ARTICLES

I Won't Do EMDR! The Use of the "Sleeping Dogs" Method to Overcome Children's Resistance to EMDR Therapy

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This article provides a comprehensive review of the challenges faced by chronically abused children and their treatment providers. The main aim of this pilot study was to explore whether chronically traumatized children, who presented as unable or unwilling to engage in eye movement desensitization and reprocessing (EMDR) therapy, could be prepared with the "Sleeping Dogs" method to complete EMDR therapy. The second aim was to determine whether there was sufficient reduction in posttraumatic stress symptoms to enable positive placement decisions. Participants were 14 children, age 3–9 years ($M = 5.1$), refusing to participate in EMDR therapy. All were living in residential care ($n = 12$) or with foster families ($n = 2$) and were considered stuck cases because of their severe problems. With the treatment package of "Sleeping Dogs" plus EMDR therapy, all children completed EMDR therapy in an average of 7.57 sessions leading to the resolution of all identified traumatic memories. At posttest, the Trauma Symptom Checklist for Young Children showed a significant reduction of scores on the Intrusion and Depression subscales. Two thirds of the children ($n = 8$) who were in residential care at study onset were placed in foster families within 2 months after the last session, some even during treatment. This is the first study on the "Sleeping Dogs" method and even though the limited sample size and research design restricts generalization of results, the present findings suggest important directions for future study.

Keywords: chronically traumatized children; review; treatment resistant; stabilization; "Sleeping Dogs" method; eye movement desensitization and reprocessing (EMDR) therapy

Children who have experienced early multiple traumas such as violence, neglect, and abuse present with trauma-related symptoms affecting most areas of development (Cloitre et al., 2009; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Schore, 2001). When traumatization after child maltreatment becomes more complex, children exhibit less posttraumatic stress disorder (PTSD) symptoms and significantly more severe nontrauma-related symptoms (Jonkman, Verlinden, Bolle, Boer, & Lindauer, 2013). According to Shapiro's (2007) adaptive information processing (AIP) model, memories

of negative events are dysfunctionally stored in neural networks and information stored in these unprocessed memories of events underlies clinical symptoms.

Eye movement desensitization and reprocessing (EMDR) therapy can be used to process these memories (Cohen et al., 2010; World Health Organization, 2013), reduce the child's symptoms, and stimulate the normal memory processing system (Solomon & Shapiro, 2008). However, chronically traumatized children often present with a wide range of problematic issues complicating or making EMDR therapy initially unsuitable. They can be avoidant

and reluctant to engage in EMDR therapy or simply refuse to do it (Farkas, Cyr, Lebeau, & Lemay, 2010; Greenwald, 2000, 2009). Some children say they do not want to talk about their memories because they are fearful of being overwhelmed. Some have amnesia for the traumatizing events in their lives (Silberg, 2013; Waters, 2016), and some drop out of treatment (Farkas et al., 2010).

There may also be resistance from clinicians and caregivers who fear EMDR therapy will activate forgotten traumatic memories and destabilize the child, they do not want to “wake up sleeping dogs.” At times parents and caregivers suggest waiting until the child is ready. Without assistance, these children may never be ready and will most likely continue to have severe symptoms. As a consequence, some end up going from one foster family to another because of problematic behavior (Barber, Delfabbro, & Cooper, 2001). This preliminary study sought to address these questions: How can these children be prepared enough to be able to process their traumatic memories with EMDR therapy? How can we attempt to wake up the sleeping dogs carefully, without having the whole pack of dogs running wild?

Barriers for Chronically Traumatized Children to Engage in EMDR Therapy

Children unable to participate in EMDR therapy are often perceived as being not motivated or resistant, but this resistance, or fear to engage, can be based on their prior experiences. The word *resistant*, or *not motivated*, implies that there is fault in the child—but in fact it is not the child—it is what has happened to the child and their current social environment that creates barriers to and challenges in treatment (Struik, 2014). In years of working with these children and their families and having conversations with them retrospectively, they have mentioned to the author several problematic issues as contributing to their inability to talk about their traumatic memories.

The following paragraphs describe these issues that can create barriers for chronically traumatized children to engage in EMDR therapy. Each problematic issue is illustrated with descriptions of what children have reported over the years.

Lack of Safety

Chronically traumatized children have experienced many unsafe situations in their lives. Some are removed by child protection services because they were unsafe or have returned to their (unsafe) families.

It is not uncommon to find that abuse or neglect and therefore traumatization is still ongoing, when they are referred for trauma-treatment (Zeanah, Cheshner, & Boris, 2016). Even when abused children are physically safe, they might still feel unsafe, threatened, or afraid of being abused again (Cohen, Mannerino, & Deblinger, 2006). Previously maltreated children with negative behaviors are at risk for being retraumatized (Zeanah et al., 2016).

Being or feeling unsafe can be one of the reasons for chronically traumatized children to be unable to talk about their traumatic memories. They are trying to survive and cannot afford to become more vulnerable by talking about their traumatic memories. They can be afraid that talking about, for example, memories of domestic violence might lead to punishment from the parents, arguments, and more domestic violence, and they prefer not to risk that.

Unstable Daily Life

Many chronically traumatized children grow up in families who experience multiple social and mental health problems, and their daily lives can be unstable (Lanktree et al., 2012). Child protection services have often been involved and some children have been placed in foster families or a residential care facility. After being placed into foster care, children can go from one foster placement to the next (Delfabbro, King, & Barber, 2010), especially when their behavioral or attachment problems are too difficult for caregivers to manage (Rubin, O'Reilly, Luan, & Localio, 2007). Foster children in the United States have on average three different foster care placements (Children's Rights, 2015) and in a study profiling children in out-of-home care in South Australia, Delfabbro, Barber, and Cooper (2002) reported that almost a quarter of all children had experienced 10 or more placements during their time in care. Besides unstable and unsafe living arrangements, their difficult behavior and/or academic impairment can create problems in school as well (Perry & Dobson, 2013).

