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Perceptions of Effectiveness of Eye Movement Desensitization and Reprocessing Treatment Intervention from Survivors of Intimate Partner Violence

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Abstract

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by

Laurinda Cumming

MS, Walden University, 2016

BS, University of Phoenix, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Forensic Psychology Concentration

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Abstract

Intimate partner violence (IPV) is a national health care problem. This violence affects 10 million people on average in the United States every year. This research focused on the treatment resistance for PTSD, a severe and disabling condition. This qualitative descriptive study provided a purposeful sampling of female survivors' lived experiences and perceived effectiveness of EMDR in treating PTSD symptoms as a result of IPV. Study participants were 7 females, 18 years or older, residing in the Southwestern United States. The theoretical framework of the self-efficacy model was used to look at how posttraumatic symptoms can be so severe from IPV that they meet the diagnostic criteria for PTSD. The data analysis for the qualitative research involved hand coding, categorizing, and interpreting as it related to the phenomenon. Audio recordings for each participant ensured accuracy in transcribing the results. The key findings revealed that 5 out of 7 women survivors of IPV considered EMDR an important treatment for healing their symptomology but with expressed caveats. Recommendations for future research are focused on a broader geographic area and larger sample size that can provide ways to bridge gaps in the effectiveness of different interventions like EMDR. The overall results provide a platform for future voices of women who experienced IPV while expanding knowledge of the effects of debilitating symptoms of PTSD and chosen interventions. The implication for positive social change is that this study provides data for practitioners and researchers as to whether EMDR is the right choice in treating PTSD resulting from IPV for long term results.

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Dedication

I want to dedicate this project to all the survivors of IPV who have had the strength to leave their abusive partner and to seek treatment for the debilitating symptoms experienced from the trauma, like PTSD.

Acknowledgments

I would like to acknowledge the women who participating and made this study possible. Their strength was an inspiration for me and the many who will have the opportunity to read their stories. Thanks to the Arizona Coalition to End Sexual and Domestic Violence and their staff who were instrumental in assisting with the study.

To my committee chairperson, Dr. Scott Gfeller, thank you for your continued leadership, guidance, and positive feedback. To my committee member, Dr. Jana Price-Sharps thanks for your support and feedback throughout this journey. Without both of you this would have not been possible.

To my special friends who continued to support me and provided encouragement during the challenging times. Without their support this journey may not have reach the success that it has.

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Chapter 1: Introduction to the Study

Intimate partner violence (IPV) as reported by Sullivan (2020) is a social problem that is pervasive yet serious, with devastating psychological, physical, and economic consequences for victims. According to Basile, Jones, and Smith (2018) IPV is often referred to as domestic violence that includes emotional, verbal, physical, sexual, and violent abuse. As reported by Petersson and Strand (2017), domestic violence is one of the most prevalent forms of violent crimes to come to the criminal justice system's attention. These crimes are a serious global public health concern and accountable for tremendous personal and societal costs.

According to Koek (2017), treatment resistance for depression has been studied for years; however, treatment resistance for posttraumatic stress disorder (PTSD), a severe and disabling condition, has not been frequently addressed in the literature. Of the world's population, 70% have been exposed to a traumatic event, while 5.6% meet the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) criteria for PTSD. Many individuals who have PTSD remain impaired both functionally and symptomatically despite alternative interventions and standard treatments. There exist several modalities used in the attempt to either alleviate the symptoms of PTSD or eradicate them. The question is the long-term effectiveness of these different interventions. The perceptions of treatment for PTSD vary, and the focus in this study is specifically on effectiveness of eye movement desensitization reprocessing (EMDR), a nontraditional psychotherapy. This chapter covers the problem statement, purpose of the study, research question, theoretical framework, nature of the study, definitions,

assumptions, and scope and delimitations, ending with a summary of significant components of the chapter.

Background

Allard, Norman, Thorp, Browne, and Stein (2016) reported how traumatic memories can cause an individual to be at a higher risk for developing and maintaining the psychopathology of PTSD. Allard et al. (2016) further stated that the results of IPV can manifest in chronic and severe posttraumatic symptoms. While maladaptive trauma-related guilt and functional impairment are often seen with survivors. One modality for treatment has been the use of cognitive trauma therapy. As reported by Allard et al. (2016), it has proven to be efficacious in treating PTSD, especially in the empirical contributors of functioning and distressing difficulties specific to IPV, thereby reducing trauma-related guilt.

IPV perpetration was defined by Brittney (2019) as an act or threat of physical, emotional, or sexual violence or abuse from one person to another in an intimate relationship causing devastating social, legal, health, and psychological effects on the perpetrators, victims, and children exposed to the abuse. Brittney (2019) further stated that practitioners and scholars must collectively assume the responsibility to address the social problems created by IPV.

Degges-White (2015) stated that both women and men can be either the batterers or the battered. Concerning evidence has shown that society has become desensitized to violence. Exposure to violence with video games, movies, and television has contributed to this issue. Further, ubiquitous reporting of violence makes it seem a cultural norm.

However, violence or abuse of any type, whether sexual, intellectual, emotional, physical, or spiritual, should not be accepted or tolerated (Degges-White, 2015).

Psychotherapy techniques like EMDR are often used to treat anxiety and PTSD (Riddle, 2020). After going through the therapeutic intervention such as EMDR, an individual can experience sensitivity to interacting with others or external stimuli, experience more vivid dreams, and sleep differently. Rosenthal (2019) reported that the aftermath of trauma could often cause difficultly for survivors to understand the changes that occur. It is essential to integrate a recovery process, starting with normalizing the symptoms of post trauma and the effects of trauma on the brain (Rosenthal, 2019)

The effects of IPV as reported Sullivan (2020) are far more than physical injuries and can be severe and life-threatening; a third of murders of women are a result of IPV. This violence has become a pervasive social problem causing devastating physical, economic, and psychological consequences for victims. Additionally, physical health consequences related to IPV can involve not only PTSD, but suicide ideation and depression.

Significant mental health distress can occur as a result of the trauma felt by survivors of IPV (Warshaw, Sullivan, & Rivera, 2013). As further reported by Warshaw et al. (2013), feelings of disbelief, terror, despair, confusion, and isolation can affect an individual's sense of self after experiencing IPV. These feelings can manifest into hyperarousal, reliving the traumatic event, and anxiety. Some victims may experience that these symptoms develop into complex PTSD and continue for years.

Symptoms of PTSD include four categories and can vary in severity. These symptoms are often intrusive thoughts that are repeated, distressing dreams, involuntary memories, and flashbacks of a specific traumatic event (American Psychological Association [APA], 2020). The flashbacks can be so vivid that it feels like one is reliving or seeing the traumatic experience before their eyes. The reminders of the event can involve attempting to avoid places, activities, objects, people, and even situations that cause reoccurring thoughts of the distressing memories. To not think about an event, people often resist talking about what happened or how they feel, often prolonging recovery (American Psychiatric Association, 2013b).

According to Leonard (2019), the use of EMDR therapy may cause some side effects, some which may include increase in distressing memories, lightheadedness, surfacing of new traumatic memories, vivid dreams, and heightened physical or emotional sensations. These side effects may lesson over time; however, some may persist causing further distress.

As reported by Warshaw et al. (2013), a gap exists in the literature on the effectiveness of treatment. Warshaw et al. identified a need for more research on which treatments are effective for survivors with such diverse ranges of trauma experiences. As reported by Koek (2017), this gap points to a need for research that applies to the success of treatment models for survivors of IPV who have PTSD.

Problem Statement

The effects of IPV can be devasting and long term. Some of the effects lead to PTSD. In treating these symptoms of trauma individuals using EMDR therapy for PTSD

have risks of side effects. The hypothesis is that EMDR may have successful outcome for some survivors but that others may experience a continuation of the symptoms. These symptoms may be heightened as a result of the use of EMDR. This study addressed these potential risks or successes through the view of survivors of IPV regarding the effectiveness of EMDR

According to Mignone, Papagni, Mahadeo, Klostermann, & Jones (2017), there is a widespread public concern of IPV and the effect on ethnic, social, and socioeconomic groups. It is essential to examine how IPV can result in trauma that often manifests into PTSD. It is reported that IPV and PTSD have an alarming bidirectional relationship with female victims (Karakurt, Smith & Whiting, 2014). Cases of severe violence tend to be chronic, complex, and predominately male perpetrated as a form of power and control (Mignone et al., 2017).

Common forms of IPV against women involve emotional, physical, and sexual abuse as forms of controlling partner behaviors. Individuals who have been involved with IPV and have developed PTSD need to be educated to ensure they seek the appropriate treatment. There are several methods of treatment that seem to be effective for those who have symptoms of PTSD as the result of IPV. One commonly used therapy is the evidence-based treatment of cognitive behavioral therapy (CBT), which often provides relief from PTSD. The use of CPT treatment has been known to assist in reducing symptoms of depression that often occur as a result of interpersonal victimization.

One of the main areas of focus in the study is EMDR is the debate on its effectiveness for treating PTSD. The APA (2017) published recommendations between

May 25, 2012, and June 1, 2016, identifying trials for supporting all of the types of interventions for the treatment of PTSD except EMDR. This may be because of the potential risks of EMDR, which, as reported by Riddle (2020), have included vivid dreams, lightheadedness, an increase in distressing memories, surfacing of new traumatic memories, and heightened emotions or physical sensations and sensitivity to external stimuli interactions.

The APA (2010a) conditionally recommended three psychotherapies. These therapies have had indications of good results; however, there exists evidence that also shows possible harm and lack of treatment benefits. Included in these interventions is EMDR, which may not be applicable in different situations.

Purpose of the Study

This qualitative descriptive study examined female survivors' life experiences and the perceived effectiveness of EMDR in treating PTSD symptoms as a result of IPV. Survivors of IPV who have PTSD often hesitate to seek help from a professional and wait for years to get treatment (Riddle, 2020). PTSD often remains misdiagnosed or undiagnosed due to health professionals' lack of training. it is common for many women to not realize that they are experiencing the effects of PTSD. Furthermore, women are known to internalize problems and assume that something is wrong with them and not a result of what happened to them.

This study represents an important investigation of women who have experienced IPV resulting in a diagnosis of PTSD as a result of the trauma. The study examined how IPV survivors view the success of EMDR treatment including any negative consequences

as a result of using the therapy. The study's findings can be used to advocate for identifying appropriate treatments and interventions for the growing numbers of women coping with PTSD and the repercussions of IPV. Further, this study's findings may benefit practitioners and researchers by helping to inform them as to whether EMDR is an effective treatment choice for women with PTSD from IPV.

Research Question

This study's central focus was on the perceived efficacy of EMDR treatment for IPV victims with a diagnosis of PTSD.

RQ: What is the patient-perceived effectiveness of EMDR treatment for PTSD of IPV survivors?

Conceptual Framework

Serving as the conceptual framework for this study was self-efficacy. According to Hoelterhoff and Chung (2020), self-efficacy addresses issues of belief and control in having resources and strengths to handle problems that may occur. Bandura's (1997) perceived self-efficacy control over potential threats during anxiety arousal. The self-protective behavior indicates that anxiety arousal and avoidant behaviors are coeffects of coping inefficacy. Self-efficacy represents as a key concept (Hoelterhoff and Chung, 2020) when examining intrusive thinking and anxiety arousal in the clinical implications of PTSD. Self-efficacy is an essential factor in the recovery of PTSD and is linked with improved psychosocial functioning. Self-efficacy has been shown as reported by Hoelterhoff and Chung (2020) to help individuals to have more control of anxious thoughts. Depending on the level of self-efficacy, PTSD symptoms of high levels of

thought intrusions, hyperarousal, or avoidance can be managed (Hoelterhoff and Chung 2020). The principles of self-efficacy theory will guide the current research. I discuss further details of self-efficacy in Chapter 2.

Nature of Study

I employed qualitative research to obtain an understanding of IPV survivors' perceptions of the treatment efficacy of EMDR to reduce symptoms of PTSD. This was an appropriate design consistent with Husserl's (1970) transcendental phenomenological approach. The transcendental phenomenological approach developed by Husserl (1970) is used to analyze data about lived experiences. Transcendental phenomenology provided a systematic approach to exploring in-depth individual perceptions of a phenomenon for a study. The approach prevents intrusions and pressures on participants, allowing them to speak freely and not be influenced by the researcher. It further offers the researcher the ability to choose the appropriate participants who have a direct relationship to the phenomenon. The purpose of this transcendental phenomenological study was to examine the participants shared descriptions IPV and the treatment modality allowing the findings to be more transferable. The sample size is often 5 to 15 participants as was with this study for the collection of data, identifying themes, and synthesizing the results.

Definitions

The following definitions clarify terms used in the study of heterosexual women who have used EMDR treatment to cope with the symptoms of PTSD and their perceptions of the effectiveness of treatment:

Depression: Depression is a common and serious medical illness that negatively affects how a person feels, think, and acts. It can cause feelings of sadness and/or a loss of interest in life activities often leading to physical and/or emotional problems that can affect the ability to function (APA, 2020a).

Eye movement desensitization and reprocessing (EMDR International Association, 2020): EMDR is a psychotherapy treatment designed to alleviate distress associated with traumatic memories (Shapiro, 2007).

Generalized anxiety disorder (GAD): GAD is excessive and persistent worry about many of different things. (National Institute of Mental Health, 2016).

Intimate partner violence (IPV): IPV is defined as sexual, physical violence, psychological harm or stalking by a current spouse or former partner (Centers for Disease Control and Prevention, 2018).

Intimate partner violence survivor: An IPV survivor is an individual who has experienced gender-based violence resulting in physical, sexual, or mental harm. (APA, 2020a).

Physical violence: Physical violence refers to the intentional use of physical force with the risk of causing injury, harm, and even death to another. Physical violence can include pushing, shoving, biting, choking, scratching, hitting, slapping, punishing, restraining, and burning Centers for Substance Abuse Treatment (2014).

Posttraumatic stress disorder (PTSD): PTSD is a psychiatric disorder that can occur to individuals who experience or witness a traumatic event such as a rape, violent

personal assault, murder, natural disaster, a serious accident, a terrorist act, or war/combat (American Psychiatric Association, 2013b).

Sexual violence: Sexual violence is an act where one person uses coercion, force, or psychological intimidation against another forcing them to carry out a sexual act (Centers for Disease Control and Prevention, 2018).

