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Exploring Therapists' Experiences of using Eye Movement Desensitisation and Reprocessing Therapy with Children and Young People

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Portfolio Abstract

Eye Movement Desensitisation and Reprocessing (EMDR) therapy was developed by Francine Shapiro in 1989 as a psychotherapeutic intervention for adult clients diagnosed with Post-Traumatic Stress Disorder (PTSD). Over time, empirical support for the intervention's efficacy and effectiveness has grown and EMDR has been recommended as an evidence-based treatment option in the United Kingdom by the National Institute for Health and Care Excellence (NICE, 2018). Furthermore, the clinical utility of EMDR with other client groups, such as children and young people, has been explored, with research and clinical studies offering promising results. However, when working with children and young people it is well established that treatment protocols originally developed with adult clients in mind, often require adaptation to ensure their developmental appropriateness. It has been suggested that therapists typically make adaptations to standardised protocols based on their areas of expertise, often drawing on and integrating other therapeutic modalities in the service of promoting meaningful engagement and enhancing outcomes for children and young people. However, what is not clear within the current literature is how therapists experience adapting and delivering EMDR to children and young people.

Aim

The aim of this study was to speak with therapists offering EMDR therapy to children and young people in order to explore their experiences of adapting and delivering the intervention with this client group. The study aimed to explore and understand the perceived barriers and facilitators to adapting and delivering EMDR therapy when working with children and young people.

Method

A qualitative approach was utilised within this study. A study advert was posted on various social media platforms inviting therapists offering EMDR to children and young people to take part in an interview lasting approximately one hour. Interviews were semi-structured and took place remotely via Microsoft Teams. All interviews were transcribed verbatim and subsequently analysed using Reflexive Thematic Analysis.

Findings

Seven female therapists participated in the study. Therapists worked in public sector and private practice settings and had between one and 15 years of experience using EMDR with children and young people. The results of the Reflexive Thematic Analysis generated two key themes and six related subthemes. The key themes identified were ‘Putting EMDR into Practice’ and ‘Working Systemically’.

Conclusions

Whilst therapists considered EMDR to be an appropriate intervention for children and young people, they agreed that often, some adaptation to the standard EMDR protocol was required to ensure the intervention’s developmental appropriateness. Most therapists believed that adapting the standard EMDR protocol served to enhance engagement and improve therapeutic outcomes for children and young people. Yet, many believed that not enough attention had been given to making adaptations during their Child and Adolescent EMDR training. In clinical practice, therapists viewed supervision as a helpful space to think about when and how to adapt EMDR, as well as for discussing the impact of the many systemic factors present when working with children and young people.

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Statement of Contribution

I, Gemma Shipley, declare that this thesis is a product of my own original work, which I completed whilst undertaking the Trent Doctorate in Clinical Psychology.

I was responsible for completing the literature review, applying for ethical approval, recruiting participants, data collection and analysis, and writing up the report.

I received support from my supervisors, Dr Mark Hudson and Dr Anna Tickle, during the development and design of the project, analysis, and write-up of the results. I also received support from my initial primary supervisor, Dr Sarah Wilde, with some aspects of the development and design of the study.

Table of Contents

List of Tables

List of Figures

List of Appendices

What do clients say about their experiences of Eye Movement Desensitisation and Reprocessing therapy? A systematic review of the literature.

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Abstract

Background: Eye Movement Desensitisation and Reprocessing (EMDR) is an effective treatment for trauma-related distress that continues to gain popularity amongst clinicians. However, within the literature, it is less clear what clients think about the intervention. This review aimed to explore accounts of client experiences of EMDR within published studies and grey literature.

Data sources: Qualitative studies containing accounts of client experiences of EMDR were identified through online database searches; published studies were retrieved from PsycINFO, SCOPUS and Web of Science, whilst grey literature was retrieved from EThOS, OpenGrey and ProQuest. A total of 2451 studies were identified and screened for inclusion in this review; 13 studies met the inclusion criteria and proceeded to quality appraisal and data synthesis.

Data synthesis: Thematic synthesis was used to synthesise data from the results sections of the 13 included studies.

Results: Four super-ordinate themes were identified from the data including 'being introduced to EMDR', 'mechanisms of change', 'change attributed to EMDR', and 'the role of the therapist'. These super-ordinate themes were comprised of 11 subthemes.