Some of these children say that talking about their trauma might worsen their nightmares, anger, depression, or anxiety and create even more problems than they already have. They feel it may lead to them being expelled from school or their (foster) parents or caregivers finding them too difficult to care for, resulting in them having to move somewhere else. Surrounded by threat and chaos, these children need all their energy to protect themselves and survive their daily lives and they cannot afford to become more vulnerable by talking about “forgotten” and suppressed memories.

Lack of a Safe and Consistent Attachment Figure

As described, many children in foster care have had several different foster parents caring for them (Children's Rights, 2015), and they might not be sure whether they can stay in their current placement. Some children in residential care facilities grow up without any attachment figure or without emotional support from a consistent caregiver in their lives. Child protection services are their legal guardian, and their parents passed away, are in prison, or have abandoned them. These children do not feel they have a consistent attachment figure to rely on for comfort and support while reliving their trauma. Without feeling loved, supported, and being noticed, these children can be reluctant to discuss their traumatic memories and relive their fear, anger, and abandonment. They do not have anyone to do it for.

Contact With the Parents

The lives of children in care can be complicated by decisions made by child protection workers like having unsupervised contact with an abuser-parent, having no contact at all with family or too frequent contact, reunifying children with their parents in unsafe circumstances, and having children reside in residential facilities without perspective (Kelly & Gilligan, 2000). These decisions can either support or undermine treatment (Greeson et al., 2011). Children in and out of home care can be reluctant to talk about their memories of traumatic events because they may be fear that their disclosures will reduce contact with their parents or minimize chances to be reunified. Children can also have unsupervised contact visits with their parents during which traumatization is ongoing or the parent pressures or threatens the child not to talk.

Lack of Emotion Regulation Skills

Chronically traumatized children have a diminished awareness of sensations, emotions, or bodily states; they may dissociate; and they have limited emotional vocabulary making it difficult to describe emotions or bodily states (Schore, 2001; Van der Kolk et al., 2009). Children can feel ashamed and as a reaction to their shame avoid, withdraw, and attack others or themselves with self-hatred (Nathanson, 1994). Without an attachment figure to coregulate the child or self-regulation skills, the fear of becoming overwhelmed by strong emotions can make children afraid to talk about their traumatic memories. Some say they do

not want to talk about their traumatic memories because they will become too scared or angry and start to feel "really bad." Some of the caregivers fear the child may dissociate or become dysregulated.

Unsafe Attachment Relationships

Children need a safe attachment relationship to be able to learn how to regulate emotions (Ellis & Alisic, 2013). However, chronic traumatization can negatively affect a child's attachment relationships (Van der Kolk et al., 2009; Zeanah et al., 2016). When harming or not protecting the child, the parent, who should be the person to comfort the child when they are overwhelmed, instead becomes the source of their distress (Lyons-Ruth, 1996; Main & Hesse, 1990). Even when provided with a safe attachment figure as addressed in the previous paragraph, some children continue to avoid or are unable to attach to this attachment figure (Lieberman & Van Horn, 2008; Zeanah et al., 2016). On the other hand, the child's difficult behavior and strong emotions can be so challenging and distressing for (foster) parents that they are unable to coregulate the child (Dozier & Rutter, 2008). Children can be unable to talk because they do not want to upset their parent or caregiver with their memories. When a parent is traumatized by the same events as the child, as in domestic violence, the child for example can trigger the parent's own traumatic memories. Parents or caregivers can become angry or so overwhelmed, they cannot comfort the child but need comfort themselves (Wesselmann, 2007). The child may then choose not to talk about their memories and take care of their parent.

Negative Core Beliefs

Chronically traumatized children can develop negative core beliefs about themselves, others, and the world. They have become distrusting of others, and their behavior has become guided by fear and defense (Ehlers, Mayou, & Bryant, 2003). During processing of a traumatic memory, children need to shift from a negative to a positive cognition (idea), related to the target image. They may, for example, blame themselves for abuse or neglect or feel they do not deserve to be treated well or are unlovable. These strong negative cognitions about themselves ("It's my fault") related to the traumatic image ("I see dad beating up mum and I do nothing") can be based on their parent's beliefs ("It's your fault, because if you had not called the police, I would not have broken my nose"). Some chronically traumatized children have parents who reinforced such negative core beliefs,

for example, by denying the abuse took place, minimizing the impact, or even blaming the child for it. Biological parents were identified as the perpetrators of 81% of substantiated cases of child maltreatment in the United States, with nonbiological parents and their partners, and other family members, accounting for an additional 12% and 4% of cases (Sedlak et al., 2010), and this relational abuse can create a barrier. When they would shift to the positive cognition (“It’s not my fault”) during EMDR therapy, this can create even more problems with their parents, who, for example, continue to hold them responsible for what happened and reject them.

Abused children often express that they feel strange, different, weird or think they are crazy (Waters, 2016). Children who have experienced extensive trauma do not realize that their symptoms are trauma-related and are actually normal reactions to an abnormal, frightening situation, and they can feel hopeless that their behavior or feelings will ever change. When the child’s trauma-related symptoms are externally expressed (i.e., through verbal or physical aggression, problematic behaviors), this can lead to more negative experiences such as rejection or even abuse (Zeanah et al., 2016), which reinforces these negative core beliefs. Children may not understand why it would be beneficial to them to talk about their traumatic memories and they can be distrustful of the clinician’s intentions in the therapy process (Greenwald, 2005).

What Is Needed to Overcome These Barriers?