Assumptions

The assumptions associated with this research involved the methodology of a qualitative research being effective in examining the effectiveness of EMDR treatment from a perspective of IPV survivors diagnosed with PTSD. I assumed the use of a qualitative research method would allow for the collection of data in the form of participant-described lived experiences. Another assumption was that I would be able to find female survivors who met the criteria to participate in the study.

A primary assumption was that during interviews participants would be honest and forthcoming with information pertaining to the research question. Another assumption was that participants would be able to recall their lived experiences accurately despite their level of trauma.

Scope

The scope of the study was female survivors who had experienced IPV resulting in a diagnosis of PTSD. These individuals were not currently living in an IPV situation. Participants were 18 years of age or older and had experienced using EMDR therapy treatment for their PTSD symptomology.

Delimitations

The criteria for the participants created the delimitations of the study. The criteria eliminated women who did not identify as having a diagnosis of PTSD as a result of IPV and who did not have a direct experience with EMDR treatment. Additionally, the study did not include male participants, which limits transferability of the findings to men.

Limitations, Challenges, and Barriers

Two main limitations existed in this study. The first was the participants may not have been entirely forthright in their responses about treatment. Also, if the participant had developed a good rapport with their therapist, they may be more likely to decide the therapy was effective when their symptoms actually remained unstable. However, if the participant did not have a good rapport with the therapist, the participant may decide that the treatment was ineffective despite a reduction in symptoms. Also, because this study was qualitative, my thoughts and beliefs may have influenced the interview or findings. As in all qualitative studies, it is essential that the researcher approaches the study from an unbiased perspective. I questioned my perspective when developing this study and worked closely with my committee to maintain a neutral perspective.

Significance

This qualitative study was focused on providing needed insight into the effectiveness of EMDR treatment for PTSD that resulted from IPV. It has significance for social justice as it allowed victims of IPV who have received EMDR to voice their thoughts and opinions about the efficacy of the treatment and will help inform providers and the perceived efficacy of EMDR for PRSD caused by IPV. Warshaw and Brashler

(2015) found that it is vitally important for clinicians to incorporate an understanding of how a traumatic event like IPV can play out in both individuals' lives and the social/institutional/political arenas. Working collaboratively with victims of IPV may create a society that will become aware of the magnitude of violence against women and thereby assist with stopping or mitigating the impact of IPV. Warshaw and Brashler (2015) reported that society does not understand IPV and that it is an intolerable situation on a personal, political, and social level. Working with survivors of PTSD trauma brings awareness of the complexity and the unpredictability of human lives that intersects with human development and culture. Understanding these complex issues can be used to promote healthy social change.

Summary

Chapter 1 introduced and examined patient-perceived effectiveness of the treatment modalities of EMDR for IPV survivors diagnosed with PTSD. The literature revealed a gap in knowledge of the effectiveness of treatment, as reported by Warshaw et al. (2013), and the need for more research to understand how the treatment is perceived by survivors. The gap as reported by Koek (2017) points to a need for the research into the success of treatment models for survivors of IPV who have PTSD.

In this chapter 1, I presented information regarding IPV survivors who have been diagnosed with PTSD and a perspective on the use of EMDR treatment. In Chapter 1 I provided information related to PTSD, treatment of EMDR, and the research problem, background, theoretical framework, purpose, research question, scope and limitations, and significance of the study.

In Chapter 2, I address the current literature on how IPV can cause PTSD. The literature review includes different treatment modalities for PTSD, focusing on EMDR.

In Chapter 3, I discuss the study's research design and methodology and the psychometrics and data collection method involved. In this study I examined the patient-perceived effectiveness of treatment modalities of EMDR for IPV survivors diagnosed with PTSD.

Chapter 2: Literature Review

Introduction

In this qualitative phenomenological study, I examined the patient-perceived effectiveness of EMDR in treating PTSD for IPV survivors. The National Coalition Against Domestic Violence (NCADV 2020) reported that, on average, approximately 20 people per minute are physically abused by an intimate partner in the United States. This rate equates to over 10 million women victimized by IPV in one year alone. In that same year, 1 in 4 women experienced severe intimate partner physical violence, consisting of shoving, pushing, slapping, contact sexual violence, rape, stalking, injury, and/or fearfulness, often resulting in PTSD. The NCADV (2020) further reported that more than 20,000 phone calls are placed on domestic violence hotlines nationwide on any given day.

IPV creates a 500% increased risk for homicide, particularly with the presence of a gun (National Center on Domestic and Sexual Violence, 2020). This type of victimization often results in depression and suicidal ideation. Not all women experience PTSD as a result of IPV situations; however, the prevalence and severity are staggering for those who do experience PTSD. As a result of abuse, PTSD rarely occurs alone; most commonly, there is a comorbid diagnosis of major depression (NCADV, 2020).

According to Dekel, Shaked, and Ben-Porat (2019), the global social problem of IPV is universal across many societies. The ramifications include continuing threats to the victims in the aftermath of physical and emotional abuse along with significant financial costs and social instability for the community. In addition to PTSD, mental

distress resulting from IPV often includes depression, anxiety, substance abuse, and suicidal tendencies.

In this literature review, I identify and expand on the background of the research problem introduced in Chapter 1. I begin with the literature search strategy I used for the literature review. The following sections include the theoretical foundation for the study, a description of IPV, psychopathy and IPV, federal and state laws relating to IPV, trauma, PTSD research, assessment, treatment, and EMDR therapy. The chapter concludes with summary of the literature review.

Literature Search Strategies

The literature used for this study was primarily from peer-reviewed journals. A few of the peer-reviewed journals included mental health practitioners' perceptions of ethical requirements and treatment effectiveness. Walden University's electronic library database was used for the literature searches. Included in the databases used were (a) ProQuest Psychology Journals, (b) PsycARTICLES (EBSCOhost), (c) PsycBOOKS (EBSCOhost), (d) PsycINFO (EBSCOhost), (e) ProQuest Dissertations, and (f) Journals of the APA. The key terms I used in the literature search included but were not limited to *intimate partner violence, domestic violence, posttraumatic disorder,* and *eye movement desensitization (EMDR),* all identified within the context of maintaining ethical compliance.

A secondary source included Hammarberg, Kirkman, and de Lacey (2016) on qualitative research methods A critical concept of words and phrases was used to develop themes along with commonalities among other studies that have been conducted. The

qualitative method is used to answer questions about meaning, experience, and perspective, often from the participant's standpoint.

Literature Review

A literature review summarized current research about the purpose of this study, theoretical foundation, survivors of IPV who have PTSD, and the perceived effectiveness of treatment. This chapter examines ethical guidelines in directing treatment that is effective for survivors of IPV.

Additionally, I present research findings related to the use of EMDR as a treatment modality that has potential undesirable drawbacks that may limit alleviating PTSD symptoms.

According to McFarlane and Yehuda (2016), the primary aim of PTSD therapy is to allow an individual to minimize the arousal and distress associated with reminders of the involuntary and recurrent trauma. McFarlane and Yehuda reported that this is accomplished using various modalities to help a person eliminate the persecution and ongoing suffering following the trauma. The critical issue is understanding how, in the immediate aftermath, symptoms of trauma develop and progress into chronic forms of PTSD.

Theoretical Foundation

I used the self-efficacy model to look at how posttraumatic symptoms can be so severe that victims of violent physical assault meet the diagnostic criteria for PTSD (American Psychiatric Association, 2013a). Previous studies of posttraumatic stress

symptoms and self-efficacy report that high self-efficacy is related to lower levels of posttraumatic stress symptoms.

Nygaard, Johansen, and Heir (2017) defined self-efficacy as an individual's belief in producing effects that are desired in an activity while managing symptoms. Self-efficacy for the reduction of posttraumatic stress symptoms involves engagement in effective regulation of affective, decisional, cognitive, and motivational processes (Simmen-Janevska et al., 2012). Individuals with high self-efficacy may consider symptoms from stress and anxiety as temporary and controllable.

According to Hoelterhoff and Chung (2020), self-efficacy is a protective factor when experiencing a life-threatening event like IPV. According to Nygaard et al. (2020), high self-efficacy has proven to decrease the severity of posttraumatic stress symptoms, and an intervention promoting self-efficacy has provided benefits for assault victims. The use of the Generalized Self-Efficacy Scale (GSE scale), as reported by Nygaard et al. (2020), has shown higher levels of self-efficacy can ameliorate posttraumatic stress symptoms in the first year.

However, posttraumatic stress symptoms may lower self-efficacy, which can have clinical implications for treating stress symptoms. Emphasis is on the importance of prevention and early treatment to prevent the increased risk of chronic 5-month post trauma PTSD (Morina, Wicherts, Lobbrecht, & Priebe, 2014). Nygaard et al. (2020) concluded that there are possible negative consequences of PTSD for self-efficacy in the first-year post trauma. There is a need for treatment for PTSD that lasts more than 3

months (NICE, 2005) to accelerate the recovery process to avoid a negative impact on self-efficacy.

This framework relates both to the study's approach and the overarching research question. Self-efficacy plays a significant role in the overall success of any type of treatment.

Intimate Partner Violence

Dekel et al. (2019) reported that IPV is a universal social health problem worldwide. It threatens the emotional state and physical safety of the individual involved while at the same time, it has implications for the community with significant medical, financial issues. As a result of IPV, survivors experience various mental distresses, such as depression, substance abuse, anxiety, PTSD, and tendencies for suicide.

According to Dekel et al. (2019), IPV is defined as an umbrella term that covers a variety of dominating and hostile behaviors. As reported by Nicolon et al. (2017), IPV is seen as a severe, preventable public health problem that typically occurs across a lifespan affecting millions of Americans. It has no restrictions on when it can begin, often starting when people start dating and experiencing intimate relationships.

According to Nicolon et al. (2017), IPV is not shared across all groups equally; it can disproportionately affect minorities, both racial/ethnic and sexual minority groups. The National Archive of Criminal Justice Data (2014) has provided data on the prevalence over a lifetime of individuals who experience physical and/or sexual violence or intimate partner stalking. The data reported that 57% of multiracial non-Hispanic

White women, 48% of American Indian women, 34% of Hispanic women, 45% of non-Hispanic Black women, and 18% of Asian-Pacific Islander women experience IPV.

IPV was defined by Sinha (2013) as a "violence committed by opposite and same-sex common-law, separated, legally married, divorced, (current and previous) and other intimate partners" (p. 20). Sexual, physical, financial, or psychological aggression, abuse or controlling behavior can occur with IPV. As reported by Dekel et al. (2019), these acts include coercion, arbitrary deprivation of liberty, and threats of physical harm, ranging from mild to life-threatening assaults. This definition encompasses physical, sexual, and psychological aggression or abuse or any kind of controlling behavior.

The APA (2020b) reported that in the United States, more than 1 in 3 women experience physical violence, rape, or stalking by their intimate partner in their lifetime. Seventy-four percent of all murder-suicides involve IPV, with 96% of victims being women. According to the APA (2020b), interpersonal violence is the leading cause of female homicides.

The severity of violence with IPV can be classified as reported by Patra, Prakash, Patra, and Khanna (2018) as level I abuse: throwing objects, shoving, pushing, grabbing, and intimidation of damage to pets or property; level II abuse: slapping, kicking, and biting, and level III: attempt to strangulate, choking, or use of a weapon. Predominantly the aggression is male to female, not only to dominate or control a partner but also to ultimately instill fear. There can exist violent resistance where partner resists such aggression, often being in the form of self-defense (Patra, et al., 2018). Then there is situational couple violence where the aggression is low in intensity, bidirectional, and

conflict situational rather than using controlling or self-defense as a tool. IPV, as reported by the American Psychiatric Association (2020) is a preventable public health problem. Millions of women, regardless of race, status, ethnicity, educational age, background, religion, sexual orientation background have experienced all levels of trauma, whereas the effects and impact of IPV can differ from survivors. Some individuals may exhibit a response of resilient and adaptive responses to the abuse, while others may develop psychiatric symptoms. Individuals who have experienced IPV may endure lifelong consequences that can include, however, not limited to chronic health problems, lasting physical and emotional trauma, or PTSD. Approximately 20% of IPV survivors reported experiencing new onsets of psychiatric disorders that co-occur with PTSD. These disorders can include major depressive disorder (MDD), generalized anxiety disorder (GAD), and a wide range of substance use disorders (APA, 2020a).

The National Sexual Violence Resource Center (2018) advocated for the prevention of sexual assault. Movements for equality and social change in the United States gained ground during the 1940s and 50s civil rights era. During that time, discussions about IPV and sexual assault were limited.

According to the National Sexual Violence Resource Center (2018), in the 1970s, with broad social activism occurring around sexual assault, it brought about heightened awareness and support for survivors. In 1971 the first crisis rape center opened in San Francisco, while seven years later, the first event of U.S. Take Back the Night event occurred (NSVRC, 2018).

The National Center on Domestic and Sexual Violence (2020) developed the well-known power control diagram, which demonstrates and understands the pattern of violence and abusive behaviors. These patterns represent what maintains control by an intimate partner. Often more than one of these types of abuse accompanies violent incidents.

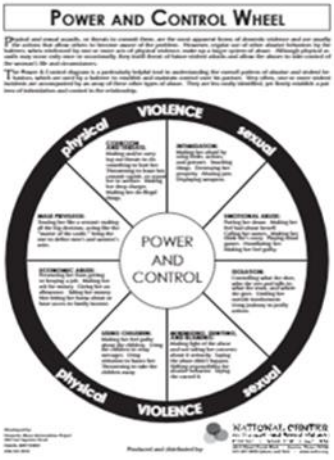

Figure 1. Power and control wheel.

Psychopathy and IPV. According to Cunha, Braga, and Gonçalves (2018), psychopathy is a combination of interpersonal personality traits; being arrogant, manipulative, and grandiose, lacking guilt, remorseless and empathy. The behavioral characteristics involving violation of moral and social conventions, impulsive and irresponsible and lifestyle (Neumann, Hare & Newman, 2007). Psychopathy, as reported by Cunha et al. (2018), has been linked to unsuccessful treatment along with a high rate of violent recidivism.

In criminal behavior and criminal violence, psychopathy is a significant predictor (Hare, 2003). Cunha et al. (2018) reported similarities exist between psychopathy

features and male batterers' subgroups and antisocial/ violent subtypes. Often batterers engage in violence outside an intimate relationship, presenting substance abuse and psychopathy with a high rate of convictions and criminal records. Psychopaths (Hare, 2003) and violent IPV perpetrators are often dangerous and usually resistant to treatment.

