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Comparative Case Study of Diffusion of Eye Movement Desensitization and Reprocessing in Two Clinical Settings: Empirically Supported Treatment Status Is Not Enough

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Abstract

An in-depth comparative case study was conducted of two attempts at diffusion of an empirically supported, but controversial, psychotherapy: eye movement desensitization and reprocessing (EMDR). One Department of Veterans Affairs (VA) treatment setting in which there was substantial uptake was compared with a second VA setting in which it was not adopted. Qualitative interviews were conducted with 10 mental health clinicians at the first site, and 19 at the second. Critical selling points for EMDR were a highly regarded champion, the observability of effects with patients, and personally experiencing its effects during a role training session. Compatibility with existing psychotherapist practices and values further allowed the therapy to become embedded in the organizational culture. At the second site, a sense that EMDR was not theoretically coherent or compelling overwhelmed other considerations, including its empirical status. Comparative studies contrasting settings in which innovative therapies are implemented versus those in which they were rejected may aid in refining theories of and strategies for dissemination.

Keywords

psychotherapy; diffusion; evidence-supported treatment; marketing; EMDR

There has been widespread discussion of the difficulties getting community psychotherapists to adopt evidence-based psychotherapies (National Institute of Mental Health, 1998) but limited understanding of how uptake and sustained use of these therapies can be ensured. Ironically, strategies for disseminating evidence-based treatments are not themselves empirically based, with little basis for specifying what influences practitioners to adopt and

sustain use of particular therapies, and limited insight into instances when this has been accomplished (Cook, Schnurr, Biyanova, & Coyne, in press).

A useful framework for understanding such processes is Everett Rogers' (2003) Theory of Diffusion of Innovations. Validated in numerous disciplines ranging from public health to marketing, this theory has direct applicability to the mental health field. Rogers (2003) explained diffusion as a social, rather than a technical process, in which communication about an innovation spreads throughout a social system. The theory identifies individual characteristics predicting who embraces innovations at what stage of diffusion (i.e., early versus late adapters). However, Rogers' primary emphases are on perceived attributes of innovations and contextual factors such as organizational milieu, social networks, and communication channels.

As applied to the diffusion of a mental health treatment, a potential adopter's decision-making process takes place in five stages: (1) gaining knowledge of the new treatment, (2) forming an attitude toward the treatment, (3) making a decision to adopt or reject the treatment, (4) implementation of the treatment, and (5) confirmation of this decision (Rogers, 2003). Perceptions of psychotherapy affect the likelihood that clinicians will adopt it. For instance, a treatment's perceived advantages and compatibility with existing practices may accelerate adoption. Contextual factors also play a role in the uptake of a new treatment, such as the presence of champions: individuals who advocate, energize, and oversee the adoption process (Greenhalgh, Glenn, Macfarlane, Bate, & Kyriakidou, 2004).

Although not without controversy, one treatment that has received designation of empirically supported status (American Psychiatric Association, 2004; Chambless & Ollendick, 2001; Department of Veterans Affairs and Department of Defense, 2004) for the treatment of posttraumatic stress disorder (PTSD) and widespread dissemination to front-line clinicians is eye movement desensitization and reprocessing (EMDR; Shapiro, 1989, 1995, 2001). EMDR may provide a good illustration of the process of diffusion of novel psychotherapies. Perhaps no other therapy has taken hold the way EMDR has, and that alone makes it a worthy candidate for study of diffusion and uptake (McNally, 1999b). Indeed, EMDR has been deemed one of the fastest growing treatments in the history of psychotherapy (McNally, 1999a). Yet, perhaps no other therapy with clear empirical support has been met with such skepticism and rejection from the academic community (Beutler & Harwood, 2002; Norcross, 2002). Heated debate has occurred regarding EMDR's marketing and purported mechanisms of change (e.g., Herbert et al., 2000; McNally, 1999b; Perkins & Rouanzoin, 2002; Russell, 2008). Regardless of one's stance on the controversies surrounding EMDR, a study of two practice contexts where EMDR has and has not been implemented can provide more general insights into the dissemination of novel treatments, and illuminate factors, other than empirical status, that come into play.