To engage these chronically traumatized children in EMDR therapy, the problematic issues that create barriers need to be addressed. Some children struggle only with one of these issues, whereas others struggle with multiple or even all the previously described issues. This calls for a customized treatment plan (Lanktree et al., 2012) focused only on the barriers for this particular child and his or her family. Other elements known to increase motivation are described in the self-determination theory of Deci and Ryan (2002), who stated that the level in which the three basic needs, autonomy, competence, and a connectedness, are met determines human motivation. When these basic needs are not met, humans are less internally motivated and as a result less persistent to reach their goals. Chronically traumatized children often feel helpless, incompetent, and disconnected from their families (Cashmore, 2002; Kelly & Gilligan, 2000; Statham & Aldgate, 2003). It is no wonder they present as unwilling or unmotivated to engage in

trauma-focused therapy. To engage these children in EMDR therapy, interventions need to increase the child’s feeling of competence, autonomy, and connectedness by involving the relational environment as major mediator for therapeutic change (Perry & Dobson, 2013). Children value their network’s support and opinion much more than the professional’s support (Cashmore, 2002; Kelly & Gilligan, 2000; Statham & Aldgate, 2003).

How Other Treatment Methods Address These Barriers

In addition to the “Sleeping Dogs” method, there are several other phased treatment methods that seek to address the barriers faced by chronically traumatized children (Adler-Tapia & Settle, 2017; Blaustein & Kinniburgh, 2010; Briere & Lanktree, 2011; Gomez, 2013; Greenwald, 2002, 2005; Saxe, Ellis, & Kaplow, 2012; Wessellmann, Schweitzer, & Armstrong, 2014), and dissociative children (Silberg, 2013; Waters, 2016; Wieland, 2015), some of which use EMDR therapy. Most treatment methods provide an extensive stabilization phase in which some of the barriers mentioned earlier, such as safety, self-regulation, attachment, psychoeducation, motivation, emotion regulation, and core beliefs, are addressed. The comprehensive description of interventions and tools in the methods mentioned enables less experienced clinicians to put these into practice with their clients. However, the large variety of interventions can make it hard for less experienced clinicians to keep an overview of what to do and in which order. The Three Tests (Spierings, 2009), the fairy tale model (Greenwald, 2005), and the integrative treatment of complex trauma (ITCT; Lanktree & Briere, 2013) use models in which cases are analyzed to develop customized treatment plans, thereby providing a helpful structure to keep that overview.

None of these phased treatment methods do contain a structured analysis with specific directions for addressing the complexities of treatment when children are in care and/or for incorporating work with the abuser-parents. The methods contain case examples detailing the negative impact on treatment of decisions made by child protection services, the clinician’s attempts to collaborate with these services and success if they do (Greenwald, 2005; Silberg, 2013). However, this is mostly done by a case-to-case approach and not part of the structured analysis and treatment planning of each case, so it depends on the clinicians’ experience to include these factors. Similarly, the methods recount clinicians’ struggles

with children's extreme loyalty toward the biological parents, and some case examples describe experienced clinicians collaborating with biological parents. However, none of these treatment methods provides a structured plan to incorporate work with the abuser-parents from the start of treatment.

Even though widely used, there is actually no evidence supporting the need for stabilizing interventions for chronically traumatized children, nor the necessity of a phased-approach for positive treatment outcomes for adults with complex PTSD (De Jongh et al., 2016). The "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder" state,

Trauma-focused psychotherapies should be considered first-line treatments for children and adolescents with PTSD. Among psychotherapies there is convincing evidence that trauma-focused therapies, that is, those that specifically address the child's traumatic experiences, are superior to nonspecific or nondirective therapies in resolving PTSD symptoms. (Cohen et al., 2010, p. 421)

However, even without evidence, it is obvious that children stating, "I won't do EMDR" need interventions in a stabilization phase to eventually be able to address traumatic memories.

By focusing these interventions only on overcoming the possible barriers for EMDR therapy, the stabilization phase can be kept as short as possible. Motivation-adaptive skills-trauma resolution therapy (MASTR; Greenwald, 2002) is a program assisting traumatized adolescents with conduct problems to overcome their resistance to EMDR therapy. In a study with 40 maltreated adolescents with conduct problems, internalizing, and externalizing behaviors, evidence was found for the effectiveness of using MASTR in preparation for EMDR. Only 2 of the 40 participants of MASTR eventually refused to address traumatic memories (Farkas et al., 2010). However, MASTR is an individual program for a specific target group, and upon evaluation, Greenwald (2009) recommends the use of parent training for caregivers and other systemic interventions in conjunction with these individual protocols.

The "Sleeping Dogs" method is developed to address the shortcomings of the already available treatment methods, incorporate and restructure the working elements, and keep the stabilization phase as short as possible.

The "Sleeping Dogs" Method

The "Sleeping Dogs" method (Struik, 2010, 2014) is developed for chronically traumatized children who are unable to talk about their memories. The "Sleeping Dogs" method provides a framework to make a structured analysis of the possible barriers creating resistance, including decision making by child protection services and the relationship and interaction with the abuser-parent. With this analysis, a customized treatment plan is created with interventions in the stabilization phase focused only on overcoming these barriers. The "Sleeping Dogs" method provides a framework of what needs to be done, in which interventions from other methods can be incorporated, rather than being another comprehensive description of interventions. Clinicians using the "Sleeping Dogs" method collaborate extensively not only with the child and caregivers but also with the child's network of attachment relationships such as his or her biological family including the abuser if possible, or previous foster families. Biological parents are not judged nor criticized, but they are invited to assist their children to heal from the trauma they have (unintentionally) caused.