Cunha et al. (2018) reported that the use of one of the most prominent assessment instruments for psychopathy in the field is the Psychopathy Checklist-Revised (PCL-R) developed by Hare (1991-2003). It combines a semi-structured interview with file information. Cunha et al. (2018) study revealed that the PCL-R total score was a predictor that proved to be significant in IPV frequency. Findings went beyond the variables of previous convictions other than IPV in addition to previous convictions that involved IPV, and the total number of incarcerations.

The core features of psychopathy have found to have similarities between specific subgroups of male batterers, often known as antisocial/violent subtypes. There are several characteristics reported by Cunha et al. (2018) that overlap between violent batterers and psychopaths. These characteristics involve high levels of drug and alcohol abuse, generalized violence, affective and interpersonal features including remorselessness, callousness, and manipulation (Cunha et al., 2018).

According to Cunha et al. (2018), men with antisocial and psychopathic traits have a 15% to 30% range among batterers who commit a disproportional amount of IPV. The pattern of behavior over an intimate partner is used to gain control, power, and personal gain, while psychopaths may use coercion or violence to achieve them.

Federal and state laws governing IPV. The NCADV (2020) reported in 1994, that Congress passed Title IV of the Violent Crime Control and Law Enforcement Act of 1994. Sacco (2015) reported that the act is known as the Violence Against Women Act or VAWA. The VAWA encourages social change and the effects of ever-increasing violence against women. New programs developed by the VAWA, as reported by Sacco (2015), have assisted law enforcement in fighting violence. The VAWA additionally provided grant money to assist in prohibiting criminal activities that have not been legally recognized in the past while strengthening penalties. Further reauthorization has expanded VAWA in combating sex-trafficking, and a rape shield law.

According to the United States Department of Justice (2017), under the Violence Against Women Act VAWA, it is a federal crime to cross state lines and psychically injure, stalk, or harass an intimate partner or violating an order of protection. The court within a VAWA case must order payment of a full amount of restitution to the victim. The restitution covers expenses incurred by a victim as a result of the offense as reported by the Socco (2015). The restitution funds are to cover medical, physical, and psychological therapy, temporary housing, transportation, childcare expenses, attorney fees, loss of income, attorney's fees, civil protection order.

In 1994 and 1996, Congress passed as reported by the United States Department of Justice (2017) changes to the Gun Control Act for abusers of domestic violence. The act possesses firearms and ammunition in making it a federal crime misdemeanor under Section 922(g)(9). State and local authorities handle most IPV cases; however, federal laws may be appropriate.

The Office of Women Health (OWH) (2020) reported that the Violence Against Women Reauthorization Act 2013 is considered to be a federal law primarily against violence against women. The law provides the support and services needed by victims of IPV and sexual assault. The services provided by this law include 1. Programs for immigrant women with different ethnicities and races, 2. No charge for civil and prosecution protection orders, 3. Program and services for women having disabilities, 4. Legal services for IPV survivors, 5. Free rape examinations, and 6. Protection for evictions from homes because of IPV (OWH, 2020).

The violence Against Women Reauthorization Act of 2013 - (Sec. 3) amended some areas of the Violence Against Women Act of 1994 (VAWA). The changes included as reported by Congress.Gov. (2020) expanding definitions of the terms of culturally specific services. The terms are referred to as community-based services offering culturally relevant resources and services to specific cultural communities. The act aids underserved populations who face barriers when using or accessing victim services due to religion, gender identity, sexual orientation, geographic location.

The OWH (2020) further reported that the Family Violence Prevention and Services Act (FVPSA) assists victims of domestic violence and their children by providing shelters and resources. The FVPSA funds program on the state, national, and community levels, such as the Domestic Violence Resource Network Established by Crime Victim Rights Act (2020). The act states that a victim of an intimate partner crime has the right during a bail hearing to speak to the Judge informing all potential dangers that could occur by releasing the defendant. Additionally, at the time of sentencing, a

victim has the further right to be heard in court. The Office of Victims of Crime (2020) reported that the Crime Victims' Rights Act was enacted in October 2004. This act has encouraged the enforcement of victim rights, promoting compliance with the laws, funding grants to implement provisions, provided enforcement mechanisms, and created the list of victim's rights for federal criminal cases under 18 U.S.C. section 3771. As reported by the Office of Victims of Crime (2020), the victims' rights include 1. The right to be reasonably protected from the accused, 2. The right to reasonable, accurate, and timely notice of any public court proceeding or any, 3. The right to be present during parole proceeding involving the crime or of any release or escape of the accused, 4. The right not to be excluded from any such public court proceeding, unless the court, after receiving clear and convincing evidence, determines that the victim's testimony would be materially altered if the victim heard other testimony at that proceeding, 5. The right to be reasonably heard at any public proceeding in the district court involving release, plea, sentencing, or any parole proceeding, 6. The reasonable right to confer with the attorney for the Government in the case, 7. The right to full and timely restitution as provided in law, 8. The right to proceedings free from unreasonable delay, and 9. The right to be treated with fairness and with respect for the victim's dignity and privacy.

According to the Domestic Violence Laws (2019) in the United States, assault, and battery by IPV are considered a Class 1 misdemeanor, and a felony on third convictions. In rape cases, sexual intercourse occurs through intimidation, force, or threat is considered a felony in the United States. Often the perpetrator of rape can face life in

prison. In a case where an individual is deemed helpless physically, it is typically defined as a heinous act and a felonious rape often caring a life sentence.

Adhia et al. (2020) reported there exists domestic violence laws protecting victims of IPV through civil protection order (CPO). A court order is granted to protect an individual from being threatened with abusive behavior in IPV situations. The use of CPOs is a common legal remedy of more than one million individuals annually in the U.S. In IPV case, as reported by Adhia et al. (2020), a CPO prohibits a perpetrator from having any contact or commit additional violence. Violations of CPO's can lead to a felony charge that could include a misdemeanor, fines, or incarceration, depending on the level of the violation. In the U.S., there is at least a 20% increase of adult women obtaining CPO's who are experiencing IPV. There are estimates of 12% to 40% of individuals who have a long history of abuse who seek CPO's (Adhia et al., 2020).

Hirschel and Deveau (2017), reported that when it comes to arrests of intimate partner perpetrators, there has been an increase in police warrantless arrest with the enactment of preferred and mandatory arrest laws. With these laws, the arrest rate of IPV cases has considerably risen. As reported by Hirschel and Deveau (2017), this increased arrest rate has not necessarily been looked at as always beneficial. Concern has developed over the increase in the percentage of arrested victims or women in some cases.

The unjust arrests of victims with the offenders have caused states to begin to pass primary aggressor laws. Hirschel and Deveau (2017) continued to report that this law ensures that the circumstances are assessed appropriately, and police officers arrest only the real offender. The first state of the United States to enact the first aggressor law in

1985 was Washington State, while at least 34 more states have followed and have now enacted the law.

Trauma

Experiencing traumatic events, such as sexual abuse, natural disasters, or physical violence often leads to severe changes in a person's psychological makeup. A traumatic sequela includes changes in motivation, cognition, and emotion. According to McGauran (2016), psychological trauma damages the psyche occurring as a result of a severely distressing event. When there occurs a perceived life-threatening situation with no escape trauma happens, individuals get stuck in the memory of what happened. Emotional trauma, with time alone, cannot heal on its own. The devastating effects of trauma can develop anxiety, depression, additions, social problems, and PTSD.

The Center for Substance Abuse Treatment (US) (2014) reported that the immediate aftermath felt by a survivor of traumatic experiences can be complicated and are affected by the individual's accessibility of natural supports, life, and coping skills. Clinically, coping efforts can regulate emotions of sadness, anger, anxiety, shame, and sustaining self-esteem while maintaining interpersonal contacts. Reactions to the trauma can include anxiety, numbness, confusion, dissociation, exhaustion, blunted affect, and physical arousal. Some may have flashbacks and other signs of PTSD. Tan and Yip (2018) reported that in 1926 Hans Selye described the findings from experiments on rats that identified three distinct stages of general adaptation syndrome (GAS) and how the body responds to stress. The first stage is the initial alarm reaction stage that occurs after the stressful event followed by stage two, the resistance stage where the body's

Autonomic Nervous System (ANS) resists the impact of the stressful stimulus, and the exhaustion stage where the body fails to cope with the distressing stimulus. (Selye 1950).

Godoy et al. (2018) reported the Selye stages of GAS as Stage 1: Alarm Reaction, the sympathetic branch of the Autonomic Nervous System (ANS), activates the stress hormone cortisol secretes from the adrenal gland, along with adrenaline. This results in an increase in breathing, blood pressure, and heart rate. During Selye's study, the rat's bodies underwent significant physical changes. These changes included the shrinking of numerous organs that included the thymus, liven, and lymph glands while reducing body fat and lowering the body's ability to conserve energy. From this, Cannon coined the term fight-or-flight response causing the body to adapt quickly to the threat posed to them. According to Selye (1950), this stage manifests and reverses or the disappearance of resistance and reappears in the exhaustion stage. Selye (1950) reported that this suggests the living organism's ability to adapt to changes in the surroundings.

Posttraumatic stress disorder. According to Oliveira-Watanabe et al. (2019), PTSD develops from exposure to a traumatic event such as actual or threatened serious injury or death, or sexual violence resulting in a debilitating condition. One can develop PTSD symptoms as reported by Oliveira-Watanabe et al. (2019), by either witnessing or having direct exposure to a traumatic event or by indirect exposure to details of the event that are aversive. The DSM-5 (2013) lists 20 diagnostics criteria for PTSD that are divided into symptom clusters: trauma-related arousal, reactivity, persistent negative feelings, or thoughts, re-experience of the traumatic event, avoidance, persistent negative thoughts, or feelings.

PTSD is thought to be determined by the interplay of complex pre, peri, and post-trauma factors of risk (Vogt, King, & King, 2015). According to Su and Chen (2018), maladaptive schemas may be preexisting in the development of PTSD through biased cognitive processing. According to Beck's theory of anxiety (Beck & Clark, 1988), the maladaptive schemas remain latent until adverse events occur and activate the schemas. The schemas then lead to information processing system distortion. Once trauma occurs, it activates, and the PTSD related schemas give rise to information-processing biases, including encoding following the trauma of contextual trauma-relevant information.

The National Institute of Mental Health (NIMH, 2019) reported that an individual who has PTSD could feel frightened or stressed at any given time. The fear that triggers can cause changes in the body in a split-second. The DSM-5 (2013) states that PTSD symptoms must last more than a month and be so severe that it can affect one's work, relationships, and even daily living. Some individuals might recover in 6 months while others last long enough for the condition to become chronic.

A common symptom of PTSD, as reported by the NIMH (2019), is cognition and mood that causes negative thoughts, distorted blame or guilt feelings, loss of interest, trouble remembering details of the traumatic event. Some factors create a higher risk of PTSD when a traumatic event occurs, that may include no social support, feelings of helplessness, loss of a loved one during the event, and even childhood traumas.

Bryant (2019) reported that within the ICD-11, there exists another PTSD diagnostic construct noted as complex PTSD. In complex PTSD, a person needs to present the core symptoms while at the same time demonstrating emotional dysregulation

such as violent outbursts, negative self-concept, and difficulties in relationships that persist.

Hendrickson and Raskind (2016) reported a Neurobiological model posits a surge of stress hormones released at the time of the trauma in conjunction with fear conditioning responses. The cues for predicting future threat results in re-experiencing fear is when exposed to external and internal memories of the trauma. According to Hendrickson and Raskind (2016), individuals with PTSD have presented evidence of neural changes occurring that are known to implicate fear conditioning being the hippocampus, prefrontal cortex, and the amygdala. There further exists, as reported by Hendrickson and Raskind (2016), evidence of threat detections and dysfunctions involving contextual processing, executive functioning, and emotion regulation. It has been well-documented as reported by Bryant (2019) that noradrenergic dysregulation in PTSD is a critical development of re-experiencing intrusive trauma memories. There is further evidence that supports prazosin, a noradrenergic receptor inhibitor in reducing re-experiencing symptoms like nightmares. While the ministration of a beta-adrenergic antagonist called propranolol just hours after exposure to trauma has proven to limit reactivity to subsequent reminders (Bryant, 2019). It does not, however, prevent overall symptoms of PTSD.

PTSD research. In the last decade, The NIMH (2019) referenced research on the foundations of PTSD, both biological and mental leading to an understanding of the underlying causes having a range of reactions by different people. The NIMH (2019) further reported additional research addressed identifying factors that determine why one

person with PTSD will respond to one type of treatment while another person does not. This research is aiming at developing more efficient and effective treatments. While further research is underway addressing the ability to prevent PTSD from developing after exposure to trauma. Additionally, research continues on brain imaging technologies along with gene research to arrive at where and when PTSD begins in the brain (NIMH, 2019).

PTSD assessment/diagnoses tools. The diagnosis of PTSD has undergone several changes since it was included in the DSM-III (American Psychiatric Association, 1980; Watkins, Sprang, & Rothbaum 2018). The DSM-5 2013) changed the diagnostic criteria for PTSD to include (Criterion A) Exposure to actual or threatening death, sexual violence, serious injury, Intrusion (Criterion B) imagery of a loved one's dying moments, Avoidance (Criterion C) pf thoughts and feelings associated with the death), Negative thoughts and feelings (Criterion D) experiencing about the death, and Hyperarousal symptoms (Criterion E) being watchful or on guard since the death.

To meet the criteria for a diagnosis of PTSD, as reported by DSM-5 (2013), an adult must have all of the following for at least one month: at least one re-experiencing and avoidance symptom, at least two arousal and reactivity symptoms, at least two cognition and mood symptoms. As reported by the NIMH (2019), the re-experiences symptoms may include flashbacks that may include sweating and racing heart, frightening thoughts, and nightmares. The avoidance symptoms may include avoiding any related feelings or thoughts to a traumatic event and staying away from events, objects, or places that remind one of the events. The symptoms of reactivity or arousal

may include feelings of being on edge or tense, angry outbursts, difficulty sleeping, and easily startled. The arousal symptoms are not usually triggered as reported by the NIMH (2019) by reminders or things; instead, they can often be constant. The symptoms of mood and cognition may include thoughts about oneself that are negative, with feelings that are distorted, of blame or guilt, and difficulty remembering specific features of the event and often losing interest in activities that were once enjoyable. These symptoms are not due to substance abuse and can worsen after the traumatic event. An individual may also feel alienated from everyone around them (NIMH, 2019).