EMDR involves an eight-phase approach, with various protocols and procedures customized to the need of the client (Shapiro, 2001). Typically, a patient with PTSD is instructed to identify aspects of the traumatic memory, including two self-referent cognitions, one negative and one positive, and associated bodily sensations. Negative cognitions are irrational beliefs about oneself (e.g., "I don't deserve love"), whereas positive cognitions are

desired self-beliefs (e.g., “I am lovable”) (Shapiro, 1995, 2001). During the reprocessing phases of treatment the patient is instructed to focus on aspects of the trauma or other memories and follow the psychotherapist’s fingers moving back and forth, approximately 18 inches in front of the patient’s eyes. After each set of eye movements, the psychotherapist stops and asks the patient to let go of the memory and to indicate what comes to mind. Depending upon the response, the client is guided to new areas of attention and the eye movements are engaged. This sequence is repeated until distress has been reduced, the belief in the positive thought has increased, and there are no disturbing physical sensations. Other forms of bilateral stimulation or dual attention stimulus can be used instead of the eye movements, such as tapping, tactile stimulation, and auditory tones.

Comparative Case Study

Case study methodology is a recognized strategy for investigating phenomena in multifaceted and complex contexts, especially where the boundaries between the phenomena of interest and context are not well demarcated (Platt, 1992; Yin, 2003). In this case of adoption and nonadoption of EMDR in two clinical settings, the boundaries between the diffusion process and the features of the treatment settings may not be clear, particularly when the context is changed by whether EMDR is adopted. Moreover, some crucial considerations may not be well specified in advance, but emerge with incoming data. Qualitative case studies can be used to engage participants in providing their own insights into the unfolding of events that provide the basis for further inquiry (Yin, 2003). Systematic case studies have a distinct place in services research and are particularly appropriate when the goal is to explain presumed causal processes that are too poorly understood for survey or experimental methodologies (Cronbach et al., 1980).

Case study methodology uses purposive, rather than representative, sampling to select cases that are rich in comparative information (Flyvberg, 2006). Systematic data concerning the extent of adoption of EMDR in the Department of Veterans Affairs (VA) are not available, but differences in the uptake of EMDR across VA are striking. Based on reputation and informal staff reports, two VA sites were selected for a comparative case study because of the contrasting receptions that EMDR received in them. In the first, EMDR was disseminated and implemented while in the comparison site, dissemination did not occur. Practitioners in two VA PTSD treatment settings were assessed via semistructured interviews concerning a set of variables shown to influence adoption of innovations in other contexts. These included characteristics of providers and setting, peer network influences, and perceived characteristics of EMDR.

Method

Participants and Procedures

Mental health clinicians specializing in PTSD treatment and services from two VA settings were recruited for retrospective semistructured interviews. The first is a VA located in a rural setting an hour outside of a major East coast city. EMDR is now the predominant modality used in this program. The comparison VA is affiliated with a large well-known university and is located in a suburban setting on the West Coast. Clinicians at the

comparison site had exposure to EMDR through reading the literature and discussions with colleagues, but EMDR did not become established there. The study was approved by the Columbia University-New York State Psychiatric Institute Institutional Review Board (IRB) and the IRBs for the two VA settings.

Interviews were open-ended so that respondents could be queried about opinions and recollection of key events. Interviews were conducted by an experienced psychologist specializing in trauma and dissemination (JMC). Interviews were audiotaped and transcribed by a professional transcriptionist and lasted 30 min to 1 hr. Twenty-nine mental health clinicians (14 male and 15 female) participated, 10 at the first site and 19 at the comparison site. Of them, 25 were White, 1 was African American, 1 was American Indian, and 2 had mixed ethnicity. Mean age was 48.55 years ($SD = 8.81$), ranging from 30 to 62 years. The majority ($n = 23$) were doctoral-level psychologists. The mean number of years since graduation was 13.69 ($SD = 7.72$). The majority of clinicians ($n = 18$) primarily provided clinical services to veterans, nine did some clinical work but primarily worked in research and education, and two worked primarily as administrators. Participants at the sites did not differ in age, gender, time since graduation, or attendance at conferences. Five participants at the comparison site had academic affiliations, while no one at the first institution held an academic appointment.