Conclusion: EMDR produces positive change for clients, but the mechanisms of how change is produced are poorly understood. Clients perceive these mechanisms to be recognising past trauma and getting to the core of their difficulties, with clients attributing within-session change to bilateral stimulation. However, the findings of this review suggest that EMDR is not a universally positive experience; further exploration and reporting of accounts describing negative client experience is advocated as an important area for future research.

Keywords: EMDR, Eye Movement Desensitisation, Qualitative, Thematic Synthesis, Systematic Review

Introduction

Eye Movement Desensitisation and Reprocessing (EMDR) was conceptualised by Francine Shapiro in 1989. Originally intended as a therapeutic intervention for clients who had experienced trauma, Shapiro suggested that EMDR could effectively reduce the distress associated with traumatic memories through the generation of, 'rhythmic, multi-saccadic eye movements (whilst concentrating) on the memory to be desensitised' (Shapiro, 1989b, p.201). Shapiro systematically studied the effects of multi-saccadic eye movements in large numbers of clients and volunteers and through these studies, the therapeutic possibilities of EMDR were explored (Shapiro, 1989b). An eight-stage protocol for EMDR was later developed as a guide to the intervention and included history taking, preparation, assessment, desensitisation, installation, body scan, closure and re-evaluation, with the generation of multi-saccadic eye movements being considered a core element of the therapy (Shapiro, 1995, 2001). The distinct contribution of multi-saccadic eye movements within EMDR has been empirically supported (Kuiken et al., 2010), however, the protocol has also been expanded to include alternative forms of bilateral stimulation, including tapping (Beer & De Roos) and the use of auditory tones (Shapiro, 2007). Bilateral stimulation is proposed to facilitate the processing and integration of trauma memories, resulting in an alleviation of associated distress (Jeffries & Davis, 2013; Shapiro & Maxwell, 2002; van den Hout et al., 2001). However, this proposal has proved contentious, with two meta-analyses concluding that the use of bilateral stimulation in EMDR is superfluous and does not contribute to individual client outcomes (Cahill et al., 1999; Davidson & Parker, 2001). In addition, Sack et al. (2016) found that the generation of eye movements did not yield significant benefits over asking clients to focus on a fixed point in front of them.

Whilst researchers continue to debate what the mechanisms of action within EMDR might be (Landin-Romero et al., 2018), research supporting the intervention continues to grow. As EMDR was originally conceptualised as an intervention aimed at reducing trauma-related distress there have been a wealth of studies conducted with adult clients experiencing the symptoms of post-traumatic stress disorder (PTSD). The efficacy of EMDR for this client group has been supported in several meta-analytic studies, with significant reductions in symptoms of PTSD (moderate effect size; Hedges' g=0.662; 95% confidence interval (CI): 20.887-20.436), anxiety (moderate effect size; g=20.640; 95% CI: 20.890-20.390), depression (moderate effect size; g=20.643; 95% CI: 20.864-20.422), and subjective distress (large effect size g=20.956; 95% CI: 21.388-20.525) being reported (Chen et al., 2014; Chen et al., 2018; Cusack et al., 2016). Studies that have compared the effectiveness of EMDR as a treatment option for PTSD with interventions such as Cognitive

Behavioural Therapy (CBT) have reported results favouring EMDR (Chen et al., 2014; Khan et al., 2018). Other studies suggest that equivalent effectiveness exists between EMDR and trauma-focussed interventions such as exposure therapy (Cusack et al., 2016; Powers et al., 2010) and Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT, Benish Imel & Wampold, 2008; Bisson et al., 2007; Seidler & Wagner, 2006). Research has also shown EMDR to be of equivalent effectiveness when compared to some pharmacological treatments used for PTSD such as fluoxetine; whilst both interventions were effective in reducing PTSD symptoms, only clients treated with EMDR maintained these improvements at six-month follow-up (van der Kolk et al., 2007).