Diagnostic assessments are conduction with the use of many different types of batteries of tests. Some of these tests include the (PSSI-5), a modified version of the PSS-I (PTSD Symptom Scale). Symptoms of PTSD are assessed using the interview-based Clinician Administered PTSD Scale (CAPS) and the DSM-4's self-report impact of the event Scale-Revised (IES-R).

The Disorders Interview Schedule–IV (ADIS-IV) and the clinician-administered GAD section of the ADIS/IV, the self-report Beck Depression Inventory-II (BDI-II), and the Anxiety symptoms using the self-report Beck m Anxiety Inventory (BAI). According to Foa et al. (2016), the PSS-I-5 is a 24-item semi-structured interview beginning with Criterion A identification and trauma screen of an index trauma if multiple events reported.

The PSSI-5 consists of 20 DSM-5 PTSD symptom questions that assess for frequency and intensity. Another four items ask about interference and distress caused by the symptoms and the duration and onset of symptoms. As reported by Foa et al. (2016),

on a 5-point scale of frequency and severity, symptoms are rated from 0 (not at all) to 4 (severe/ more than six times a week). The sum of the 20 symptoms yields the severity score of PTSD symptoms ranging from 0-80 (Foa et al., 2016). The scoring breakdown, as presented by DSM-5 states: Having unwanted distressing memories about the trauma? 0 = Not at all, 1 = Once a week or less/a little, 2 = 2 to 3 times a week/somewhat, 3 = 4 to 5 times a week/very much, and 4 = 6 or more times a week/severe.

Roffer (2014) reported that the focus today in with the primary use of the Posttraumatic Cognitions Inventory (PCTI), the PTSD Checklist 5 (PCL-5), and the Clinical Administered Scale for PTSD 5 (CAPS-5). Roffer (2014) reported that Checklist 5 (PCL-5) consists of 20 items self-report measure, 1-5 Likert Scale ("Not at All" to "Extremely"), Adheres to DSM-5 diagnostic criteria (American Psychiatric Association, 2013a), 5-10 minutes to complete and can be used to screening, monitor change/progress over time, and to assist with diagnosis.

Wells et al. (2017) reported that The Posttraumatic Cognitions Inventory (PTCI; Foa et al., 1999) assesses posttraumatic appraisals and how it relates to PTSD and symptoms of anxiety and depression. The PTCI measure contains 33 items representing three factors: Negative Cognitions of the World, Negative Cognitions of the Self (21 items), and Self-Blame (5 Blame subscales).

According to Oliveira-Watanabe et al. (2020), the Clinician-Administered PTSD Scale (CAPS) as an assessment for PTSD is considered the gold standard. The CAPS-5 is a 30-item structured interview non-self-administered scale most widely used for PTSD assessment in clinical and research scenarios. The CAPS-5 assesses for PTSD symptoms

over the past week, makes current (past month) diagnosis of PTSD, and makes Making lifetime diagnosis of PTSD.

The questions that target the 20 DSM-5 PTSD symptoms is the duration and the onset of symptoms. The (CAPS) further targets as reported by Oliveira-Watanable et al. (2020) presented symptoms that have to impact the social and occupational functioning, subjective distress, and improvement in symptoms since the administration of previous CAPS, overall PTSD severity, response validity, and specifications for the dissociative subtype (derealization and depersonalization). Other Self-Reporting Questionnaires used for PTSD symptom diagnostics

DSM -5 on PTSD. The Checklist (PCL) a 20-question Likert scale self-report measure. They are used widely for measuring PTSD according to DSM-5 criteria (American Psychiatric Association, 2013a). Weathers et al. (2013) reported that the PCL has shown to be a measure for assessing the severity of PTSD symptoms Posttraumatic Diagnostic Scale (PDS) (Blevins et al., 2015).

The Detailed Assessment of Posttraumatic Stress (DAPS-2) is a comprehensive questionnaire that assesses PTSD diagnostic criteria. Addresses symptoms of suicidality, dissociation, and substance abuse. The assessment has proven to demonstrate validity, reliability, and other questionnaires for PTSD (Petri, Weathers, Witte & Silverstein, 2019). PTSD Symptom Scale Interview (PSS-I and PSS-I-5) PTSD Symptom Scale Interview (PSS-I and PSS-I-5) is a 17-item semi-structured interview. The PSSI-I and PSS-I 5 address known trauma history, identifying single traumatic events that cause the most recent distress associated with the DSM-4 PTSD symptoms (APA, 2018).

Multiscale. The Minnesota Multiphasic Personality Inventory (MMPI-2) is a self-administered, objective personality test that provides a broad assessment of personality patterns and potential personality disorders. The information gained from interpretation concerns both the structure and content of personality. The MMPI-2 results interpret cautiously, conservatively, and in light of all the data obtained and available during this evaluation (Framingham, 2018).

The Beck Depression Inventory-II (BDI–II), created by Aaron T. Beck, is a 21-question multiple-choice self-report inventory, used for psychometric tests for measuring the severity of depression (APA, 2020b). Generalized Anxiety Disorder Scale (GAD-7) frequently used for diagnostic self-report scales for diagnosis, screening, and severity assessment of anxiety disorder (Jordan et al., 2017).

Treatment for PSTD. There exist several modalities for the treatment of PTSD. The primary consideration is in knowing the cause of the trauma and not every treatment has a successful outcome. As reported by Tartakovsky (2019), the conventional psychotherapies include CBT, which focuses on the relationships of behaviors, feelings, and thoughts, then focusing on changing the patterns that cause functioning difficulties. Tartakovsky (2019) stated that cognitive-behavioral therapy is often used with prolonged exposure (PE). This therapy gradually teaches an individual to approach trauma-related memories by facing what has been avoided, therefore learning that the memories are not dangerous.

Treatments of PTSD, as reported by Ruglass et al. (2019), are often based on trauma-focused psychotherapies, and pharmacotherapy which can be a useful

enhancement to the outcomes of treatment. Psychotherapies are typically the first line of treatment over medications except in cases where they have proven to be ineffective, or the client is not interested or when there are comorbid disorders.

Pharmacotherapy, as reported by Tartakovsky (2019), is used to treat symptoms of PTSD; however, during daily medication side effects can be problematic. Whereas trauma-focused psychotherapies are more likely to achieve PTSD remission over medications. There exists a high rate of dropout with medications, as many clients find them ineffective. When administrating medications to relieve PTSD symptoms, there is a need to evaluate the specific symptoms. There exist several types of antidepressant medications, as reported by Tartakovsky (2019), most commonly are the SSRIs (selective serotonin reuptake inhibitors) and SNRIs (serotonin-norepinephrine reuptake inhibitors). There are four common ones often prescribed for PTSD are Sertraline (Zoloft), Paroxetine (Paxil), Fluoxetine (Prozac), and Venlafaxine (Effexor; APA, 2020a). There are concerns about side effects associated with medications, some of which include sexual dysfunction, fatigue, drowsiness, nausea, diarrhea, and excessive sweating (Tartakovsky, 2019).

According to Ot' alora et al. (2018) an approach to psychotherapy in assisting people who have PTSD is the inclusion of administrating 3,4-Methylenedioxymethamphetamine (MDMA). In two randomized trials, it promised efficacy and safety, and showed to reduce the fear response effectively and an optimal state complementing that works through traumatic memories (Mithoefer et al., 2016; Yazar-Klosinski and Mithoefer, 2017). Additionally, the FDA granted the treatment of

PTSD with a designation for MDMA-assisted psychotherapy called "Breakthrough Therapy." As a result of both short-term and long-term trials, positive results occurred, showing that the treatment is well-tolerated and safe.

Eye Movement Desensitization Reprocessing Treatment

According to Riddle (2020) the use of EMDR can allow individuals to safely reprocess traumatic information lessening psychological symptoms. Individuals who have PTSD experience memory-related symptoms such as involuntary, recurrent, and distressing intrusions. In addition to flashbacks of feelings of recurring events of the traumatic event (American Psychiatric Association, 2013b). As reported by EMDR Institute, Inc. (2020), eye movement desensitization and reprocessing (EMDR) therapy was first developed in 1987 by Francine Shapiro, an American psychologist. In 1987 Shapiro, while walking through a park, observed that by igniting the awareness while moving her eyes from side to side, reduced disturbances of negative memories and thoughts. Shapiro went on to examine the phenomenon systematically for the treatment of PTSD (Farrell, 2016) as an empirically validated intervention for trauma and use of a comprehensive eight-phase protocol (Proudlock & Peris, 2020). EMDR therapy is a trans-diagnostic, integrative psychotherapy treatment for resolving symptoms of traumatic and adverse life experiences (EMDR, 2020).

Landin-Romero et al. (2018) reported that the underlying action of EMDR focuses on eye movement while the individual retrieves the autobiographical and emotional memories and rates them on an emotionality and vividness scale. Landin-Ramero et al. (2018) speculated that horizontal eye movements of EMDR might be

similar to when rapid eye movement REM that occurs during sleep. They both have shown promoting reorganization of memories of traumatic events with subsequent emotional processing. Simultaneously, as reported by Landin-Ramero et al. (2018), there is another speculation that communication between hemispheres increases during horizontal eye movements. The effects of EMDR have also found with vertical eye movements, can contradict the interhemispheric hypothesis of the therapeutic value of the horizontal eye movement.

Recently, de Voogd et al. (2018) reported that eye movements might reduce amygdala activity, where the observed reduction emotionality could be biological. According to the EMDR Institute (2020), despite EMDR's popularity, it has received some controversy. Some critics have referred to EMDR as pseudoscience, and even though some individuals have experienced symptom reduction, the actual drawbacks as a result of the eye movements have received a limited number of known studies.

According to Houben et al. (2018), while performing EMDR eye movements, the focus is on the salient aspects of traumatic memory, requiring the working memory capacity. This dual task interferes with memory recall capacity, resulting in a decline in the memory's emotionality and vividness. The essential ingredient of EMDR, as reported by Shapiro and Laliothis (2015), is eye movements, alternative dual tasks. These tasks included tapping and bilateral tones. To reduce the vividness and emotionality of trauma, a comparison of these alternative dual tasks is as useful as eye movements. In contributing to the therapeutic effects of EMDR, it has presented doubts on the typical role of eye movements.

Houben et al. (2018) reported that therapists engage in a comprehensive conversation before and after an EMDR session. This conversation allows the opportunity to ask follow-up questions allowing for a clarifying aspect during the session (de Jongh & ten Broeke, 2016). There are times where a therapist does not have adequate knowledge about the issues that were related to memory functioning of the trauma. In this situation, a therapeutic conversation can have the potential of having misinformation, unintentionally. Hence, there remains a question about whether eye movements can have a susceptibility to the enhanced misinformation.

The process of EMDR therapy, as reported by Gotter (2019), involves eight phases, which include as follows: Phase 1: Client history and treatment planning that involves an evaluation of the client, and their ability to tolerate exposure to distressing memories. Then a formulation of a treatment plan is done based on behaviors and the symptoms that need to be modified. Phase 2: Preparation, where the therapist lays out the treatment by educating the client on EMDR and establishing a therapeutic relationship. At this phase, the therapist teaches the client's self-control techniques for coping with the memories and distress that may arise. Phase 3: Assessment in the phase, the therapist identifies the memories from the trauma. The client then chooses an image that will represent each memory, noting the psychical sensations, and negative beliefs that accompany the memories. Then positive thoughts are developed to replace the negative thoughts. Phase 4: Desensitization involves reducing severe reactions and psychical sensations they have from the traumatic memory. The physical sensations can include sweating, stomach problems, and rapid heart rate. While focusing on the traumatic, even

the therapist facilitates desensitization through eye movements. Phase 5: Installation focus is on installing thoughts that are positive that were identified in phase 3. Phase 6: Body scan meditation where the individual scans their body to identify any physical sensations. Phase 7: Closure where the therapist stabilizes the client with techniques of self-control discussed in phase 2. Explanations to the client on what they can expect to occur while asking them to keep a record of any negative experiences for use in further sessions. The last phase 8: Reevaluation, reviews the effectiveness of the treatment and what future treatment needs to target (Gotter (2019).

The EMDR looks at the human memory as reported by Houben et al. (2018) and not as a reproduction that is literal of the past instead as a process that is reconstructive or constructive and prone to distortions or errors. Limited research has occurred as to whether eye movements can enhance misinformation. The paradigm of misinformation shows how individuals who first witness an event and then receive additional information that may be suggestive about the event.

Houben et al. (2018) reported that exposure to misinformation could cause an individual to include the information as part of their memory. Individuals who have experienced PTSD as a result of IPV, are most susceptible to misinformation memory of the event due to a high risk of becoming vague. The study's focus is on the effectiveness perceived by individuals who have been victims of IPV and who have a diagnosis of PTSD.

Summary

The literature review in this chapter has identified critical issues that clarify how IPV can cause PTSD while summarizing some of the current literature regarding IPV. The literature identified different treatment modalities for PTSD, focusing on the EMDR treatment and how it correlates with the research question of patient-perceived effectiveness for PTSD survivors of IPV.

The topics in this chapter included IPV, psychopathy, and IPV, trauma, federal and state laws governing IPV, PTSD, PTSD research, PTSD assessment /diagnosis tools, treatment for PSTD, and EMDR treatment.

The introduction to this chapter described the purpose of the study and the literature review strategy. The elements mentioned contributed to the research gap regarding the psychological distress of individuals with PTSD from IPV and the perceived effectiveness of the intervention of EMDR.

In Chapter 3, the study's research design and methodology presented. Also, the psychometrics and data collection method involved. This design will help further to understand the impact of PTSD from IPV and viewed the success of treatment. The psychological distress method, rationale, researcher's role, questions, study context, sampling, sampling criteria, data collection, data procedures, participation, recruitment strategy, and trustworthiness issues. Finally, the literature on the effects of IPV, the patient-perceived effectiveness of EMDR treatment for PTSD, and the impact on society.