Data Collection and Analysis

The preferred strategy for conducting case studies is the collection and analysis of theoretically driven qualitative data (Yin, 2003). Key concepts from Rogers' (2003) Theory of Diffusion of Innovations were used to develop a provisional set of interview questions (available from the first author). Specific content areas addressed included: the decision process (knowledge, persuasion, decision, implementation, and confirmation of EMDR); peer influences; and perceived characteristics of EMDR (i.e., relative advantage, compatibility, complexity, trialability, and observability as described below). The attributes of an innovation that affect its adoption rate are its relative advantage (Is EMDR judged better than what clinicians were doing in terms of efficacy, satisfaction, convenience and prestige?), compatibility (Is EMDR consistent with clinicians' existing values, experiences and needs?), complexity (Is EMDR difficult to understand and use?), trialability (Can EMDR be used on a limited basis or installment plan?), and observability (Are the results of EMDR visible to others such as the clinician and patients?).

Explanation building (Yin, 2003), the qualitative research strategy adopted for the present study, is an iterative process in which: (a) investigators make initial theoretical statements, (b) compare findings of an initial case against theory, (c) revise theory, (d) compare other details of the case against revision, and (e) compare revision with the facts of a second case. General principles in guiding case studies are attention to all evidence, presentation of evidence separate from any interpretation, and adequate concern for exploring alternative interpretations (Yin, 2003).

Results

Storied History and the Influence of One

Clinicians at each site provided a shared narrative, a remarkable consensus story about how the treatment was initially adopted or thwarted in their setting by the actions of a key stakeholder. They recounted some version of this story, even if they differed with respect to key details or, in many instances, lacked personal knowledge of what had actually occurred.

The point of entry for EMDR at the first VA was a charismatic psychologist who had served in Vietnam and provided therapy since the early 1970s. He recalled reading the first published article about EMDR (Shapiro, 1989) and thinking this “must be a hoax.” Ultimately, two experiences convinced him of the value of EMDR. One was the experiential role-play exercise, standard in EMDR training, in which he used a stressful grief memory and his distress was appreciably reduced. The other was a clinical experience using EMDR with a veteran who apparently had by the third set of eye movements an “incredible revelation,” in which distress from a traumatic memory was immediately resolved and maintained for over 17 years.

Most of the clinicians interviewed at this site said that when they first heard of EMDR they thought it was weird. Yet, because this well-respected psychologist endorsed EMDR, they were willing to accept training. One said, “____’s a huge influence on me, so you can’t, for me you can’t ever underestimate the power of the personality ... not that I would take everything ____ says ... without testing it, but pretty close.”

In contrast, a reason EMDR did not diffuse at the comparison site was an apparent history of EMDR’s originator approaching this VA’s administration with the offer to train staff, which was declined. Nine clinicians commented on this early history and expressed negative feelings that EMDR was in general not “initially put out in a very open spirit,” was being “marketed first more as a business than a science.” They noted that in order to learn the treatment, they had to pay money. One said, “There was a big backlash as to how she [Shapiro] was promoting the treatment because she started training and charging big money to learn how to do this treatment, and trying to then control it in a way that looked very much like a pyramid scheme, with no research, there was no research supporting it at the time that she initially came to us ... And then over the next few years ... her rationale for how and why this worked seemed to change. And so it wasn’t something that we wanted to buy into the process was offensive.” Another said, “When mental health approaches are aggressively marketed and when you have a series of increasing workshops that cost a lot of money that you have to pay for the higher certifications, I generally go running the other way.” These clinicians stated the marketing felt like a “social movement,” or a “money-making proposition.” Several clinicians at the first site were aware of such concerns and one commented, “I think a lot of the resistance (to EMDR) has been because it is very popular with clinicians. I think that’s really made people anxious ... you can’t have something taking over the field that comes from outside of academia, hasn’t really been reviewed or carefully thought through and now that it has, they won’t forgive it anyway.”