Analyzing the Barriers

A systematic analysis of the possible barriers to engage in EMDR therapy enables the clinician to focus interventions only on these factors. Based on information from the child's referral, and if applicable reports, from child protection services or previous therapists, the clinician fills in a Six Test Form, available at http://ariannestruik.com/pdf/six_tests_and_worksheets_struik2014.pdf to analyze the child's situation. In the Six Test Form, the previously described problematic issues contributing to the child's inability to talk about the traumatic memories are translated into items with a set of questions called a test. The questions in each test have a fixed order and guide the clinician in his or her clinical judgment to determine whether this factor does or does not require focus in treatment. If needed, additional information is acquired from caregivers, parents or other professional in a face-to-face meeting or via phone, Skype, or e-mail. This analysis provides the clinician with a clear picture of possible barriers to the child to engage in EMDR therapy, which can assist in explaining to child protection services and the child's network how their decisions or involvement can positively (or negatively) impact on the child's engagement (Greeson et al., 2011).

Planning Interventions

After the analysis is discussed with the child's network and their views are incorporated, interventions can be planned to overcome the barriers. Interventions in the stabilization phase are as brief as possible and used in the service of the subsequent EMDR therapy. Preparation work is done with parents, caregivers, and child protection services and sessions with the child are kept to the minimum. The following describe per test some of the most common factors and possible interventions to overcome these barriers. For a more extensive description with case examples, see Struik (2014).

Psychoeducation and Motivation. Psychoeducation is a standard intervention and therefore not a separate test. It provides the child with the information needed to understand why EMDR therapy would be beneficial so he or she can decide whether he or she wants to do EMDR therapy. Psychoeducation increases the child's competence and autonomy (Cohen et al., 2010) and is provided in simple language for children from the age of 4 years and their family and network continuously throughout treatment. For example, a simplified version of the Window of Tolerance (Struik, 2014, pp. 69–71) is drawn to explain stress reactions and the way chronic stress impacts the brain and reduces the amount of stress a child can tolerate. Processing traumatic memories would enlarge the child's window and enable them to tolerate more stress in daily life. Dissociation is explained by using a Russian Matryoshka doll (Struik, 2014, pp. 73–74), a wooden doll filled with several smaller dolls, one inside the other. The Volcano (Struik, 2014, pp. 65–67), a metaphor of a volcano exploding, is used to explain how traumatic memories can become triggered in a day-to-day situation and cause the child to overreact emotionally. It is explained that processing these old feelings would stop the triggering and enable them to control their feelings better.

Test 1. Safety. When the child is or feels unsafe, creating safety (physically and emotionally) should be the first intervention (Boris & Zeanah, 2005). Any form of safety planning (Parker, 2011; Turnell & Edwards, 1999; Turnell & Essex, 2006) can be used to help families build safety for the children. When children are not sure of a positive reaction from their parents to disclosures, the clinician can discuss with parents whether they can give the child permission to talk and how they can inform the child of their permission in face-to-face contact, during phone contact, in a letter, or even just a text message.

For children without an attachment figure in their lives, their legal guardian needs to provide them with someone to fulfill that role. The clinician assists the legal guardian in this search by exploring the child's network together and by advising on how to reconnect the child to (extended) family, a father in prison, previous foster families, parents from friends in school or a new part-time foster family.

Test 2. Daily Life. When the child's environment is too unstable to deal with a possible temporary worsening of symptoms, interventions focus on improving the caregiver's and school's ability to help the child. The clinician can provide psychoeducation about trauma and trauma reactions to increase their understanding of the child. A form of parenting skills training can help parents to improve their skills (Cohen et al., 2010). When improvement seems impossible, the clinician drafts a plan with parents and school to compensate the expected difficulties. With the family for example is discussed who can stay with the family on the day of the session or whether the child can stay with them. Sessions can be planned during school holidays. This plan is presented to the child, so he or she is reassured that his or her environment understands how hard it is going to be and they can deal with a possible temporary worsening of symptoms.

The clinician can teach the child interventions, while involving the parent or caregiver, to increasing the child's feeling of control, such as The Safe Deposit Box (Struik, 2014, pp. 95–96), where the child locks his or her bad memories away in an imaginary or real safe deposit box to control intrusions, or The Here and Now exercise (Struik, 2014, pp. 96–97), to help the child orientate in the here and now and prevent dissociation and triggering.

Test 3. Attachment. When the child's attachment figure becomes overwhelmed by the trauma being focused on in the child's therapy, and for that reason, the child does not want to talk about his or her memories, then interventions focus on teaching the attachment figure to cope with his or her own emotions (Laor, Wolmer, & Cohen, 2001). Psycho-education can be used to improve the parents understanding of the child's needs and his or her own reactions. When that is insufficient, again a plan is made to compensate for the parent's inability. For example, when a parent is not able to talk with the child about their memories of traumatic events, another suitable family member can be identified to talk to the child instead, and take the child to therapy and stay for the day. When the child asks the parent difficult questions, child and parent can agree to write them down and discuss the

questions in a session with the clinician present. The parent and clinician draft a plan, which they present to the child to reassure the child the attachment figure can deal with his or her memories.

When the caregiver and clinician suspect that during trauma processing, the child will shut down or dissociate, interventions focus on activating the child's attachment just enough for him to be able to rely on the attachment figure for regulation of the strong emotions that might come up (Lieberman & Van Horn, 2008; Osofsky, 2004). Elements from attachment-focused therapies (Booth & Jernberg, 2010; Hughes, 2017; Lieberman & Van Horn, 2008) can be used to improve the attachment relationships just enough, so the caregiver is confident the child can get through the trauma processing phase.

When the analysis indicates that the child may be unable to talk about his or her memories out of fear his or her disclosures might lead to changes in contact arrangements with his or her parents or even negatively impact reunification, the child protection worker discusses the possible outcomes of the child's disclosures with the child. The clinician can prepare this conversation with the child protection worker by going through all possible options and assist the child protection worker to think from the child's perspective.