Whilst evidence to support EMDR as an effective treatment option for clients with PTSD is well established, several limitations to the evidence base must be acknowledged. Firstly, high levels of heterogeneity exist between studies, including participant characteristics, experiences of trauma, length of treatment, symptom and outcome measures used, length of follow-up, and study design (Chen et al., 2014; Chen et al., 2018; Cusack et al., 2016; Davidson & Parker, 2001; Bisson et al., 2007). Secondly, a large proportion of studies have not reported information relating to adverse treatment effects; it is unclear whether this is due to adverse effects not being experienced, or whether they are simply excluded from the discussion (Bisson et al., 2007; Cusack et al., 2016). And thirdly, although perhaps most importantly, there is a lack of representation of clients with comorbid presentations within the evidence base (Bradley et al., 2005); this limits the generalisability of research findings into clinical practice, especially given the high percentage of clients presenting to services with comorbid difficulties (Hamner et al., 2000). Addressing these limitations in future research would ensure that findings could be confidently generalised into clinical practice and enable clinicians to make more informed judgements about the potential effectiveness of EMDR for the individual client sitting in front of them.

Based on the growing research evidence supporting EMDR as a treatment option for adult clients with PTSD, the World Health Organisation (WHO, 2013) have recommended EMDR and cite moderate evidence to support the intervention's effectiveness; the American Psychological Association (APA, 2017) has also, conditionally, recommended EMDR as an effective treatment option. Whereas the National Institute for Health and Care Excellence (NICE, 2018) advise that EMDR can be offered to clients: if they request it, if the trauma is not combat-related, and if the symptoms of PTSD have been experienced for three months or more.

Given that so much of the research focus has been directed towards using EMDR with adult clients with PTSD, it is unsurprising that this area has the strongest evidence base.

However, the possibilities of using EMDR as a treatment option with other client groups, such as adults with intellectual disabilities (Unwin et al., 2019) and children (Moreno-Alcazar et al., 2017) are beginning to be explored. There is also increasing evidence to support the use of EMDR in the treatment of trauma-related distress trans-diagnostically, including clients experiencing depression (Wood et al., 2018), psychosis (van den Berg & van der Gaag, 2012), obsessive-compulsive disorder (Nazari et al., 2011), generalised anxiety disorder (Gauvreu & Bouchard, 2008), borderline personality disorder (Brown & Shapiro, 2006), and specific phobias (De Jongh et al., 1999). In addition, a recent review by Valiente-Gomez et al. (2017) concluded that EMDR appears to be a safe and useful intervention for clients presenting with comorbid difficulties including PTSD, substance misuse, psychosis, and bipolar affective disorder; this review was particularly helpful in addressing the earlier criticism relating to the exclusion of clients with comorbid difficulties from many research studies.

Rationale

The evidence to support the effectiveness of EMDR as a treatment option for PTSD is well-established, with support for the use of EMDR across a range of clinical presentations and comorbidities continuing to grow. However, knowing that an intervention is effective is not enough, interventions must also be acceptable and tolerable to those they are offered to (Milosevic et al., 2015) to ensure engagement in therapy and increase the likelihood of positive outcomes (Hommel et al., 2013). Within the research literature it seems that the client experience of EMDR has received relatively little attention (Whitehouse, 2020), yet understanding how clients experience EMDR is likely to provide valuable insights that may change how therapy is talked about with clients, and enable individuals to make informed decisions about whether or not EMDR is the right treatment option for them.

A recent systematic review by Whitehouse (2020) focussed on clients' experiences of EMDR; he included five qualitative studies, conducted in the United States of America (USA), published in peer-reviewed journals, in which all clients reported positive experiences of therapy. Although the review was only recently published, Whitehouse's searches were conducted on or before the 13th December 2016, meaning that any more recent literature was not included. It is important to address two main issues with Whitehouse's review; firstly, given that his searches were conducted almost four years ago it seems worthwhile investigating whether more recent studies of client experiences of EMDR have been conducted. Secondly, given the apparent bias within Whitehouse's review towards positive accounts of EMDR, it would be important to explore the literature further, acknowledging and

including accounts of adverse experiences if they are uncovered; understanding negative experiences of EMDR is crucial and may provide valuable learning opportunities. Furthermore, Whitehouse recommends that a further review, which includes grey literature may be beneficial in providing additional insight into client experiences of EMDR, moreover, the inclusion of grey literature may help to address any potential publication bias towards positive experiences of therapy.

Aims of the review

The main aim of this review is to explore the qualitative accounts provided by clients about their experiences of EMDR. Through the consultation of published and grey literature databases, Whitehouse's (2020) review will be expanded to ensure the voices of clients from unpublished studies are represented within the literature. It is also within the aims of this review to explore whether accounts of clients who have not benefitted from EMDR exist, and to incorporate these into the review, ensuring a holistic view of client experience is presented.