It's (Not) What We Do Here

At both sites, adoption depended on whether EMDR could be incorporated into the organizational culture (Table 1). On-site free yearly trainings on EMDR were offered at the first VA site, and new staff and trainees were encouraged to attend. This facilitated the spread of EMDR: "It kind of was handed to me on the silver platter." Another clinician stated, "This is the first setting that I've worked in where EMDR, is considered to be the treatment of choice ... where it's almost an expectation that you be trained in or versed in it. I mean it comes (up) in interviews, colleagues ask you do you do this, patients will ask are you going to be trained in EMDR; whereas in other settings where I've worked that's never been a part of the culture or climate."

Most clinicians at this site used EMDR to varying degrees. Those who used it infrequently wanted additional training, citing a lack of confidence in their level of skill for conducting this therapy safely. Nine out of the 10 mental health clinicians believed in EMDR's efficacy.

In contrast, most clinicians at the comparison site did not report knowing anyone who used EMDR. Two of the 19 were formally trained in EMDR, but neither had paid for the training. The EMDR Institute paid for one and a supervisor in graduate school paid for the other. Use of EMDR was not part of the organizational culture and others' use of it was viewed with skepticism. "Frankly, I don't know if we hired somebody who is an EMDR kind of enthusiast if we'd just make a space for that to happen or whether that person would be brought into the CPT (cognitive processing therapy) fold ... it's just the culture and ethic of the place. That's not how we do trauma work and there's nobody that has particularly pushed it. If that was their bent when they were being interviewed I'm not sure that they'd be hired, so it may be that cultural force."

Proof of Value: Experiencing Is Believing

In addition to a champion and an organizational culture that supported the use of EMDR in the first setting, an additional influence on clinicians' belief in the efficacy of EMDR and willing to use it was *observability*. Consistent with Rogers (2003) theory, observability was provided by clinicians participating in the experiential role-play exercise, with most reported that they experienced substantial relief in distress. "So it was very powerful. I worked on a trauma experience that I had had ten years before ... but that I was still quite upset about. And it resolved so quickly and in such an unusual way that I thought, well, she (the teacher) could never have told me to come up with what I eventually came up with during that session."

Many clinicians at the comparison site stated that in deciding which interventions to adopt, they valued "theoretical soundness." None thought EMDR met this standard. Most said that their first reaction to EMDR was that it seemed "gimmicky." "It sounded like a far-fetched almost crazy idea that something that seemed so simple could treat PTSD. It seemed 'out there.'"

Mechanism of Therapeutic Change

Most clinicians at the first site said that although they did not know how EMDR worked, this was not a deterrent to use. “If it works ... how it works is the secondary question”. Another said, “I have no idea ... I don’t have to understand why. I’m more interested in looking at the, you know, hypothesis testing, does it work or not, to the extent that it does work, and it’s very interesting academically to figure out why it does and that’s cool and everything but if, if controlled studies show that it makes a difference and there’s an effect size that convinces me.”

When prompted, all of the clinicians at the first site explained how they thought EMDR worked and only a handful accepted a once prominent hypothesis that it promoted inner hemispheric communication and healing in the brain (Bergmann, 1998). Most agreed it had elements of exposure therapy (Baum, 1970) and relaxation and distraction components, such that the patient’s eyes focus on something external preventing them getting caught up in emotion.

All of the clinicians at the comparison site said they would not use EMDR in large part because they did not understand the mechanism of change. None of these clinicians accepted the interhemispheric communication hypothesis and most thought EMDR was a repackaged cognitive-behavioral treatment intervention: “I don’t get it and nobody’s really been able to explain to me in a satisfactory way”. Another said, “The theory sounds sound and complex and it seems as if it requires expertise to pull off and if you’re not in a position to evaluate that critically, yeah, it’s easy to see how people would be sort of swayed by the, you know, apparent complexity of the theory and sort of wowed by it.”