Test 4. Emotion Regulation. When a child fears being unable to tolerate the strong emotions that might arise during EMDR therapy, interventions such as psychoeducation about feelings, for example, feelings are like waves increasing in intensity but after a while extinguishing (Dorrepal, Thomaes, & Draijer, 2008), relaxation exercises (Cohen et al., 2006; Kabat-Zinn, 2005; Perry & Dobson, 2013), or elements from emotion regulation skills training (Perepletchikova et al., 2011) can be used to improve emotion regulation skills. Emotion regulation does not have to be perfect, but the child needs to state feeling confident enough to deal with the emotions during EMDR therapy.

Test 5. Cognitive Shift. When the child does not want to talk about his or her traumatic memories because he or she feels unable to make the cognitive shift without his or her parents becoming upset or angry, interventions focus on increasing the abuser-parent's acknowledgement for the child's innocence by conversations in which psychoeducation, reframing, mentalizing, or other systemic conversational techniques are used. The clinician and the abuser-parent can make a Trauma Healing Story (Struik, 2016), a brief story with simple language and drawings describing the child's life story and the parent's views on the child's responsibility for the traumatic events

and what the abuser-parent's intentions were. In the process of making this story, the often "unspoken" is discussed and the abuser-parents become important in assisting their child heal. The story can help abuser-parents to reframe things and even process part of their own trauma and alleviate self-blame. When both abuser-parents continue to blame the child, a third person's views need to be included, such as from a grandmother or foster parents.

Lovett (1999) describes using similar stories, in which she guides parents to make statements to correct the child's possible negative cognitions. Rewriting the narrative is a fairly common technique when working with adopted children and their nonabuser parents and is used in EMDR's trauma processing phase.

Test 6. Nutshell. After working on interventions within the previous tests, this last test determines whether the child is ready for the trauma processing phases of EMDR therapy. When the child can and wants to make a brief overview of his or her memories, this is called "tell them in a nutshell," without becoming overwhelmed, the child is ready for EMDR therapy. A child can for example state, "I have bad memories of my dad abusing me, memories of dad hitting my mum, of children bullying me in school, and of granddad locking me in the cupboard." One of the memories can be selected for processing, whereas the other memories are stored away in the Safe Deposit Box. When the child fails this test and for example becomes very angry or anxious and refuses to continue after naming some of the memories, more work needs to be done on previous tests.

Evaluation. The "Sleeping Dogs" interventions are used for children who state they do not want to engage in EMDR therapy with the aim of overcoming possible barriers. Children from the age of 3 or 4 years are given an explicit choice to engage in EMDR therapy or not. The child's readiness is regularly checked by the clinician or caregiver asking the child whether he wants to engage or not, for example after providing psychoeducation. Caregivers are instructed to actively refer to the psychoeducation provided in daily life situation and encourage the child to engage. When during these interventions the child states to be ready, the child ideally starts with EMDR therapy in the next session or as soon as possible, so no momentum is lost. The rest of the intervention plan is then skipped.

Trauma Processing Phase

Although the "Sleeping Dogs" method does not specify which treatment should be used for the processing

of traumatic memories, EMDR therapy was used in this study. EMDR therapy involves standardized procedures including focusing simultaneously on associations of traumatic images, thoughts, emotions and bodily sensations, and bilateral stimulation, most commonly in the form of repeated eye movements. The use of EMDR therapy with children diagnosed with PTSD has been demonstrated to be effective in several randomized controlled trials (RCTs).

At least three recent randomized clinical trials have shown EMDR's effectiveness with children. De Roos et al. (2011) randomly assigned 52 participants (age 4–18 years) to four individual sessions of cognitive-behavioral therapy (CBT) or EMDR along with four sessions of parental guidance and found both treatments to significantly reduce posttraumatic stress symptomatology, anxiety, depression, and behavior problems. Treatment gains of EMDR were reached in fewer sessions. In an RCT, Diehle, Opmeer, Boer, Mannarino, and Lindauer (2015) randomly assigned 48 children (8–18 years) to eight sessions of trauma-focused cognitive-behavioral therapy (TF-CBT) or EMDR. Both TF-CBT and EMDR showed large reductions in posttraumatic stress symptoms from pre- to posttreatment. Treatment duration was not significantly shorter for EMDR. Recently, de Roos et al. (2017) randomly assigned 103 participants (age 8–18 years) to EMDR ($n = 43$), cognitive behavior writing therapy (CBWT; $n = 42$) or wait-list (WL; $n = 18$). EMDR and CBWT yielded equally large remission rates for PTSD, reductions in the severity of PTSD, and comorbid difficulties. Rodenburg, Benjamin, de Roos, Meijer, and Stams (2009) meta-analytically examined the efficacy of EMDR in children with posttraumatic stress symptoms. Overall posttreatment effect size for EMDR was medium and significant ($d = .56$). Comparing children treated with EMDR to children treated with CBT, EMDR showed incremental efficacy; however, comparison effect sizes were small ($d = .25$).

“Sleeping Dogs” and EMDR

Because the “Sleeping Dogs” method involves history taking, treatment planning, and preparation, only the phases of the EMDR protocol addressing the traumatic memories were used. For this pilot study, the Dutch “EMDR Protocol for Children and Adolescents 0–18 Years Old” (de Roos, Beer, de Jongh, & ten Broeke, 2011) has been used. In this protocol, the language is appropriately adjusted for the age groups: 1–3, 4–5, 6–8, 9–11, and 12–18 years old. This protocol uses seven phases and starts with the introduction,

followed by the assessment phase. In the desensitization phase, the child focuses on the target image while focusing simultaneously on associations and bilateral stimulation, preferably repeated eye movements. When the level of disturbance related to target image is reported by the child to be zero, the positive belief is installed in the installation phase. In the fifth phase, the body scan checks for any negative physical sensations in relation to target image.

