

GUEST EDITORIAL

EMDR Therapy With Children and Adolescents

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This special issue aims to highlight the importance of exploring the empirical base for eye movement desensitization and reprocessing (EMDR) therapy with children and adolescents. Such an endeavor is set within a context where the American Psychological Association recommends trauma-focused cognitive behavioral therapy (TF-CBT) as the treatment of choice and the National Institute of Health and Care Excellence (NICE) recommends EMDR for children when TF-CBT fails to be effective. Studies in this special issue suggest otherwise and represent EMDR's global reach over seven different countries. The studies address a range of conceptual gaps and evaluate differing EMDR protocols for individual and group delivery. Participants from preschool to adolescence experienced single event, cumulative violence, and trajectories of trauma and present with a range of trauma symptoms. Although studies with differing methodologies highlight the efficacy of EMDR with differing populations, recommendations are made for rigorous research designs in order to influence professional guidance organizations.

Keywords: eye movement desensitization and reprocessing (EMDR) therapy; children and adolescents; trauma exposure; resultant symptomatology; rigorous research

Exposure to traumatic events in childhood and adolescence involves big and small traumas (T/t) including single events, clusters of traumas, and/or cumulative experiences (Gonzalez, Monzon, Solis, Jaycox, & Langley, 2016; Hensel, 2009; Trentini et al., 2018). Globally, for example, children experience trauma within war-torn contexts and mass migration, terrorism, and domestic violence, as well as man-made and natural disasters (Barron, Abdallah, & Heltne, 2016; Chemtob et al., 2016; Trentini et al., 2018). In short, trauma is pervasive in millions of children's lives across the world. Without treatment, studies suggest trauma symptoms can be extensive and enduring throughout the life course (Cloitre et al., 2009). The availability of empirically based treatments is, however, limited with trauma-focused cognitive behavior therapy (TF-CBT) recommended as the treatment of choice by the National Institute for Health and Care Excellence (NICE) and American Psychological Association (APA). Eye movement and desensitization reprocessing (EMDR) therapy, although recommended by the World Health

Organization, is only recommended for children by NICE when TF-CBT fails to be effective (National Institute for Health and Care Excellence, 2018). In contrast, randomized controlled trials (RCTs) and other experimental studies indicate EMDR therapy is an effective treatment for children from 7 to 17 years (Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009); and in direct comparisons, EMDR has matched TF-CBT variants in effectiveness and acceptability while outperforming in efficiency (de Roos et al., 2011; Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2015; Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004). In addition, numerous case studies and quasi-experimental studies suggest EMDR therapy may be effective with children in the early years as well as for a wide range of mental health conditions (Adler-Tapia & Settle, 2009). Within a context of critical national guidance organizations (e.g., NICE/APA), it is vital that EMDR child and adolescent therapists and research communities collaborate to conduct rigorous efficacy studies. Whatever the outcome of these studies, our aim as a healing community is for

the delivery of therapy to millions of children that is well tolerated, effective, and efficient.

Given EMDR therapy has over 70 child studies and much gray literature (unpublished dissertations and theses), indications are there is a growing international empirical base for EMDR therapy with children and adolescents (Farrell, 2018). This special issue contributes with studies from the Netherlands, United Kingdom (UK), United States, New Zealand, and Australia as well as a UK study involving Syrian/Libyan child refugees. We are fortunate to be able to begin this issue with a review of EMDR efficacy studies for children with posttraumatic stress disorder (PTSD) and PTSD symptoms. Beer's review of 18 studies, including 10 RCTs, evidences significant change in PTSD for a wide age-range of children and adolescents. The review does, however, highlight the need for more robust evaluative research designs. A helpful list of standardized measures for children and adolescents is contained in an Appendix for practitioners and researchers. Wesselmann, Armstrong, Schweitzer, Davidson, and Potter shift the focus to the efficacy of EMDR therapy with developmental trauma utilizing a case series with 23 adopted children aged 7–12 years with histories of maltreatment and orphanage placement. The Integrative Attachment Trauma Protocol for Children (IATP-C) was found to be a promising treatment resulting in reduced symptoms of traumatic stress and behavior problems while improving mothers' positive feelings and the quality of attachment relationships. Hurn and Barron, also studying a developmental trauma population, utilized a qualitative design to evaluate the outcomes for eight young (6–11 years) Middle East refugees who experienced the Integrative Group Treatment Protocol (IGTP) within a novel psychosocial program. Children and therapists reported reduced disturbance for child refugees, indicating the value of group-based EMDR in combination with a psychosocial program. Of relevance to EMDR therapists and researchers working with international populations were the cultural challenges identified by Syrian interpreters, that is, differences in word meanings, the stigma of mental illness, and the differing levels of communicative control across cultures.