Perceived Characteristics of EMDR

There were no consistent themes around complexity or trialability, but 9 out of 10 clinicians at the first site agreed that EMDR had advantages over other treatments for trauma, including patient empowerment, speed of action, and ability to bypass shame, because patients do not have to say their traumatic experiences out loud. Most clinicians also saw EMDR as compatible with who they are and how they want to practice. “Part of the power of EMDR is that ... they’re sitting right there and they’re in the driver’s seat.” Another said, “It’s nicer than exposure therapy With prolonged exposure (PE) you’re with the trauma the whole time and there’s no choice about it, this is what you need to do and you need to go over this trauma ... I feel as though I’m hitting somebody over head with something.”

In contrast, all of the clinicians at the comparison site reported that they could see no advantage of using EMDR relative to other trauma-processing treatments (PE and CPT) and, instead focused on disadvantages, such as high cost of training, an organizational culture that does not support its use, and perceived absence of unique therapeutic properties. “I’ve seen enough evidence saying this works, but suggesting to me that it’s not unique, so why not do something I can explain to somebody a little better.” Another said, “It’s not clear to me what it does that anything else doesn’t. I’m not aware of a better advantage for it, so I’m more interested in the disadvantages, in that it costs me to get trained, it, at least locally, is a harder thing to sell people on. I think it’s ‘cause it looks weird.”

The clinicians at the comparison site reported not paying a lot of attention to the research literature on EMDR beyond knowing that it has empirical support. In addition, EMDR was not compatible with their understanding of psychotherapy. “Well, I’ve looked at those meta-analytic studies and I know that ... the effect sizes for the most part are not significantly different. I think what the deal is for me is that the theory behind say CPT or PE is pretty straightforward and clearly articulated by the people that have generated those kinds of treatments. And it makes sense to me, you know, the mechanisms of action, they’re not proven but they’re logical and I think that some studies support the theory behind it. It’s kind of like the theory makes sense to me and I can see directly how the treatment is related to the theory. Now with EMDR ... the theory behind it doesn’t make a whole lot of sense to me.”

Different Lens, Different Criteria

All clinicians at the comparison site indicated they would be willing to learn a new treatment if it had empirical support. Yet, when the interviewer pointed out that EMDR was empirically supported, they gave a host of reasons as to why they did not adopt it. Some said they would be willing to train in EMDR but only if it was mandated by VA. Even fewer said they would be willing to actually use it and all qualified this potential use with caveats that made it near impossible. One said, “If she’d (Shapiro) gotten a NIMH grant and was collaborating with _____ (Ivy League university) on something or ... you know what I’m saying? That would really start to get people’s attention here, but she doesn’t take that approach.” Two clinicians at the first site expressed concern that EMDR was viewed differently than other PTSD treatments. “People who aren’t reading this research all the time reached a decision ten years ago that it was crap and haven’t revised that. The stink of controversy is still being attached to EMDR and it means that we are always working uphill. The controversy is about the eye movements but a lot of people still think the controversy is about whether it works or not.”

Aesthetics and Comfort Level

Clinicians at the comparison site expressed discomfort about conducting EMDR, in particular using their hands to facilitate patients’ eye movements. “I think probably a lot of us have all been trained with talk therapy and the use of talk therapy and so the idea that you could train somebody to be following something with your eyes to process memories and things just seemed unusual ... So before even looking into it I thought this is crazy.”

Several expressed concerns about the credibility of EMDR, equating it with invalid therapies and procedures, e.g., “It sounds like a touchy feely kind of therapy, which was very popular during encounter groups and all this other stuff and I am surprised that it’s still around” Another said, “I think that psychology has ... been very determined to not be seen as a quack field. We really embrace science as an effort to show legitimacy ... and so my sense is that there’s a sense of I don’t do that weird thing.”

In addition, some expressed concerns about persuading patients of EMDR’s credibility. Specifically, one said, “I mean if there was good solid scientific reasons for why we were, why we thought that that would be an important component and I believed it and I could sell

the rationale, feeling totally that I believed it I probably would do it. But right now, with what we know I wouldn't feel comfortable trying to convince somebody that this is real and this is based on science. I mean I wouldn't feel good about myself doing that."