For children in foster care or residential care, the “Sleeping Dogs” method encourages biological parents to provide extra support by taking the child to therapy, sending a support postcard or text message before every session, or by having the clinician and child call the parent briefly after every session.

Integration Phase

The “Sleeping Dogs” method describes interventions in this phase to assist children with the integration of their trauma and increase resilience and skills to deal with difficult and stressful situations in the future. These are not described because this pilot study focused only on the stabilization and trauma processing phase.

Aims and Hypotheses

The primary aim of this study was to see whether children, who presented as not able to engage, could be prepared to participate in and complete EMDR therapy. It was hypothesized that the systemized strategies of the “Sleeping Dogs” method (Struik, 2014) would enable the participants to overcome resistance and eventually participate and complete EMDR therapy.

A further aim was to see whether children's posttraumatic stress symptoms improved after the “Sleeping Dogs” method plus EMDR therapy. It was hypothesized that after the treatment package of “Sleeping Dogs” and EMDR therapy, participants' symptoms would reduce to nonclinical scores on all subscales of the measurements used and positive decisions regarding future living arrangements could be made. This being the first study on the “Sleeping Dogs” method, an aim was to also attain information about the use of the “Sleeping Dogs” method, for example, what type of traumatization did participants have, in how many sessions did participants complete treatment (“Sleeping Dogs” plus EMDR), how participants presented at a 2-month follow-up and what the challenges and difficulties in this study were.

Method

Design

The institutional review board of Herlaarhof in Vught, The Netherlands, a Child and Adolescent Psychiatric Hospital, granted ethical approval of the pilot study. The author, a child and adolescent clinical psychologist, family therapist, EMDR consultant, and developer of the “Sleeping Dogs” method, treated all participants in this pilot study and conducted both “Sleeping Dogs” and EMDR sessions. Before the first “Sleeping Dogs” session, the treating clinician and the participants’ caregivers completed standardized assessment questionnaires. Treatment started with “Sleeping Dogs” sessions. As soon as the participant stated to be ready to talk about his or her traumatic memories, EMDR sessions began by using the basic protocol previously described. The caregivers completed posttreatment standardized questionnaires within 4–6 weeks after the final EMDR session. After 2 months, the referring psychologist or case manager provided the clinician with qualitative information about the child’s well-being and his or her context.

Participants

Included in the pilot study were 14 children younger than 13 years of age, referred to the clinician for EMDR therapy from January 2012 till December 2013. Children, who were able to start EMDR therapy, were excluded from the pilot study ($n = 5$). All children, 8 boys and 6 girls age 3–9 years ($M = 5.1$), suffered from chronic, physical, and emotional abuse, of which 7 were sexually abused, and were placed in residential care ($n = 12$) or foster families ($n = 2$) by child protection services. According to the referring clinicians, all participants were considered stuck cases. The children in residential care were assessed as presenting with behavior too challenging for a foster placement, and for the two participants in foster care, termination of the placement had already been discussed. Some of the children’s behavior was too challenging to attend school full time.

The clinician conducted treatment at Herlaarhof, an outpatient child and adolescent psychiatric unit, at the locations in Reek and in Vught, The Netherlands. For children referred within the child and adolescent psychiatric unit, treatment was conducted in a therapy room within the hospital. Children residing in a residential youth care facility for children younger than 13 years were referred by the residential psychologists, and received treatment in a therapy room at the residential facility.

Procedure and Treatment

Upon referral, the treating clinician checked whether the child had been provided with psychoeducation about EMDR therapy. If not, the residential staff or the referring clinician with the caregiver were instructed to do so. Children, who declined the offer, were selected for the “Sleeping Dogs” method combined with EMDR therapy. The treating clinician completed a Life Events Checklist (Williamson et al., 2003) based on information from the child’s referral, the child protection files, and information from the biological parents. The treating clinician discussed with the referring clinician the possible barriers for the child to talk about traumatic memories and completed the Six Tests Form based on clinical judgment. The referring clinician, not involved in the clinical part of this study, asked the residential staff or foster caregivers to complete the pre- and postquestionnaires.

The treating clinician selected interventions from the “Sleeping Dogs” method matching the most likely blocking items. Almost all participants were accompanied to therapy by their caregivers. Before therapy, spontaneous feedback from the caregiver on changes in symptoms and behavior was used in therapy to increase the child’s motivation. After therapy, feedback and instructions were given to the caregivers with the child present. The “Sleeping Dogs” interventions were used until the children agreed or asked to process their traumatic memories with EMDR therapy, for example, after being provided with psychoeducation. The EMDR sessions continued until the child had scored a subjective units of disturbance (SUD) score of 0 (where 0 = *no disturbance* and 10 = *worst possible*) and validity of cognition (VOC) score of 7 (where 1 = *feels totally false* and 7 = *feels totally true*); for all of the identified target images, the child stated not to have any more distressing memories, and child and caregiver reported symptom reduction. If children needed further treatment on other areas of development (attention deficit hyperactivity disorder [ADHD], learning disabilities), they were referred to another clinician. An independent psychologist (JE), not involved in any clinical part of this project, performed the analysis of the provided data.

Measures

Trauma symptoms were measured with the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005; Briere et al., 2001; Tierolf & Lamers-Winkelmann, 2014). The TSCYC is a questionnaire scored by parents/caregivers for children

(3–12 years old) with 90 questions on trauma symptoms. Items score the frequency of symptoms during the previous month, between 1 (*not at all*) and 4 (*very often*) scored on nine clinical scales. The TSCYC demonstrates good reliability and moderate convergent and discriminant validity (Briere et al., 2001; Lanktree et al., 2008).