Method

A systematic review of the EMDR literature was undertaken following the stages proposed by Siddaway et al. (2018).

Protocol and Registration

The development and registration of a review protocol are considered important stages when preparing to conduct a systematic literature review. The review protocol sets out the research question, including details about the population, intervention, and outcomes under review, the proposed search strategy including the data sources to be consulted, eligibility criteria, and details of any planned analysis (Shamseer et al., 2015). It is considered good practice to publicly register the review protocol as it serves to promote transparency in the review process, as well as acting as a check and balance against reporting bias (Drucker et al., 2016).

The protocol for this review has been registered with the University of Lincoln (reference: 2020_3647) and an application for registration with PROSPERO has been submitted (196853); registration confirmation is awaited.

Eligibility Criteria

To address the review question 'What do clients say about their experiences of EMDR?', studies were considered eligible for inclusion in the review if they focussed on clients (population), experiences (outcome) of EMDR (intervention), with the review being open to including studies from across the world (context). Following the recommendations by Whitehouse (2020), and in an attempt to address possible publication bias relating to positive experiences of EMDR, the review sought to include grey literature sources and was open to including studies reporting adverse experiences of therapy.

The pre-determined inclusion and exclusion criteria are presented in Table 1; justification for the exclusion criteria is provided in Appendix A. The search included published and unpublished studies, reporting qualitative data, focussing on client experiences of EMDR on or before the 20th June 2020. A date restriction was not deemed necessary given that EMDR was developed in 1989 thus providing a natural period of approximately 30 years of research evidence.

Table 1

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
The study has used qualitative methodology	The study is not available in English
The study represents client perspectives	The study is unavailable as a full-text article
The study is related to the experience of EMDR as a therapy	EMDR is offered as part of an integrated approach
	The study represents therapist or carer perspectives

Searching

Published studies were identified using three electronic databases (PsycINFO, SCOPUS, Web of Science), a further three databases focussing on grey literature were also consulted (EThOS, OpenGrey, ProQuest). The following search terms 'EMDR', 'eye movement desensitisation' and 'eye movement desensitization' were used to search all six databases; an example of the search strategy used for the Web of Science and EThOS databases is included in Appendix B. Hand searching of the reference sections of potentially eligible articles was also undertaken to identify further relevant articles not returned by the database searches.

Study Selection

Studies were identified as eligible for inclusion in the review after passing several stages of screening. Studies were initially identified by entering the search terms into each of

the six databases, the search results from each database were transferred into a reference management programme (EndNote) and duplicate results were removed. The titles and abstracts of all studies were screened using the pre-determined inclusion/exclusion criteria and ineligible studies were removed from the database. The remaining studies were deemed to be potentially eligible, and their full-text articles were retrieved; the inclusion/exclusion criteria were re-applied and further ineligible studies were removed. At this stage, all remaining studies were considered eligible for inclusion in the review and proceeded to quality assessment and data synthesis. The reference section of each eligible study was searched by hand to identify other potentially relevant studies; the same screening process was applied to these studies.

Data Abstraction

Information was extracted from the abstract, aims, method and results section of each of the eligible studies. A data extraction form made available by the University of Nottingham was adapted for use in the review. Each study was read thoroughly, and data related to authors, location, aims, methodology, analysis, sample characteristics and key findings were copied verbatim into the data extraction form.

Data Synthesis

Thematic synthesis (Thomas & Harden, 2008) was selected as the method for synthesising the qualitative data included in this review. Thematic synthesis is a three-stage process; findings of included studies are initially coded line-by-line before descriptive themes which remain close to the original findings are developed, the third stage involves developing analytical themes which represent a stage of interpretation by the reviewer. A key advantage of thematic synthesis is that clear links between the conclusions of a systematic review and the findings of the original studies are maintained. Thematic synthesis was applied to the results sections of the studies included in this review; results that were not presented qualitatively or related to topics other than EMDR were excluded. All coding and theme generation was completed by hand, by a single reviewer.

Results

Identification of relevant studies

The process of selecting studies for inclusion in the review is detailed in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Moher et al., 2009) presented in Figure 1.