For therapists who work with children who refuse treatment, Struik presents three case descriptions to demonstrate the successful use of the Sleeping Dogs (trauma memories children can't/won't discuss) method, a three-phased trauma-focused treatment, with young children who had experienced severe trauma/abuse and initially refused EMDR. The children, two aged 6 and one aged 3, presented with severe

trauma symptoms to the extent they were placed in a residential facility. Following Sleeping Dogs, all three engaged in EMDR and as a result processed their identified trauma memories and their placements were stabilized. This is a promising finding that invites further research.

This special issue then presents four case studies that highlight novel and cutting edge applications of EMDR. Cusimano highlights the successful application of EMDR with a 13-year-old adolescent with obsessive-compulsive disorder (OCD). Fifteen sessions of the standard three-pronged approach (past, present, and future) led to a substantial decrease in symptoms. This article also highlights the value of follow-up evaluation, with gains being maintained at 3 months. Rathore explores attunement and trust-building strategies, based on neurobiology and attachment research, alongside EMDR in a qualitative case study with a 5-year-old girl who had experienced early life traumas. Eighteen weekly sessions over a 6-month period led to not only the achievement of developmental milestones but also numerous signs of posttraumatic growth. The article provides a novel approach to identifying neurobiological and behavioral markers.

Swimm presents the youngest case presentation, of a 17-month-old with PTSD and attachment trauma caused by a life-threatening choking incident, and the second study in this issue to explore the efficacy of IATP-C. A relatively small number of sessions ($n = 5$), including customized adaptations, resulted in reduced posttraumatic stress symptoms and a repaired attachment relationship. Swimm's article is an important contribution to the emerging exploration of EMDR with very young children. In the final case study, Swinden presents another example of exploring the efficacy of EMDR with developmental trauma, using Klaff's (2016) child-centered protocol with a 9-year-old girl who experienced familial child sexual abuse. Swinden/Klaff's approach is based on Shapiro's Adaptive Information Processing (AIP) model and did not require the direct processing of traumatic memories of the abuse. Despite the nondirect approach to processing with a focus on current concerns and emotional triggers, rather than past traumas, scores on the child and parental report standardized measures of PTSD indicated PTSD reduced to nonclinical levels. This is an important study, as it provides support for a nondirect approach that may provide a pathway to healing horrific unconscious material.

Finally, my hope is that the authors and studies in the special issue, by highlighting cutting edge

developments in EMDR therapy with children and adolescents and by demonstrating the value of differing and accessible research methodologies, will inspire others to engage in research and to publish. Indeed, I would argue that evaluation of EMDR including standardized measures needs to be embedded into day-to-day practice. As a community seeking to explore the boundaries of EMDR therapy efficacy, my hope is that increasing numbers of “practitioner researchers” and “practitioner and researcher partnerships” conduct robust research designs that provide sound empirical evidence. Further, as a scientific community, I would argue that we need to identify as well as create funding opportunities for both small- and large-scale projects utilizing a variety of methodologies. In order to influence professional guidance organizations that make recommendations on what therapies to use, the child and adolescent EMDR practitioner/researcher community will need to keep a primacy of focus on seeking to conduct the most rigorous research designs.

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