Results

All 14 children, who initially refused EMDR therapy, became willing or able to engage in EMDR therapy. All children processed their memories with EMDR therapy until they reported not having any more traumatic memories. There was no dropout from treatment. “Sleeping Dogs” and EMDR therapy was conducted in an average of 7.57 sessions with a range of 4–26 sessions. All children had at least one “Sleeping Dogs” session; two EMDR therapy sessions; and for all children permission from the abuser-biological parent (12), abuser-biological grandparent (1), or the adoptive parent (1) to talk about the traumatic memories was expressed to the child. For 10 children, decisions by child protection regarding the identification of an attachment figure, the perspective of contact with biological parents, and living arrangements were reviewed and discussed with the child, and for 6 children, a Trauma Healing Story was created and presented.

The caregivers of 13 children completed the before and after evaluation on the TSCYC. For 1 participant, not all questionnaires were filled in because the caregiver had other priorities. For 8 of the 12 children who

were in residential care at the start of the study, there was such a reduction in problematic behavior that the referring clinician placed them in new or their previous foster families or they were returned to their families, which these families had refused previously according to the referring clinician. This transition was made within 2 months after treatment was ended, some even during treatment. For 3 children, this meant the pre- and posttreatment questionnaires were filled in by a different caregiver.

The scores on subscales of the TSCYC before and after treatment were compared, and all the subscales with *t* scores were explored. Because the data were not normally distributed, the mean differences of scores on the eight TSCYC subscales were estimated with a Wilcoxon signed-rank test (two tailed). Post hoc power analysis for a Wilcoxon signed-rank test were conducted in G*Power Version 3.1.7 (Faul, Erdfelder, Buchner, & Lang, 2013), and determined that with a number of 13 participants and Cronbach’s $\alpha = .05$ and power of 0.80, only very large effect sizes (Cohen’s $d = 0.85$) could be detected.

The Wilcoxon signed-rank tests indicated that the median posttest ranks were lower than the median pretest ranks, for the TSCYC subscale PTS-Intrusion ($z = -1.067, p = .033$) and for the Depression subscale of the TSCYC ($z = -2.136, p = .033$). There were no significant findings for the other subscales: PTS-Avoidance ($z = -1.067, p = .286$) and PTS-Arousal ($z = -1.509, p = .289$), Anxiety ($z = -1.246, p = .213$), Anger/Aggression ($z = -0.489, p = .653$), Dissociation ($z = -1.492, p = .136$), and Sexual Concerns ($z = -0.315, p = .752$; Table 1).

TABLE 1. Measurement Pre and Post Treatment Package Sleeping Dogs Plus EMDR Therapy

	Preintervention <i>M (SD)</i>	Postintervention <i>M (SD)</i>	<i>z</i> and <i>p</i> Scores
TSCYC Intrusion	61.0 (13.5)	52.4 (9.1)	$z = -2.136, p = .033^*$
TSCYC Avoidance	72.8 (21.5)	60.8 (18.4)	$z = -1.067, p = .286$
TSCYC Arousal	73.0 (13.5)	64.9 (16.6)	$z = -1.059, p = .289$
TSCYC Dissociation	59.3 (14.3)	55.2 (13.4)	$z = -1.492, p = .136$
TSCYC Anxiety	59.7 (15.6)	51.5 (11.7)	$z = -1.246, p = .213$
TSCYC Depression	65.0 (19.2)	50.6 (8.8)	$z = -2.136, p = .033^*$
TSCYC Anger/Aggression	66.0 (16.2)	61.7 (20.3)	$z = -0.489, p = .625$
TSCYC Sexual Concerns	49.5 (5.1)	50.5 (7.2)	$z = -0.315, p = .752$

Note. Before and after intervention mean scores on subcategories of the Trauma Symptom Checklist for Young Children (TSCYC).

* $p < .05$.

Discussion

The main aim of this study was to see whether the systemized strategies of the “Sleeping Dogs” method would enable the participants to overcome resistance. It was hypothesized that the “Sleeping Dogs” method would enable the participants to participate and complete EMDR therapy, and they all did, without drop-out. This outcome is hopeful for other chronically traumatized children with challenging behavior, who are considered stuck cases, and it supports the idea to provide trauma-focused treatment for these children and not “let sleeping dogs lie.”

A further aim was to see whether children’s posttraumatic stress symptoms improved after the “Sleeping Dogs” method plus EMDR therapy. It was hypothesized that after the treatment package of “Sleeping Dogs” and EMDR therapy, participant’s posttraumatic stress symptoms would reduce and positive decisions regarding future living arrangements could be made. Pre- and postmeasurements show a significant reduction of the subscales Intrusion and Depression and a nonsignificant reduction for the other subscales. For most of the children, positive decisions about future living arrangements and school attendance were made at the 2-month follow-up, so they did benefit from “waking up their sleeping dogs.”

It would be interesting to see whether these changes sustained on a longer term and whether eventually a lower level of care became possible for all the children. The “Sleeping Dogs” method is developed for children stuck in a high level of care. If more chronically traumatized children could complete trauma-focused treatment, this might potentially limit time in residential care, reduce the number of foster placements in children’s lives (Barber & Delfabbro, 2003; Barber et al., 2001; Delfabbro et al., 2002; Delfabbro et al., 2010; Greeson et al., 2011), and, as a result, lower the reabuse rate (Zeanah et al., 2016). Besides improving the quality of these children’s lives, treating childhood trauma, that is, waking up sleeping dogs, could also lead to a substantial cost reduction in health care (Kezelman, Hossack, Stavropoulos, & Burley, 2015).