Discussion

This comparative case study of the adoption or nonadoption of EMDR in two VA treatment settings provides insight into clinicians' decision-making regarding empirically supported psychotherapies. Different but related factors explain EMDR's success in one setting but failure in the other. Points of entry into a setting made a strong difference in whether it was adopted. The psychologist who championed EMDR at the first VA was highly regarded and charismatic. His initial resistance to the therapy and subsequent conversion became part of the story of the PTSD services at this VA. Without him, individuals may have been trained in EMDR, but it would not have become embedded in the culture. This psychologist harnessed support from both clinicians and administrators.

Successful dissemination at the first site was facilitated by on-site free yearly EMDR trainings and by on-site free year-round supervision. Observability of EMDR's efficacy both during initial training sessions and subsequently with patients further promoted adoption. Perceived advantage of EMDR over other trauma treatments as well as compatibility with existing beliefs about treatment sustained use also influenced adoption. These factors along with administrative support allowed EMDR to become part of the organizational culture. Together these influenced creation of a community of practice (Wenger, 1998), a network facilitating face-to-face interaction, information exchange, and a collective approach to learning.

Despite evidence of EMDR's effectiveness (Davidson & Parker, 2001), it was not disseminated in the comparison setting for a host of reasons, and not simply due to the absence of a champion. No champion was possible because of skeptical interpretations of empirical support and theoretical soundness. Many clinicians at the comparison site did not view EMDR as a novel treatment, but rather as a repackaging for marketing of other treatments, particularly exposure therapy.

Other clinicians at the comparison site were unsure why EMDR worked but echoed Hyer and Brandsma (1997) in saying that EMDR without the eye movements "equals good therapy." Some attributed EMDR's efficacy to the application of common and generally accepted principles of psychotherapy (e.g., accessing associative networks unique for each person, treatment expectations, and focus on cognitions, feelings and sensations).

Empirical support for EMDR was disregarded, but its perceived lack of clear theory was emphasized. Many clinicians at the comparison site could not cite reasons why EMDR might work. They had difficulty comprehending the once popular purported mechanism of change, interhemispheric communication. Although there has been recent investigation of proposed mechanisms of change including action distraction, conditioning, orienting response activation, and REM-like mechanisms (e.g., Gunter & Bodner, 2008; Propper,

Pierce, Geisler, Christman, & Bellorado, 2007), clinicians at the comparison site were unfamiliar with this research.

At the comparison site, clinicians were unable to overcome their distaste for what was viewed as initial aggressive marketing by EMDR's originator. This echoes the broader academic community's attitude toward EMDR. Thus, when Rosen and Davison (2003) explained that American Psychological Association's (APA) committee on empirically supported treatments included EMDR on their list as "probably efficacious for civilian PTSD," many psychologists were startled. Apparently this precipitated a yearlong debate on a listserv exchange among a group comprised largely of academic psychologists, with some threatening to withdraw membership from the APA. Beutler and Harwood (2002) argued that these scientists had developed such a strong negative reaction to Shapiro that they ignored scientific evidence that supported her viewpoints and thus inconsistently applied the criteria of empirical evidence. Norcross (2002) noted that EMDR has been mired in controversy since its inception and surmised that many sociopolitical considerations likely influenced the psychotherapy research community in neglecting, dismissing or mischaracterizing the positive outcome data on EMDR. These factors included the emergence of EMDR from personal observations outside the scientific community, initial restrictions on EMDR training viewed by many as proprietorship restrictions (Shapiro [1995] explained that she deemed them necessary for clinical effectiveness and client safety), widespread training in EMDR before several controlled outcome studies were available (what some saw as premature dissemination, others believed was appropriate, because little research and effective treatments were available), its application to disorders beyond trauma/PTSD, and the use of eye movements in its title. Norcross also added that a number of these were "early self-inflicted wounds" on the part of Shapiro, including initial exaggerated claims of efficacy and initial failure to place EMDR into existing theories and research.