Chapter 3: Research Method

Introduction

In this qualitative descriptive study, I examined the patient-perceived effectiveness of EMDR in treating PTSD for IPV survivors. The study was an important step in investigating the effectiveness of the treatment modality of EMDR for IPV female survivors. The findings may be useful for clinicians by providing relevant data when choosing successful long-term interventions. This chapter contains a description of the methodology and includes a justification of the research method and design chosen for this study. In addition, sections include discussions on participants, the sampling procedure, the instruments used in the study, the research procedure, the data analysis process, and the trustworthiness, transferability, dependability, and conformability of the study. The chapter concludes with a discussion of the ethical procedures and a summary.

Research Design and Rationale

The research design for this study was a qualitative, transcendental phenomenological approach, as it aligned with the research question regarding the patient-perceived effectiveness of EMDR treatment for PTSD of IPV survivors. Data consisted of semi structured interviews conducted with victims/survivors of IPV using a phenomenological approach. Data sources were survivors of IPV who have received EMDR treatment to address symptoms of PTSD. All data consisted of the survivors' perception of the effectiveness of treatment.

Qualitative researchers seek to understand a phenomenon from the perspective of individuals who have a collective experience (Wilson, 2015). I found no literature that

examined the perceived success of EMDR treatment for IPV victims with PTSD. Therefore, the qualitative methodology was appropriate for achieving the stated purpose of this research.

Neubauer, Witkop, and Varpio (2019) reported that phenomenological research begins from a perspective free from preconceptions or hypotheses and mainly describes rather than explains a phenomenon. The phenomenological methods are useful in bringing forth the perceptions and experiences of each individual.

There are different kinds of phenomenology that investigate the *how* and *what* of human experience (Neubauer et al., 2019). The phenomenological approach evolved from different schools of philosophy. Husserl was credited by many historians for defining phenomenology in the early 20th century (Neubauer et al., 2019).

This phenomenological study was focused on the effectiveness of an EMDR intervention for women with PTSD resulting from repeat intimate partner domestic violence. The qualitative approach was appropriate because of its emphasis on the exploration of personal life experiences, unlike the quantitative method, which involves the statistically measurable relationships between variables, often in terms of frequency and quantity (McCusker & Gunaydin, 2015).

Role of the Researcher

The researcher's role in a qualitative narrative study is to collect and analyze the participants' responses to the open-ended interview questions. I had no personal or professional relationships with any participants; they were only researcher/participant

relationships. I managed bias by asking nonleading questions, refraining from asking closed-ended questions during the interview process.

In qualitative research, the role of the researcher is to access the thoughts and feelings of the participants of the study. It may include asking individuals to talk about personal matters. The process may require exploring areas of the participant's life that could bring up painful past experiences (Yip, Han, & Sng, 2016). In collecting the data, it is the researcher's primary responsibility to safeguard each participant.

Researchers must follow the ethical code of “do no harm.” A critical component of ethical research is an informed consent form whereby a participant voluntarily confirms that they are willing to participate in a study and understand their risks, rights, and responsibilities. All participants were aware of all aspects of the study and that could be relevant to their participation. According to Yip et al. (2016) researchers have a duty to protect all study participants’ dignity, life, health, right to self-determination, and privacy.

The researcher must obtain authorization to conduct the study from the Institutional Review Board (IRB) while securing a study site and obtaining approval from the participants to conduct the study. To conduct qualitative research that demonstrates reliability, validity, and credibility, researchers should maintain the confidence that they are capable of fulfilling the research role, duties, and responsibilities.

As a researcher, it is essential to be aware of refraining from any biases even though a person cannot completely disconnect their own beliefs about the research study (Roulston & Shelton, 2015). However, research bias can be minimized by maintaining

awareness of preconceived thoughts, beliefs, and ideas about the topic (Fusch & Ness, 2015).

Managing Researcher Bias

According to Sarniak (2015), researcher bias can be managed and minimized if caution is maintained when conducting a study. One potential type of bias is confirmation bias, which occurs when a researcher forms a hypothesis and uses the participant's responses to confirm a predetermined belief. To minimize this possibility, a researcher needs evaluate the responses of a participant while challenging any preexisting ideas. Cultural bias (Sarniak, 2015) is a spectrum of ethnocentricity in which a researcher may ascribe motivations, assumptions, and influences on subjects. To minimize this, a researcher should attempt to practice cultural relativism. A question-order bias involves a single question that influences answers to other questions. A participant can be primed by ideas or words that impact their attitudes, thoughts, and feelings (Sarniak, 2015). To minimize this bias, a researcher needs to ask questions that are general before asking about specifics. Another bias results from using leading questions that falsely impute a participant's true thoughts. This often occurs due to a researcher attempting to confirm a hypothesis, while overestimating their understanding of the participant.

Methodology

Participant Selection

The population for this study comprised individuals who had been victims of IPV. Participants in the study were female, 18 years or older, and residing in the Southwestern United States. Participants had been out of an abusive relationship for no less than 12

months, had a PTSD diagnoses, and had used EMDR therapy to treat their symptomology. A sample size of seven yielded relevant results and attainment of saturation.

The diagnosis of PTSD was assessed using the DSM-5 criteria. A potential participant was considered if they met or exceed the behavioral or symptomatic criteria of PTSD. Individuals not meeting the PTSD criteria were not included as they may have been diagnosed under a new category in the DSM-5, trauma- and stressor-related disorders specific to adults, adolescents, and children older than 6 years (American Psychiatric Association, 2013a).

I used purposeful sampling techniques as described by Palinkas et al. (2015) in this qualitative research. The selection of information-rich cases from limited resources involved identifying individuals who were knowledgeable about and had personal experience with the phenomenon. It was appropriate to use the purposeful sampling method as the study's main focus was the lived experience of survivors of IPV with PTSD and their perspectives on EMDR.

According to Gentles et al. (2015), a phenomenological qualitative study should range from seven to 10 participants. All participants were contacted for research purposes through direct e-mail service provided by the Share Committee from the Arizona Coalition to End Sexual and Domestic Violence, which agreed to send the invitation to participate to IPV survivors who met the criteria. The e-mail contained full disclosure of the study including specific details as provided by me as the researcher. Individuals who met the criteria of the study were given instructions to contact me directly. Participants

who met the criteria for the study were members of the Share Committee of the coalition as survivors of IPV. I screened the potential participants were screened, asking whether they had a PTSD diagnosis and had experience using EMDR therapy. Given the limited number of participants potentially meeting the criteria and the rigorous data analysis that qualitative research involves, the study was limited to seven participants. According to Gentles et al. (2015), data from six or more participants are sufficient for qualitative saturated interview research.

Instrumentation

Collecting data in a phenomenological study is frequently done by using an interview method. The most common format for the collection of the data necessary to conduct the study will be semi-structured interviews. A copy of the protocol for the interviews is found in Appendix B.

A guide served as a foundation for obtaining reliable descriptions for the study's phenomenon. Assisting in the data collection, a digital audiotape was used to assure quality while interviewing (De Felice & Janesick, 2015).

According to Reeves et al. (2015), a study that applies qualitative interviews can provide a voice to individuals in society that may not be heard otherwise. When striving to understand an interviewee's perspective of the phenomenon, it is preferable to use qualitative research interviews. Unlike generating generalizable understandings from a larger group of participants (McGrath, Palmgren & Liljedahl, 2019). The interview questions for the study were posited by Heinonen (2015), who states that questions should be grounded in research literature addressing the phenomenon's unknowns.

Therefore, the research questions were developed as the result of reviewing literature aligning with the research question.

The implementation of the interview protocol refinement (IPR) framework was used to develop the questions. The framework provides four-phases as reported by Castillo-Montoya (2016) in developing interview questions: The Four-Phase Process to IPR, Phase 1: Ensuring interview questions align with research questions, Phase 2: Constructing an inquiry-based conversation, Phase 3: Feedback on interview protocols, and Phase 4: Conducting the interview protocol.

By refining through the IPR framework, a qualitative researcher can strengthen the interview protocols' reliability and quality (Castillo-Montoya, 2016). Reassuring that the interviews are anchored in the study's purpose. Having alignment in the research process can increase the interview questions while at the same time, ensuring their necessity. Interviews' purpose is to gain further relative information for the study. To have both inquiry and conversational goals, the IPR includes four types of questions: (1) introductory questions, (2) transition questions, (3) key questions, and (4) closing questions.

There were three instruments utilized during the interview process, including a general questionnaire (Appendix A) and an interview guide (Appendix B) to assist in both the interview process, and the interview questions. Feedback from the researcher's committee was conducted covering content readability and clarity of the interviews. Feedback from the committee will help refine and structure the content, ensuring that the questions represent the research's concepts.

Descriptive field or reflective notes were utilized to reflect the account of what will be learned during the interviews. According to Deggs and Hernandez (2018), the notes contain speculations, ideas, feelings, and problems in order to provide clarity during the data collection process. The reflective notes enable a researcher to provide insight into the interpretation of the data, which may not be captured through the audio-recordings alone.

The use of field notes allows for the researcher's comment on any nonverbal cues, impressions, environmental contexts, and behaviors that could be captured through audio-recording. The interpretation of the audio-recording as reported by Sutton and Austin (2015) in the field notes that notes provide essential context that can assist the researcher during data analysis of situational factors.

Participation

Potential participants were first given a prescreening questionnaire to ensure that each one met the criteria for participating in the study (Appendix A). The prescreening process was covered in the event saturation was not reached. Each participant was given the option to withdraw at any time at the start of the interview process. Participants went through a debriefing after the interviewing.

Data Collection

The data collection method were one-to-one interview questions collected by the researcher. The collection took place at a convenient, safe location determined by the researcher and the participant. The participant had the opinion to complete the interview

questions via the telephone or internet platform. An interviewing format of semi-structured, in-depth interviews was extensively utilized.

The questions guided the researcher through the interview process. The interviews enabled the ability to incorporate guided conversation and the flexibility to probe for additional details. The interview protocol allowed the researcher to focus on gathering all the information needed to answer the research questions (Jamshed 2014).

As Jamshed (2014) reported, an interview guide is used to focus on the desired comprehensively and systematically line of action. Additionally, to adequately capture the interview data effectively, audio recordings were done. Each interview session was approximately 60-90 minutes in length and conducted via the telephone.

According to Farooq (2015), qualitative interviews traditionally have been conducted based on face-to-face. Arguments among scholars, as reported by Farooq (2015) is that there is a need for building and maintaining a natural encounter of face-to-face. This encounter allows for building a stronger rapport by creating a friendly and relaxed environment, therefore, allowing one to speak openly and freely. The face-to-face interview process is thought to be essential in being able to gather rich, in-depth data. Additionally, face-to-face enables the ability to view body language, which can be crucial in ensuring that the messages are understood correctly (Farooq, 2015).

However, there are advantages of phone interviews, as reported by Marshall (2019), which can provide reduced costs, quicker turnaround time, the possibility of centralization, and assuring a greater administration standardization. Telephone interviews allow for interpersonal communication. Drabble, Trocki, Salcedo, Walker, and

Korcha (2016) reported that literature had documented the viable option of in-depth telephone interviews for qualitative research. Many methodological studies have pointed to the practical advantages and logistical conveniences like increased safety during the interview, access to enhanced interviewees geographically, and added flexibility for scheduling.

All participants were asked the same interview questions and probing questions to allow them to express themselves. The interview was comprised of open-ended questions in order to avoid receiving only yes or no answers. Follow-up questions were used to provide clarification of information initially obtained during the original interviews. At the end of each interview, all participants received acknowledgment of appreciation for participating in the study. Each participant was asked if they have any further questions about their involvement in the study while providing a debriefing.

The collection included notes, tape recordings, and written consent of each participant during the study. The participant's confidentiality and privacy were protected by giving an identification number to each before conducting any interviews. The informed consent was explained as to the participant's intended role, the right to receive the results, and how the results would be used and published. The informed consent disclosed the use of an audio recorder asking for the participant's permission before starting the interview. Participants were further allowed to voice any concerns about the research.

A secure file is maintained for all field notes, including observational, analytical, and theoretically used for the data analysis. All written data have been stored in a locked

cabinet, while all data stored on a computer will be password protected. To maintain protected data, a backup copy was developed on a separate flash drive and placed under the same security measures.

Procedures of Recruitment

The participants' recruitment procedures began by receiving the Walden University IRB approval. After obtaining approval to conduct research, the organization was contacted that serve survivors of IPV who provided a listserv of potential participants in the study. The study's topic and the purpose of the research, along with the criteria for participation, were incorporated. The location for conducting the interviews were identified as by the telephone. Contact information for the researcher and the benefits of anticipating was provided to each participant. The potential participants were instructed to contact the researcher via email or phone if they feel they are interested in participating and have met the criteria. All participants were instructed to follow the researcher's protocol and instructions and provided with a debriefing after the interview process.

Data Analysis Plan

A qualitative research data analysis involves coding, categorizing, and interpreting as it relates to a phenomenon. All audio recordings, as defined by Sutton and Austin (2015), interviews were transcribed verbatim. Once the transcription was complete, the researcher listened to all the recordings while reading the transcripts. This process allowed for any corrections of any errors, taking measures to anonymize the transcript to keep each participant's identity protected.

All of the research interviews transcribed, and compiled field notes were reviewed for meaning, themes, and descriptions of experiences. Due to the small number of projected participants, a manual analysis of the data was conducted. Careful attention was be given to any gap in time between the interview, transcribing, and coding that could present a risk of memory bias as it pertains to the environment or nonverbal context. This gap could have potentially affected the interpretation of the data.

The coding enabled the researcher to understand the perspective of each participant. Due to the small number of participants, coding was completed first by hand using a hard copy of each transcript.

Issues of Trustworthiness

Sutton and Austin (2015) reported that there are questions that arise in qualitative research relating to the reliability of the participants' representation and the researcher's interpretation. Unlike quantitative research in qualitative research, according to Sutton and Austin (2015), there is no statistical tests used for checking reliability and validity.

Trustworthiness is a way to establish confidence in the findings. There are four criteria for trustworthiness: transferability, credibility, dependability, and confirmability, where the study's findings are defined by the interviewees and not the researcher's bias, interest, or motivation.

Transferability

Transferability comes after a study can be generalized or useful in a different setting (Morse, 2015). To establish transferability, a researcher needs to provide evidence that the research findings could apply to other situations, contexts, situations, and

populations. To enhance transferability, the use of an audit trail provides a record that describes the research process from start to finish (Leung, 2015).

Transferability provides thick descriptions to validate the overall truth of the findings. Identifying survivors who lived experiences of IPV and have used EMDR treatment modality enables readers to gain a clear understanding. This knowledge will allow the reader to compare the findings defined in the transcripts with other populations.