Because this is the first study on the “Sleeping Dogs” method, an aim was also to attain information about the use of the “Sleeping Dogs” method. The treatment package (“Sleeping Dogs” and EMDR therapy) was conducted in an average of 7.57 sessions with a range of 4–26 sessions. This is a relative small number of sessions, which is attractive for children who are resistant to treatment. The amount of preparation time, for example, search for

information, read files, locate parents and contact them, and prepare trauma healing stories, was not measured, which should be taken into account in future research.

Limitations

The small sample size and lack of control group are major limitations of this study. This target group is hard to study because the “Sleeping Dogs” method is used only for chronically traumatized children who are unable to commence EMDR therapy. Many chronically traumatized children are perfectly able to participate in EMDR therapy and do not need preparation, so the inclusion rates of participants in one location is low. Contextual factors can make it hard to recruit a large number of participants. Participants are suddenly transferred to another location; major life events happen such as divorce, suicide, or incarceration of a biological parent, and child protection issues may interfere with for example acquiring consent for participation.

Other limitations were the inclusion criteria, the change in raters for three participants, and the lack of standardized measures to assess the positive changes in these children’s lives. The inclusion of participants was based on the clinician’s judgment that the children who stated they did not want EMDR therapy had received sufficient information about EMDR and that receiving additional information would not have changed their minds. This could have led to the false inclusion of participants who were actually more willing and did not need the “Sleeping Dogs” interventions and therefore a more positive outcome of this study.

Environmental factors of the study design may have influenced the lack of significant symptom reduction on all subscales of the TSCYC. Because the questionnaires need to be filled in by the current caregiver, for three children, the residential staff filled in the pretreatment questionnaire and the foster parents the posttreatment questionnaire. This could have influenced assessment of symptom reduction. Because trauma symptoms are unfamiliar to them, foster parents’ scores may have indicated a higher level of disturbance than would have been scored by residential staff. However, it would not be ethical to hold a child back from a new foster placement for the study. Children who have made such a great improvement in functioning that foster placement becomes possible during treatment should be able to make this transition when it becomes available. This complicates measurements in future research as different

respondents for pre- and postmeasurements can lead to an over- or underestimation of treatment benefit.

The available instruments to measure the complex trauma symptoms might not be optimal to determine treatment outcome. There is, for example, no measurement of change in the attachment relationships of these children. Comorbidity, such as ADHD or fetal alcohol spectrum disorder, is common in this child population (Lanktree et al., 2012; Van der Kolk et al., 2009) but was not measured and might have influenced the scores on subscales such as "Arousal and Anger." The TSCYC is a long and time-consuming questionnaire, and the limited age range (3–12 years old) restricts the number of children that can be included.

Treatment outcome was measured for the full treatment package. The lack of a measurement of symptoms between the last "Sleeping Dogs" session and the first EMDR session makes it unclear which component of the intervention led to symptom reduction. Although the "Sleeping Dogs" method does not target symptom reduction, it is possible that it had a positive effect. It is also possible that all symptom reduction occurred during the EMDR therapy. The study on the MASTR/EMDR treatment package experienced the same limitation (Farkas et al., 2010). Nevertheless, even if the "Sleeping Dogs" intervention did not produce symptom reduction, its important effect was that the participants who initially refused EMDR agreed to treatment. Ideally, future research should include an assessment between the last "Sleeping Dogs" session and the first EMDR session.

Recommendation for Future Research

Future research will need a multicentered set-up, over a long time and requires a high level of flexibility in treatment procedures with a control group receiving treatment with another method focused on overcoming resistance such as the fairy tale model (Greenwald, 2005) or the ITCT (Lanktree & Briere, 2013) depending on the target group and age of participants in the study. Standardized procedures and measures should be developed to select participants to measure the decisions regarding the future living arrangements.

The "Sleeping Dogs" is an assessment-driven treatment and no child and network receive exactly the same treatment. This is a common problem in treatment fidelity when studying this target group (Lanktree et al., 2012), and it is therefore hard to determine the working elements of this method.

In future research, documentation should note which interventions were used for each participant. This would allow the exploration of which key factors of the "Sleeping Dogs" method contribute to a positive treatment outcome. It is hypothesized that one key factor may be the involvement of the abuser-parent. Restorative justice programs (McLaughlin, Fegusson, Hughes, & Westmarland, 2003) emphasizing accountability and making amends can facilitate meetings between victims, offenders, and other persons to repair the harm caused by crime. Research has shown this improves victim satisfaction and offender accountability (Sherman et al., 2007). Even though the relationship between a perpetrator and a victim, who are strangers to each other, as opposed to a child-parent-perpetrator relationship creates a totally different dynamic, there might be similarities in the underlying processes.

The active involvement and collaboration with child protection services should be also included as a possible key factor. Strengthening ongoing partnership across disciplines can ensure children have to the best chances to have their needs met (Greeson et al., 2011).

For future research, it is recommended to use shorter, less time-consuming questionnaires combining self-report with caregiver's reports, with a larger age range, to be able to measure symptom change objectively and include more participants. A long-term follow-up, measuring level of care, stability of living arrangements, and symptoms could provide more information on the stability of the reported positive changes. Three other pilot studies are currently in preparation or being conducted with this target group in The Netherlands, Denmark, and Australia.

Conclusion

The primary outcome of this current exploratory pilot study is that with the "Sleeping Dogs" method, all participants, who were initially unwilling to participate in EMDR therapy, successfully participated and completed EMDR therapy. For most of the children, who were considered stuck cases, positive decisions about future living arrangements were made at the 2-month follow-up. This is a promising outcome for chronically traumatized children who refuse treatment. It supports the idea to "wake up sleeping dogs," not give up but help traumatized children to process their trauma. Even though the limited sample size restricts generalization of these results, the present findings suggest important directions for future research.

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