Clearly, the clinicians at the comparison setting were guided by additional criteria beyond empirical support for acceptance of a novel treatment. Namely, these include theoretical soundness, unique properties, and their own comfort doing the therapy and presenting it to patients as a sound psychotherapeutic intervention. The comparison site's nonacceptance of EMDR could be viewed as scientific resistance to innovation (Barber, 1961), but also as a rejection of pseudoscience (Herbert et al., 2000), although this position could, in turn, be disputed (Perkins & Rouanzoin, 2002). There is little ground for a nonpartisan position with regard to EMDR, a nonevaluative assessment of conditions of its acceptance or rejection.

Lastly, social networks of clinicians from the comparison site included few individuals using EMDR. These clinicians did not believe EMDR had relative advantage over other trauma processing treatments, viewed it as lacking compatibility with their treatment philosophy, and some expressed discomfort with having to move their fingers in front a patients' eyes. It was not part of the organizational culture, and in general, others use of EMDR was viewed skeptically.

The determinants of the effective diffusion of psychotherapies remain an important, but neglected set of issues. Perceptions of clinicians as well as the support available in the

institutional settings where they practice are crucial in determining whether psychotherapies are adopted or rejected. Understanding both individual practitioners and their context will aid in the future dissemination of treatments as well as help explain why and when spread might fail.

Although there are transferable lessons from this theory-testing and building case comparison, generalizations should be tempered by recognition of the controversial nature of EMDR. Although several of Rogers' key concepts (i.e., relative advantage, observability, and compatibility) appear to influence the adoption of treatments, additional standards or criteria also seem to apply. Namely, there may be differences due to clinician's initial training model as research scientists, scientist-practitioner or practitionerscholars, and current theoretical orientation. There is undoubtedly segmentation of the clinician market that need to be understood better in order to tailor strategies of dissemination.

Innovators might consider articulating a treatment model that integrates with extant theories at an early stage of the treatment's development, and building in experiential components into training sessions. Attention should also be given to integration of a new therapy with treatments clinicians are already providing (Cook et al., in press). Once a clinician decides not to adopt a new treatment, the decision may not be revisited. To foster receptivity, practitioners may consider speaking to practitioners of new treatments to ascertain outcomes in clinical settings, seek out opportunities to observe and/or read transcripts of client sessions, and seek divergent opinions through queries of those currently using the new treatment.

Rogers (2003) criticized researchers for studying innovations as if it were independent of others and advised that attention be paid to the diffusion of technology clusters. Thus, future investigations might examine how treatments diffusing at the same time, separate but interdependent, become either adopted, rejected, or reengineered. For example, studies could be conducted examining clinicians' training in and choices of use of one trauma-processing treatment over another (e.g., choice of EMDR, PE, or CPT).

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Table 1

Quantifying the Perception of Eye Movement Desensitization and Reprocessing (EMDR) From Adopting and Nonadopting Site Participants

Aspects of EMDR	Adopting site, <i>n</i>	Comparison site, <i>n</i>
Perceived characteristics of EMDR		
Relative advantage		
Yes	9	0
No	1	19
Compatibility		
Yes	9	0
No	1	19
Complexity		
Yes	6	0
No	3	0
NA	1	19
Trialability		
Yes	7	0
No	2	0
NA	1	19
Observability		
Yes	9	0
No	1	0
NA	0	19
Perceived empirical support, theoretical soundness, and comfort level		
Awareness of empirical support for EMDR		
Yes, empirical support exists	6	12
NA	4	7
Believe in theoretical soundness or uniqueness of EMDR		
Yes	9	0
No	1	19
Psychological discomfort with using EMDR		
Yes	0	15
No	6	0
NA	4	4
Familiarity with other trauma treatments		
Yes	9	19
No	0	0
NA	1	0

Note.

NA = The category is not applicable, not available, or was not easily quantifiable. The table needs to be interpreted with caution because whether particular topics were raised depended on the flow of an interview and adapted to what the respondent had already disclosed.