Dependability

The study will utilize an audit trail document records to establish dependability by describing the research process, and the step taken (Leung, 2015). Further enhancing and assuring that all data was accurately recorded and stored. The data will be inclusive of the interviews, audiotapes, records, and reflexive documentation gathered, informed consent, and related research (Leung, 2015).

Confirmability

Confirmability refers to the degree where the results are corroborated or confirmed by others. A strategy to enhance confirmability is where the researcher documents throughout the study by checking and rechecking the data. Confirmability can exist where the researcher searches for any discrepancies while observing any instances that are negative and contradictive. After the data collection the researcher will analyze and make decisions regarding any potential distortion or bias (Trochin, 2020).

Ethical Procedure

Ethical standards establish the reduction of any potential harm to participants within the research process. Researchers need to acknowledge these ethical standards

when conducting a research study (Patton, 2015). One core requirement of ethical standards is to maintain the confidentiality and privacy of all participants. Therefore, a researcher needs to refrain from obtaining any private or personal information that is not related to the research question. There was no known risk of doing harm to any of the participants in the research, interviews, or any follow-up conducted.

All of Walden's IRB policies, procedures, and rules were adhered to as it related to the qualitative transcendental phenomenology study. The IRB application included all required documentation. Upon the approval from Walden's IRB, the recruitment of participants commenced. Before partaking in the research, participants were allowed to ask questions about the study. Each participant was aware that they will have the option to remain anonymous and that their participation will be strictly voluntary. It was disclosed to the participants that they will have the right to withdraw at any time throughout the research study.

All participants were informed that only the approved research committee and the researcher have access to their data. Throughout the study, participants had the option to stop the interview and leave the study if any anytime they are triggered and feel anxious, stress, or experience any feeling of traumatization. The typed semi-structured interview questions will remain on a USB flash drive in a secure lockbox until they are destroyed after transcribing and analyzing. Each instrument was coded, encrypted, and labeled confidential before being securely locked. According to the research protection rule criterion, all research documentation will be destroyed after no more than five years of

being in locked storage. All password-protected electronic records were secured on a USB flash drive labeled confidential and placed in locked storage.

Following the conclusion of the research study, it will be available to all participants. All issues of privacy will be addressed in the original consent form.

Summary

Chapter 3 chapter summarized and outlined the research methodology for the research study that began with the purpose of qualitative research. Details of Edmund Husserl's transcendental phenomenological research design was incorporated, as reported by Warren and Wakefield (2016). This design allowed the researcher to explore the phenomenon to gain an understanding of the participants.

The chapter's content covered the research design, the rationale, the researcher's role, manager's research bias, methodology, procedures for recruitment, data collection, and analysis, issues of trustworthiness (credibility, transferability, dependability, confirmability) and ethical procedures for the research.

Chapter 4 encompassed the data analysis results from semi-structured interviews. The chapter contains the results in a written summary. Chapter 5 describes the interpretation of the findings, the limitations, recommendations for future research, implications for social change, and a conclusion to the study. The purpose of this qualitative descriptive study was to examine the patient-perceived effectiveness of EMDR in treating PTSD for IPV survivors. The gap exists in identifying the success of alternative coping strategies and treatment needed for abused victims/women who have

PTSD and whose fear, depression, cognitive problems, and lack of social support make it difficult for them to heal.

In this chapter, the discussion incorporates the research design and instrumentation, rationale, methodology, data collection, data analysis, recruitment procedures, ethical systems, issues of trustworthiness followed in this study.

Chapter 4

Introduction

Walden University IRB granted research approval on September 24, 2020, to conduct the study for exploring survivors of IPV and effectiveness of EMDR interventions (approval number 09-24-20-0461698). To explore the participants' lived experiences for this qualitative study, I used the transcendental phenomenological approach. The purpose was to identify and report survivors' lived experiences of IPV and their perspectives on the effectiveness of EMDR therapy intervention. The research question guiding this study was:

RQ: What is the patient-perceived effectiveness of EMDR treatment for PTSD of IPV survivors?

In Chapter 4 I report this study's findings resulting from the exploration of a sample size of seven survivors of IPV.

Chapter 4 begins with an explanation of the methodology for recruiting screening participants, sample selection and size, interview procedures, data collection, and the basis for data analysis.

The participants' stories provided clear, lived accounts of the women's experiences of using EMDR to cope with their PTSD symptoms from IPV. A realistic platform was provided to each participant in this phenomenological study to voice their lived experiences and perspectives in their own words.

Setting

The research study was conducted in Arizona. Participants were offered the option to be interviewed either by internet platform or by phone to accommodate their schedules. No interviews were conducted face-to-face due to the COVID-19 pandemic. The participants' confidential interviews were conducted by phone between September 26, 2020, and October 26, 2020.

A folder was maintained for each participant with individual labels with different pseudonyms (1-Smiley Face, 2-Cross, 3-Diamond, 4-Triangle, 5-Heart, 6-Circle, 7-Sun) to ensure confidentiality. All participants were prescreened to determine that they met the criteria for the study. Upon completing the screening, all participants were allowed to select their interview time and the date and were scheduled immediately after that. It was determined that no personal or organizational restraints were present that would influence any of the participants. There were no conditions nor disturbances that potentially restricted the data collection or results of the study.

Demographics

All participants were recruited using a purposeful selection for the qualitative research from the Southwestern United States, Arizona. Seven women survivors of IPV participated in this study. Each was at least 18 years old. Each participant had been out of an IPV relationship for no less than 12 months. All participants presented with appropriate characteristics and demographics relevant to the study.

All seven participants identified as survivors of IPV diagnosed with PTSD and who had experienced EMDR therapy. All were free of an abusive relationship. Table 1 provides the four prescreening questions and answers.

Data Collection

The data collection's began with making participants feel comfortable by thanking them for choosing to participate. All seven participants were informed that they could withdraw at any time during the interview if they felt uncomfortable. They were further told that their involvement could provide a clearer understanding of EMDR therapy treatment's effectiveness for other women and clinicians.

The data collection was completed by phone conversation due to the current pandemic. The period of the data collection was approximately 60-90 minutes. Prior acknowledgment and approvals were obtained by all participants to record all data. There were no variations of the data collection previously noted in Chapter 3. During the collection of data, no circumstance was considered unusual. A total of seven female IPV survivors were interviewed for this study. After completing interviews with seven participants, it was apparent that no new data was being obtained, which indicated that no new themes would be available. Additionally, the received data answered the research question for the study, and therefore, data saturation was reached. As reported by Saunders et al. (2018), data saturation is not accomplished by the number of participants but rather by the richness and depth of the obtained data.

Each of the seven study participants was asked the same five interview questions (Appendix A). All interviews were conducted via telephone using a private phone for

each participant. I recorded all interviews using an audio digital voice recording device, which ensured the integrity of each participant’s responses. The data collection process did not deviate from the data collection method described in Chapter 3.

A variety of open-ended interview questions were used that elicited the full context and content of each participant's lived experiences (see Bevan, 2014). During the process, all participants' anonymity was maintained. Interviews lasted from 60 minutes to 90 minutes. All digital audio recordings are held in a secured computer file. All seven interviews were transcribed verbatim using Microsoft Word. During the interviews, I took a minimal amount of field notes to ensure all information was obtained. Following each interview, I composed additional notes to capture the participant's initial impressions and reflections on the interview encounter. Recruitment efforts were undertaken through the use of invitations sent to the Arizona Coalition to End Sexual and Domestic Violence S.H.A.R.E. Committee's e-mail list serve. Participants who were interested in participating as a result of the e-mail were directed to contact me via my Walden University e-mail address. A screening e-mail was sent to all interested potential participants to make sure they met the established criteria for the study. For all individuals who agreed to participate, I scheduled an appointment for the interview to take place via telephone at a time agreed upon by study participants. Each participant was sent an informed consent form before the scheduled interview. Implied consent was noted by participant-initiating contact with me as the researcher. The contents of the informed consent form were repeated and acknowledged verbally at the beginning of the recorded

interview. All instances were documented and recorded prior to the start of each interview.

I conducted the data collection using the interview protocol (Appendix B) that included five open-ended questions based on this study's research question. None of the scheduled participants had any emotional distress or withdrew from the study due to revisiting any stressful situation. The same procedures were followed for each interview; all interviews were conducted according to the guided interview questions, with no significant deviations from the interview topic and no significant interruptions.

The participants all agreed to be audio recorded and were interviewed using a digital voice recorder. Immediately following the interview conclusion, the recording was uploaded to a password-protected computer for transcription. Once completed, a comparison was done for accuracy between the original audio files and the transcripts. The transcripts were saved to a USB drive to ensure further safekeeping. All audiotapes, USB drives, and related documents were securely locked in a file cabinet. I am the only one having access.

Table 1

Prescreening Questions

Participant Pseudonym	P1-Smiley	P2- Cross	P3-Diamond	P4-Triangle	P-5 Heart	P-6 Circle	P-7 Sun
Older than 18	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sex	F	F	F	F	F	F	F
Years out of IPV	8	6	7	10	2	2	6
Diagnosed with PTSD	Yes	Yes	Yes	Yes	Yes	Yes	Yes
EMDR therapy	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note. F- Female, PTSD – Post Traumatic Stress Disorder, EMDR- Eye Movement Desensitization and Reprocessing, IPV- Intimate Partner Violent

Data Analysis

Focusing on the participants' lived experiences, I commenced the data analysis using thematic analysis, looking at how they make sense of those experiences (Pietkiewicz & Smith, 2014). Within the use of thematic analysis, there is flexibility and variability. The process included coding, categorizing, and interpreting data. In evaluating a standard method for qualitative data analysis, I looked at using software like NVivo; however, I elected to use transcribing by hand due to the small number of participants.

The data analysis began with developing rich descriptions, open coding, and then data reduction. The descriptions were written, including a structure of the phenomenon by utilizing both textural and structural means. The digital analysis transcription was obtained after listening to the recording multiple times, therefore capturing each word verbatim. When necessary to further validate responses, I contacted each participant.

Coding was done for all critical statements that aligned to the research problem. The data were coded as described by Vaughn and Turner (2016). I arranged the data collected from each interview. I organized and sorted the codes into categories that merged into themes consistent with 5-step data related to the overall research problem (Dillard, 2020).

The data was interpreted by developing a structural description and analyzed from each participant's lived experiences using their perspective of EMDR Therapy for the PTSD symptoms. The data analysis process addressed the research questions guiding this qualitative study. Each of the 7 participants' responses was obtained, analyzed, transcribed by hand, coded, and separated into themes with a provided sample transcript excerpt. The audiotaped interviews were played several times, and the written transcription was sorted whereas, developing into themes and subthemes emerging from the raw data. The themes aided in answering the studies research question, of what is the patient-perceived effectiveness of EMDR treatment for PTSD of IPV survivors? The themes and subthemes are included in Table B below.

At the end of the data analysis process, six common themes were developed. From these six main themes, 12 sub-themes emerged corresponding with the lived experiences. For example, in the theme of Learning EMDR, the subthemes emerged, identifying therapist, shelter, and groups.

Table 2

Themes and Subthemes

Themes	Subthemes	
Learning EMDR	Therapist	Shelters/Groups
Comparison	Intensive	Trained
Success	Triggers	Coping Skills
Recommendation	Secondary Therapy	Grounding
Other Therapies	CBT Therapy	DBT Therapy
Overall Experience	Resilience	Recovery

Theme 1: Learning EMDR

Question 1: What was your experience in learning about EMDR, and how was that process explained? All participants shared their lived experience in learning about EMDR and how that process was explained, which was the first interview question. Each definition of EMDR included words that categorized the sub-themes.

Most of the women described learning about EMDR from their therapist. For example, P-1 Smiley Face commented that EMDR Therapy was explained to her as processing through a method of tapping, causing bi-lateral stimulation. That broke down the trauma and allowed for processing the deep-seated effects during and after the sessions. She reported that her therapist stated that EMDR goes more in-depth than other therapies and is proven to be successful in treating PTSD.

Participant-2 Cross discussed that she could not talk about the trauma but that the groups brought her to where she is now. She stated she used EMDR Therapy every two weeks in the middle of August 2019, and as of today, has had three sessions total. She reported that her therapist explained that it resets the wiring and that she used it four times six years ago. She stated the method used was buzzers held in each hand as she gave thought to the trauma, she experienced.

Participant-3-Diamond went on to state that about a year ago her therapist got certified in EMDR and explained to her that it would help her process the traumatic memories and possibly lessen her triggers. She stated, "I cannot say I could grasp what it was all about until we started therapy in Oct. 2019. She went on to say that she had to stop in Dec 2019 due to her insurance. She commented that when she was able to start again, she had a new therapist that did not administer the therapy in the same way. She reported that she felt that it worked effectively initially and that using the bussers was more intense, requiring more down time afterwards. She went on to state, " I thought it work, but it brought up memories for things that we were not even working on. I think the way we are doing it now is more effective."

Whereas while living in a shelter P-4 Triangle reported that she came about EMDR by chance around 2010 at the age of about 50. She stated, "I was hiding out in a shelter, so to speak where facilitators and counselors were trained in EMDR Therapy." She voiced that in those days, the "Therapist moved their fingers back and forth as there was no high-tech equipment, no beeping lights, nothing like that." She explained that she

found the sessions very useful and even had "ha hah" moments and flashbacks. She stated, " It was the first time I was cognitive that I had even been psychically assaulted."

Another perspective from P-5 Heart who voiced that she initially got started with an organization that provided therapy for about four months within a shelter where they specialize in trauma-informed therapy. She stated that when she first left the relationship, she realized that she had multiple concussions and received treatment from the Barrows Neurological Center for traumatic brain injuries (TBI). She stated that she first was sent to a clinical psychologist who began using EMDR Therapy, but after one attempt, she felt she did not experience any benefits. She reported that later on, while she was in a shelter, another therapist gave a more detailed explanation of EMDR, and after a couple of sessions, she reported that she could then see the benefits. She stated, " It was a drastic difference."

Having trust in a therapist as P-6 Circle expressed is essential as learning about EMDR from her first therapist. She explained that the eye movements allowed you to remove the emotions of the experience of the memory. She stated, "I was very skeptical, but I trusted my therapist, so I said, let us give this a try because the trauma symptoms were debilitating." I had multiple dissociative experiences every day. When we started working with EMDR in the first session, we just reached back for any early memory of trauma, and it opened a time when I was three. It was shocking, then during the following sessions, it was more guided and addressed what the first traumas were from the abuser, and we just followed that rabbit hole for the next two sessions. Two years ago, after three sessions, I asked to stop EMDR because of the intensity, and I have not gone back.

