WAI-O.
- Design: Mixed-Methods Case Study.
- Procedure: Video recorded sessions & post-therapy interviews.
- Analysis: Visual analysis (quantitative) & Framework Analysis (qualitative).

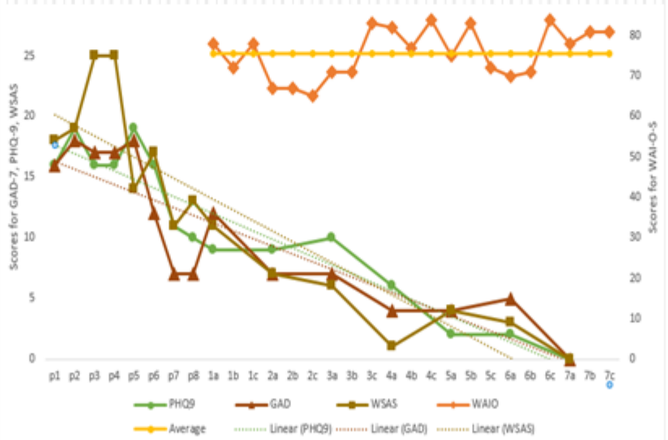
Results

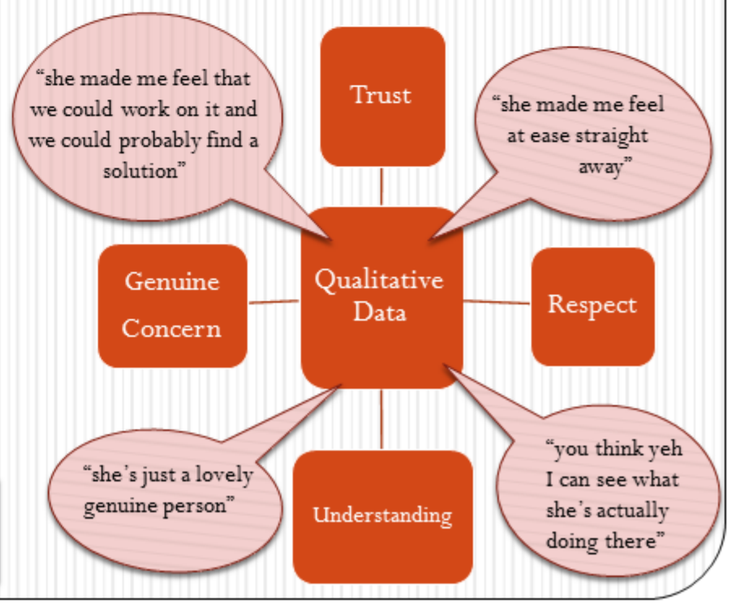
- See graphs below for visual analysis.
- Reliable Change Index (RCI) and Clinically Significant Change (CSC) criteria demonstrated positive, significant, change from pre to post therapy for both cases.
- Framework Analysis revealed a relatively strong and steady TA throughout each of the successful therapy cases.

Conclusion/s

- The correlational results suggest the existence of relationship variables within a predominantly protocolised therapy.
- The qualitative suggests that the TA is a highly valued aspect by therapist and clients in EMDR, although sample size limits generalisability.
- EMDR may benefit from being considered as both technical and relational to maximise outcomes.







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