Finally, P-7 Sun stated, "A therapist explained that EMDR would address the symptoms I felt that were related to the triggers." "That it helps to peel away the layers of the memories and helps ground and release the emotional and physical pain that is debilitating."

Theme 2: Success of Eye Movement Desensitization and Reprocessing

Question 2: How would you compare EMDR Therapy to others you have used? All participants described a comparison of EMDR therapy with other therapies that they had used in a free-flowing and unique way. The participants described that they all had used other therapies before using EMDR and felt that it was necessary due to the intensity of using EMDR.

The participants stated that they felt it was important that the therapist have formal training in administering EMDR and to know the importance of grounding oneself after treatment. For example, P-1 Smiley Face stated that EMDR is fast track, it allows for getting to a baseline to start treatment for the trauma, unlike other therapies. She reported that she had used DBT, and DV support groups before EMDR. Throughout a period of a couple of years, she used EMDR therapy with both the light bar and the buzzers for bi-lateral stimulation . She reported having used it the last time in 2017 for four or five sessions.

In describing the affects P-2 Cross reported that EMDR felt like a hypnotic state. She said that she had used CBT talk therapy but felt that EMDR was much more intense. P-3 Diamond commented that she felt the therapy at first was slow however she was taking a lot of medication at the same time. She further mentioned that she was

experiencing disassociation with what had happen. She mentioned that she initially talked with her therapist, then in a PTSD group. She reported she had a lot of injury and several surgeries, and her body was inflamed with severe pain. She reported she could not talk about the trauma but that the groups brought her to where she is now. She stated she used EMDR Therapy every two weeks in the middle of August 2019, and as of today, has had three sessions total.

One participant expressed how EMDR was not effective as P4-Triangle stated that one type of therapy is not adequate. She went on to say that she would not put EMDR on the top of her list because her second EMDR therapy was utterly ineffective. She reported that EMDR's focus is on repetitiveness, whether it is the lights or tapping, and to her, it felt just like a transaction. She said that she was grateful for the first one, where she discovered the more painful things, that she had repressed. Those things have to be healed before moving forward. However, "I do not think EMDR is the best thing for me; the light did not work at all; it could have partially been the therapist."

There were recurring statements from participants that involved the importance of doing other therapies before and after using EMDR as P-5 reported she had used DBT and support groups. In comparing these to EMDR, she stated that EMDR helps build a future template of allowing one to get to a safe place internally and learning effective grounding techniques to process the trauma. She further reported that she experienced different emotions and having the ability to heal beyond the traumatic brain injury she experienced from her IPV.

The intensity of EMDR was expressed by P-6 who reported that EMDR Therapy was the more intensive than other therapies she had used. She expressed it was a feeling she had never felt however, thought it was very effective. She further stated that after only three sessions she felt her goal had been met, stating that "I find that remarkable after 22 years of abuse."

Other comparisons as provided by P-7 Sun who reported that she had used CBT initially after leaving her abuser after 28 years. She stated that she felt that it was helpful in processing her thoughts, however, the trauma and triggers were still an issue. Further explaining that EMDR, even though it can be intense in dealing with the traumas, it helps break down the memories allowing for healing.

Theme 3: Recommendation

Question 3: Would you recommend EMDR to someone else like yourself and why? Findings from this interview question yielded women having a relatively positive response. One of the main areas reported by most participants was the recommended that an individual should find a therapist who has had formal training and is certified to administer EMDR. That it is important to be aware that there are different administering methods, such as a light bar, buzzers, tapping, and finger movements. Some report that these different methods make a difference, while others say it is the eye movement that is most effective with EMDR Therapy.

Most of the participants highly recommended EMDR with a caveat of doing other therapies before using EMDR for the first time as reported by P-1 Smiley Face who commented that she would recommend EMDR to others, and in fact, she has already told

several other women who have experienced trauma from IPV but that it is important to do other therapies beforehand.

Another comment as provided by P-2 who stated she would recommend EMDR; however, not as the first course of action. To do other therapies first that are not as invasive that can give a person a place to begin working through emotional feelings. P3-Diamond went on and stated that she would recommend EMDR, but only if they did some other therapy first. A person needs to learn to process their feelings, being able to know when to reach out to someone, while doing other things like talk therapy, and support groups. EMDR can cause a strong emotional experience. You need grounding after each session, even at home. She reported that she does some meditation before she goes home, otherwise, it can be overwhelming. She stated, “I found more benefit from EMDR because of the work that I did at the beginning.”

On the other hand, P-4 Triangle reported that she would not recommend EMDR as a sole method of treatment. She stated that she felt it was not the best choice for her but that it might be for others experiencing many flashbacks. Whereas P-5 Heart commented that she would "absolutely recommend EMDR." “However, it is important to learn how it is done before starting and to have an experienced trained therapist.”

Participant -6 Circle remarked that “she would recommend EMDR in a heartbeat” as it is very effective in relieving the symptomatology that typically occurs with IPV. Finally, P-7 stated she would highly recommend EMDR for survivors of IPV who have traumatic symptoms like PTSD. However, it helps to understand first how EMDR is administered and what to expect after the treatment. To further know that it is essential to

have the willingness to go deep and work towards relieving any symptoms. To end each session by processing the trauma through the use of grounding techniques is essential.

Theme 4: Use of Other Therapies

Question 4: In what ways has EMDR therapy has been helpful in managing/reducing your PTSD symptomology? There were mixed opinions among the participants regarding EMDR Therapy and managing their PTSD symptoms. However, most felt that they experienced relief from most of the symptoms even though some felt the triggers still exists, and the fight or flight sensation remained. On the other hand, most participants had positive remarks about EMDR, and PTSD symptomatology's and the overall effectiveness as presented by P-1 Smiley Face who reported that after a couple of sessions of EMDR, she had trouble getting out of bed, having to take long showers, however, the social anxiety had lessened, and she was able to return to work.

After four sessions P-2 Cross felt that EMDR assisted her with her anxiety, and the intensity of the memories and flashbacks. P-3 Diamond commented on feeling that EMDR brought down her anxiety level even though she still is experiencing triggers. She stated, however, that her triggers were reduced to a management level. She reported that it did bring up things like childhood issues and a pool of other things that did not pertain to the trauma that she was there to process.

On the other hand, another participant did not feel EMDR helped with her PTSD symptoms as presented by P-4 Triangle who expressed that she did not think when she did EMDR that she understood that she had PTSD. She expressed that she was not that far along in the education process to put it all together. She reported that she walked

away at first, thinking she did not feel good about EMDR. She stated, "I felt disturbed and uncomfortable like I was not sure I could digest it, and a part of me finally realized that the situation did happen and that I did not imagine it." She further stated that most survivors have questions because people are known to minimize their problems. She stated, "That is probably what happened when I first used EMDR Therapy." She went on to say, "After the first time, I processed while I was sleeping, and that is when I started to work on it and realized that I had deep scares and real problems." She went on to say that in the first month, she did four sessions. She reported that there had been years between the first EMDR sessions and the second time in 2008 when she felt that it did not help with any of her PTSD symptoms.

Other participants felt EMDR was helpful for their PTSD as with P-5 Heart who reported that because of EMDR, she was able to become fully functional, and she was able to handle her PTSD symptoms. P-6 went on to report that EMDR exposed memories that had been repressed, causing dissociation. Through this experience, along with the assistance of a good therapist, she was able to process the feelings, handling the panic attacks, and flashbacks and, through the use of EMDR, the PTSD symptoms lessened.

A final statement from P-7 Sun reported that she felt EMDR lessened the loss of self and numb feelings. She continued by saying that it helped create a safe place, a peaceful feeling after grounding and processing the emotions.

Theme 5: Overall Experience and Resilience

Question 5: How would describe your overall experience with EMDR?

Findings from this question yielded various suggestions from developing ways in

which the woman spoke with enthusiasm in sharing her experiences.

Most participants expressed that their overall experience with EMDR was positive and helped to resolve deep-seated trauma and the debilitating symptoms like PTSD. As for example P-1 Smiley Face who stated that her experience with EMDR was necessary in order to completely help in educating her about the actual trauma experienced and how to process the feeling.

Whereby, P-2 Cross stated, "The experience was pleasant enough, and that it slowed the progressive thoughts." "It felt like being in a meditative state and restorative while working through the anxiety, panic feelings, and taking off the hardest edge." P-3 Diamond stated that it had helped her to reprocess, to remember the thoughts and emotions. That it has helped in many ways, such as lessening the triggers and feelings of anxiety. She stated that EMDR had been one of the most critical parts of this journey. She went on to say that a person should not jump into using EMDR that they need to take initial time for preparation, to understand the trauma.

Another perspective from P-4 Triangle reported that from her experience with EMDR, she would rate it fair to good, so a 3 or 4 out of a scale of 1 to 5. If someone was working with a professionally trained person; she might rate it higher. She said, "Just because it did not work for her does not mean it will not work for someone else. She again stated that she felt that a person needs more than one treatment type, inclusive of group therapy.

Whereas P-5 Heart stated that she felt her overall experience with EMDR was very positive. It allowed her to process her PSTD symptoms more than other types of

therapy she had used. She went on to say that not all therapists are trained to administer EMDR in the same way; therefore, it is important to understand the process and the effects before using. As with most of the participants P-6 Circle reported that a person needs to have an established relationship with their therapist and an established support group before doing EMDR for the first time. She further stated that "This is because a person can experience multiple traumas that surface when using EMDR Therapy."

Finally, P-7 Sun reported that her experience with EMDR was one that allowed her to relearn and understand what happened by opening up more memories while learning how to process them.

Evidence of Trustworthiness

Transferability

According to Morse (2015), the issue of transferability reflects the ability to generalize the findings outside the studies setting. The transferability of the results was strengthened by providing a detailed description of the responses given by each participant. Doing this provided adequate facts of the participants' reactions to other researchers regarding the study's scope and purpose.

Dependability

The reliability and consistency refer to the dependability of the research (Noble & Smith, 2015). To increase the study's dependability, each participant received an audit trail of the raw data for authenticity. Detailed field notes were taken during each interview. After listening to the audio recording several times, all critical points were noted to capture all vital moments while cross validating each participant's responsibility

to ensure transcription accuracy. All data were recorded and stored. The data is inclusive of the interviews, audiotapes, records, and reflexive documentation gathered, informed consent, and related research

Confirmability

Confirmability is the level of confidence that the findings of the study are based on where the participant's words and narratives were used rather than the researcher's biases (Forero, 2018). A strategy to enhance confirmability was done by documenting throughout the study by checking and rechecking the data. Confirmability existed when the researcher searched for any discrepancies before doing an observation of any instances that are negative and contradictive. After the data collection, I analyzed and made decisions regarding any potential distortion or bias (Trochin, 2020). An audit trail was made of details of the process of data collection, analysis, and interpretation of the data. Note-taking was done of the unique and interesting topics during the data collection, and thoughts about coding, bracketing out any personal biases to decrease any flawed analysis that could have pertained to defining participants ' lived experiences into themes.

Results

In this section, I presented the findings from 7 participants using direct statements from their interview responses and field notes. Each participant was not in an intimate partner violent relationship at the time of the interview. Each woman voluntarily participated in the interview process and felt no significant discomfort during the interview session. Each woman spoke with enthusiasm, self-love, a sense of peace that created her awakening. Some of my field notes included how the women displayed

moments of emotions with sighs, raised voices, and deep pauses during the interview. All of the women were open when describing the event that led them to decide to use intervention. The women were not asked, nor did they intentionally speak in detail about the actual violence they endured. However, many of the women said in general about the type of violence they suffered from their intimate partners.

Many of the participants wanted information on how they can obtain the results of the research findings. Each participant was provided with the Facebook page link set up for posting the study results. As a result, five themes were identified and outlined in Table 2. A couple of the participants reported that they were currently going through more healing process. Furthermore, continued therapy due to the lifelong process of recovery.

Each participant was given resources for mental health and counseling for IPV before their interview. Participants' lived experiences from the emotional, physical, and psychological trauma of IPV had many facets to how their peace and harmony were attacked, disturbed, and threatened. This study revealed the effectiveness of the use of EMDR Therapy to assist in either alleviating or eradicating the symptomology of PTSD according to the survivor's perception and experiences. Two of the participants indicated that they are still in counseling and periodically use EMDR Therapy even years later.

The overall results indicated that all participants felt it was necessary to have a therapist that is trained and certified in EMDR Therapy. Second common denominator was to understand EMDR Therapy before experiencing the treatment, while equally important was to use other therapies before using EMDR due to the intensity of the

treatment. Finally, another key component is the need for grounding work to be done immediately following each therapy session.

Summary

In summary, the findings addressed the research question. The research study purpose was to learn patient-perceived effectiveness of EMDR treatment for PTSD of IPV survivors. The findings illuminated attention on women who shared lived experiences and their perspectives of EMDR. During the interviews, some participants used terms like trauma, flashbacks, traumatic brain injury, and grounding. Overall, each participant described how seeking help provided a sense of worth and coping skills for the trauma they had experienced from IPV.

Further aligning with the Center for Substance Abuse Treatment (US (2014) who reported on the aftermath felt by survivors of traumatic experiences and the use of EMDR Therapy. In Chapter 5, the interpretations of the findings related to the theoretical framework and literature outlined in Chapter 2 are defined. The chapter presented the study's limitations, recommendations for future research, implications for social change, and conclusion.

Chapter 5

Discussion, Conclusions, and Recommend Introduction

The purpose of this phenomenological study was to identify the perspectives of IPV survivors who have lived experiences of using EMDR therapy for PTSD symptomology. All participants were women who had experienced IPV resulting in a diagnosis of PTSD from their abuse. With the use of the transcendental phenomenological approach developed by Husserl (1970), I obtained detailed descriptions of the symptomology of PTSD and the results of EMDR therapy. In recruiting the participants, I used a purposive sampling method for selecting seven women who had the lived experiences of using EMDR and their perceived effectiveness from the treatment. The scheduling for interviews from the women deemed eligible took place within days of the initial contact. The interviews were conducted after obtaining informed consent and following the protocol set up for using semi structured questions. The approximate time for each interview was 60-90 minutes long.

Each participant received a follow-up appreciation e-mail upon completing each interview with an implied future follow-up if deemed necessary to validate responses. The opportunity to stop any time and withdraw from the interview without judgment was given to each participant. All participants completed all five questions. If saturation was not reached, the use of snowball sampling was considered, as described by Kirchherr and Charles (2018). One interviewee provided me at least one or possibly more potential interviewees she felt might meet the criteria.

With the aid of an audio recorder, I captured verbatim the participants' words, which I transcribed and clustered into themes. Each participant's answers to the interview questions were given equal importance. I gathered field notes to aid throughout the processing of the phenomenon. During the interview process, I was able to report the perspective of IPV survivors' use of EMDR for their symptoms of PTSD. The nature and purpose of the study were reiterated to each participant prior to the interviews.

Interpretation of the Findings

The purpose of the study was to explore the lived experiences and perspective of IPV survivors and their use of EMDR therapy for PTSD. Data were collected from seven female survivors whom I interviewed using semi structured open questions (see Appendix B). All interviews were conducted via the telephone due to the pandemic. One research question was addressed in this study:

RQ: What is the patient-perceived effectiveness of EMDR treatment for PTSD of IPV survivors?

Each participant in the study described her lived experiences of using EMDR therapy. They described their experiences of IPV as pervasive and how it affected them physically and emotionally. Past research showed that, on average, 20 individuals are physically abused by an intimate partner every minute (NCADV, 2015). The resiliency shown by many of the survivors of IPV has indicated the belief that humans have the capability to meet challenges, as reflected in Bandura's (1997) theory of self-efficacy. The participants in this study showed the ability to survive extremely difficult experiences. Bandura proposed that self-efficacy influences coping behavior when an

individual is met with stress and challenges. Bandura posited that self-efficacy is a self-sustaining trait occurring when a person is driven to work to find solutions to their traumas (McKerman 2020), as was the case for most of these participants.

The purpose of the study was to identify and report women's lived experiences of using EMDR therapy to cope with the aftermath of IPV. As a result of these findings, I hope that the information may be taken in account in programs designed to provide this population a better quality of life. In addition to the program implementation of these findings, there is a possibility of bringing attention to the overall effectiveness of treatment and how it can vary in alleviating the symptoms of PTSD.

The premise of the study was to explore the experience of IPV that caused long-lasting effects of PTSD and the perspective of survivors who had used EMDR therapy. The literature specifically lacked the survivor's perspective after the experience of life altering IPV and the treatment of EMDR. Therefore, the goal of this research was to report the findings of such lived experiences. The findings may bring attention to the perceived effectiveness of using EMDR therapy for IPV survivors.

Chapter 2 reported that the EMDR Institute (2020) had reported some controversy regarding the use of EMDR despite its popularity. Some critics have referred to EMDR as pseudoscience. Even though some individuals have experienced symptom reduction, the actual drawbacks resulting from the eye movements have received a limited number of general studies.

The essential ingredient of EMDR, as reported by Shapiro and Laliothis (2015), is eye movements with alternative tasks. These tasks can include tapping, buzzers, a

moving light bar, and finger movements creating bilateral eye movement. To reduce the vividness and emotionality of trauma, a comparison of these alternative dual tasks is as useful as eye movements. Whereas the therapeutic effects of EMDR has presented doubts on the typical role of the eye movement. Some women expressed that the tasks they used did not make a real difference, while a couple felt that the use of buzzers was more effective. Others said they thought it was the eye movement and not the task that caused effective changes in their PTSD symptomology.

Most of the women in the study discussed their ways of understanding and connecting to EMDR Therapy. One of the main themes was the intensity of EMDR therapy and the need to have other therapy treatment before using EMDR. Additionally, most participants felt that the effectiveness of EMDR was firmly based on the therapist and whether they had formal training. Except for a couple of participants, most reported that they would recommend EMDR for treatment of PTSD; however, they would recommend that it not be the sole method of treatment. Participants unanimously expressed that a person should also have a support group while retaining complete awareness of the process of EMDR and the need for grounding after each session. Some of the women had moments where they would pause before answering the questions. Throughout the interviews, each participant was able to respond in detail to their lived experiences. There was no force or coercion for a participant to answer the questions presented. This interviewing style allowed each participant to give thought to their responses and take time to elaborate as much as they felt comfortable doing.

Additionally, I followed the informed consent guidelines that allowed for the process to be unforced and voluntary.

Limitations of the Study

In the collection and interpretation of the rich data, this study had some limitations. This research's focus was to identify and report on female survivors of IPV who have been diagnosed with PTSD and their perspectives of EMDR intervention for their symptomology. In this phenomenological study, the collection of rich data was vital to understanding the phenomenon of IPV and effective PTSD treatment therapy. One limitation was the geographical location and inclusion criteria. Recruiting of participants took place in the Southwestern United States only; thus, generalizability to other survivors' outside the area may be limited. The survivor's lived experiences of intervention may differ between different geographical regions. The findings provided data on lived experiences of seven women who identified experiencing IPV and having PTSD diagnoses and their perspective of EMDR interventions in Southwestern United States. Another limitation noted in Chapter 1 may be that if the participants had developed a good rapport with their therapist, who had the specific training in the modalities, the belief may be that the therapy was effective when, in reality, her symptoms remained. However, if a participant did not have a good rapport with the therapist, the participant may have decided that the therapy was ineffective, despite actual reduction of symptoms.

The development of the interview questions could have been another limitation of the study. The implementation of the IPR framework steps ensured that the interview

questions aligned with the research question (see Castillo-Montoya, 2016). This study received approval from the IRB and committee members as it related to the five interview questions. Some moderate difficulty was shown by a couple of participants with providing answers in the open-ended question format. Therefore, this created the need to restate the interview questions while providing necessary probing comments. The interview was structured using the disclaimer from the prescreening questions (Appendix A) to help participants answer the questions. A pilot study was not conducted for this research study. However, to reduce this limitation's impact, I used probing questions and analysis of the reflective journals.

Another area of possible limitation was openness and transparency about IPV's sensitive nature. The participants shared openly and honestly with their responses to the interview questions. The reactions were not based on desirability or untruths to appease the researcher. I acknowledged the topic's sensitive nature at the beginning of each interview while encouraging each participant to share to the best of their ability openly and honestly. Before the interview, each participant was assured that there were no right or wrong answers. Finally, there is always a risk of bias due to nature of phenomenological methods. One way to alleviate this limitation is by having the ability to bracket the researcher's bias. However, the preconception of a researcher is not always detached (Brinkmann & Kvale, 2014). Therefore, even when asked, I refrained from discussing my personal opinions or views (see Morse, 2015). When I suspected possible bias, I restated the question with a statement of what I understood the answer to be and then asking for correction or clarification.

A final note as it pertains to the observation that typically takes place from face-to-face interviews: these nonverbal reactions were not observed due to the current pandemic and conducting all interviews via the telephone. Survivors of IPV may not receive adequate emotional or psychological care necessary during and after their IPV incident (Center for Disease Control, 2019). Therefore, intervention by other modalities than EMDR were noted for comparison.

Recommendations

This study focused on women who experienced IPV, resulting in a diagnosis of PTSD and their perspective of interventions for their symptomology. Future research can focus on how women in an even broader geographic area utilizing interventions, like EMDR can help alleviate symptoms suffered from IPV. This research identified and reported specifically on how seven women in the Southwest area of the United States used interventions to cope with PTSD. The study could help future researchers perform a quantitative study related to women who experience the same abuse. Research that will report and identify the different modalities and more specifics on the perspective of the treatment. Furthermore, future research can further provide ways to bridge gaps in the effectiveness of different interventions in addition to EMDR.

The findings of this phenomenological study established an increased understanding of women diagnosed with PTSD in the Southwest area of the United States. The focus was on the survivor's perspective of interventions and coping with IPV and the use of EMDR Therapy. The population in this geographical area in previous and current research studies did not cover the perspective of interventions through the lived

experiences. Therefore, this study was needed to start the research process for accessing the lived experiences of women who have experience with interventions to cope with PSTD from IPV. This study addressed a gap in the literature for the absence of the lived experiences for this population. The participants described their lived experiences of using interventions to cope with PTSD. Therefore, there remains a need for further qualitative and quantitative review. With the delimitation of the geographical location, future research would be vital to capture the lived experiences in various places to help bring forth awareness of this phenomenon on women and their use of an intervention for symptomology of PTSD. Other recommendations for future research are to explore more modalities as they compare to EMDR and the survivor's perspective of their lived experience. The use of workshops and webinars where the woman can continue to share their stories helps other women who may experience that same phenomenon. Participant's ability to share their unique lived experience with IPV and examine the patient-perceived effectiveness of EMDR in treating PTSD allowed survivors to access ways of copying and gain feelings of empowerment.

With limited research obtained suggesting that EMDR therapy could be a promising psychotherapeutic approach for the treatment of PTSD and comorbid symptoms it is further recommended to conduct research with larger samples to confirm this claim and to analyze the efficacy of EMDR therapy versus other therapies like CBT (Moreno-Alcázar et al., 2017). Additional research is recommended to focus on the impact of IPV and the negative effects that can differ from one population to another

depending on factors of duration, intensity of triggers, flashbacks, personality traits, and demographic variables as again perceived by survivors (Javidi and Yadollahie, 2012).

The current study was grounded in self-efficacy, whereby contributing to understanding the participants' lived experiences. The participants of this study reported their use of effective coping mechanisms, and ways they approached their symptomology, and how effective it was in either relieving or alleviating themes. According to Hoelterhoff and Chung (2020), self-efficacy is a protective factor in experiencing a life-threatening event like IPV. The current study has implications for the continued use of self-efficacy in future research projects for women who have been affected by IPV and the use of treatment modalities like EMDR for coping and recovery.

Research shows that IPV against women remains a significant public health issue that results in devastating health consequences for women in the United States (Stockholm, 2015). Most women are unaware of the availability of interventions in the treatment of PTSD due to IPV. This research was an in-depth phenomenological study that aimed to identify and report the lived experiences of women who experienced IPV that used interventions like EMDR to cope and finally recover. Findings suggested that other women would be willing to share their lived experiences of coping with PTSD due to IPV. Allowing them to express their perspective of interventions to help other women. Social change can occur through the assistance of local communities, legislations, and survivors to remove stigmas and stereotypes.

The word victim is a term often used to describe women who experience IPV, and not all women accepted that term as part of their identity when using treatment

modalities. Therefore, future research should include exploring alternative terms such as survivor for women who identify outside the term and other modalities. There exists overall importance of understanding these types of lived experiences and the need for further research.

Finally, completing this study allows these findings to provide information to future researchers, IPV advocates, social workers, medical personnel, and the survivor's perspective of interventions. Although some participants who shared their stories may have felt vulnerable to the possibility of having uncomfortable feelings from revisiting painful events, as they spoke on their use of interventions like EMDR Therapy. Most felt supported and a sense of accomplishment by possibly helping other survivors. Further allowing them to display and demonstrate strength, optimism, and self-efficacy, which helped overcome the ramification felt from having experienced IPV.

Implications for Positive Social Change

The implications for positive social change are diverse. This phenomenological study involved identifying and reporting women survivors of IPV's lived experiences and interventions' effectiveness. The data collection will contribute to previous and current research efforts to promote awareness of this population and their experiences. Findings potentially may inform the public and health professionals to help reduce IPV incidents and reduce extensive harsh effects of PTSD.

This research further identified a variety of common themes shared by the participants from their lived experiences. Some of the themes that came about included coping skills, success, and resilience. The overall results of this study may provide a

platform and future voices for women who experienced IPV. Providing the potential of social change through awareness of the effects of debilitating symptoms of PTSD and the support of chosen healing interventions. This research may help health professionals and advocates establish a more explicit awareness and understanding of how interventions can help IPV survivors creating a social awareness and change.

Conclusion

This phenomenological study aimed to identify and report on female survivors of IPV lived experiences when using interventions such as EMDR Therapy. A purposive sampling method was used to recruit seven women to report their lived experiences and perspective of the treatment modality they used to treat PTSD. I utilized an audiotape, along with semi-structured interviews that lasted from 30 – 90 minutes in length. Saturation was reached after interviewing 7 participants. The University's IRB approved this study for data collection on September 24, 2020. Commencement of data collection began from September to October 2020. The guidance of this study came from a self-efficacy model as according to Hoelterhoff and Chung (2020), self-efficacy is a protective factor in experiencing a life-a threatening event like IPV. According to Nygaard et al. (2020), high self-efficacy has decreased the severity of posttraumatic stress symptoms. This type of intervention of promoting self-efficacy has provided benefits for assault victims.

Participants were women who have been in an IPV relationship during the time of their abuse. Each participant had unique lived experiences; therefore, their perspective on the success of the treatment modality such as EMDR Therapy was in many ways similar

however different in the same respect. Based on the limited research of IPV survivors and intervention perspective, this study allowed survivors the opportunity to have a current platform to share in their voices and their lived experience. The findings suggest that future research will extend this transcendental phenomenological research to further explore this phenomenon by identifying more female survivors and their perspective of interventions.

Summary

This chapter presented the content of my research findings and the interpretations of results as they related to the theoretical framework and literature. This chapter reviewed the study's limitations, recommendations for future research, implications for social change, and conclusion.

This chapter found supportive evidence that interventions like EMDR can help some survivors, as presented by the participants in this study. The research findings showed how IPV women are open to sharing their stories about their experiences, coping strategies, and interventions to recover. I am indebted and grateful to the courageous women who came forward to make this critical study possible.

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Appendix A: Prescreening Questionnaire

- Are you 18 years old or older?
- Have you been out of your intimate partner violence relationship for at least one year?
- Have you been diagnosed with PTSD?
- Have you used Eye Movement Desensitization and Reprocessing (EMDR) therapy?

Appendix B: Interview Guide

Interview Questions

Full Interview Guide: Interview Questions

Date of Interview: _____

Pseudonym:_____

Type of Interview: Phone_____ Internet_____

Interview Questions for Study:

"Survivors of Intimate Partner Violence and Effectiveness of Intervention"

1. What was your experience in learning about EMDR, and how was that process explained?
2. How would you compare EMDR Therapy to others you have used?
3. Would you recommend EMDR to someone else like yourself, and why?
4. In what ways has EMDR Therapy has helped manage/reducing your PTSD symptomology?
5. How would describe your overall experience with EMDR?