As shown by the PRISMA flow diagram a large number of studies were initially returned by the database searches; following the screening process described above it was possible to exclude the majority of these with 13 studies being considered eligible for inclusion in the review. After hand searching the reference section of these 13 studies it was possible to identify a further seven potentially eligible studies, however after screening the title and abstract of these studies they were ultimately excluded.

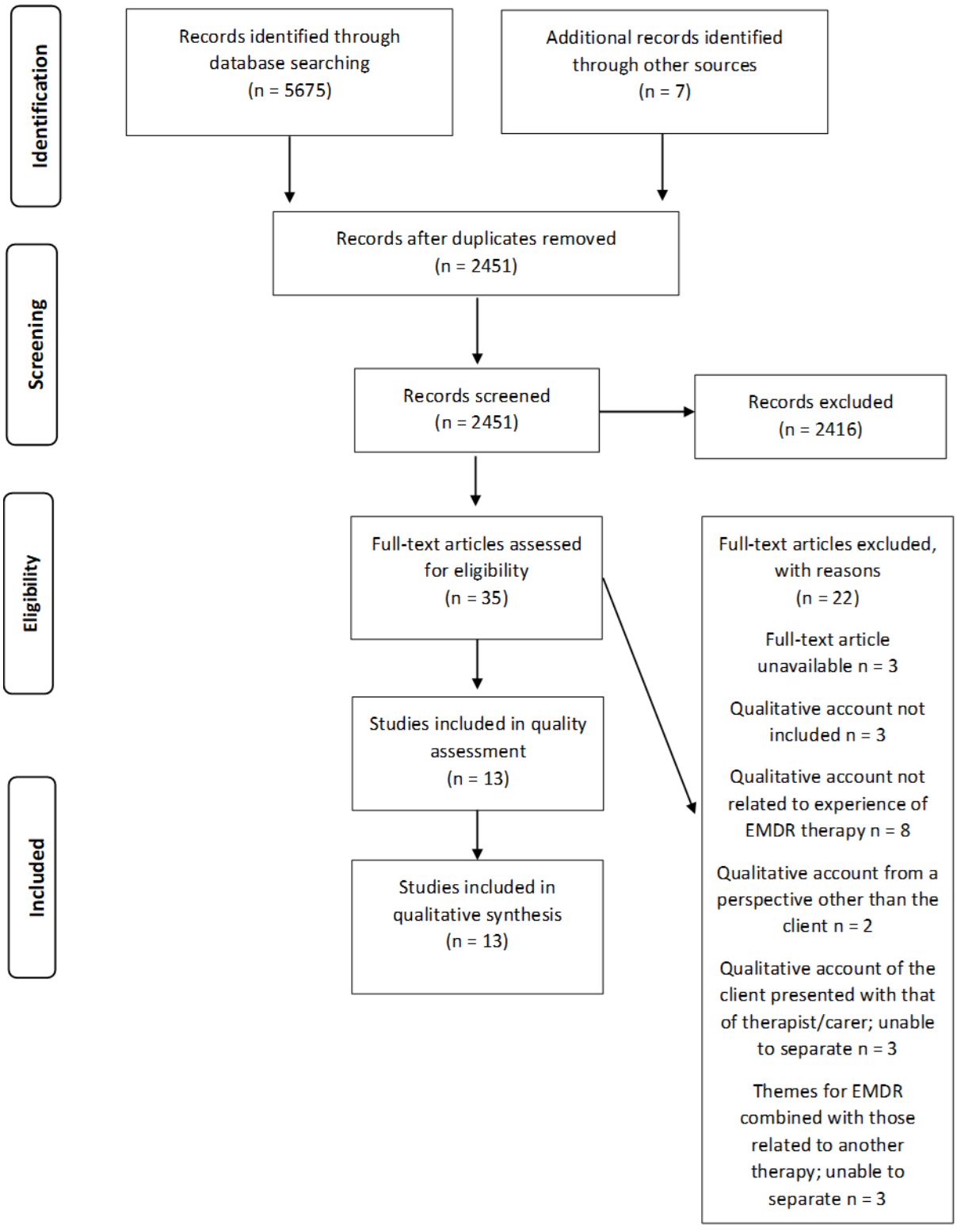

Figure 1. PRISMA study flow diagram of the search process used in the systematic review.

Careful consideration was given to two potentially eligible studies (Marich, 2012; Skinner, 2017). Whilst both articles initially appeared to meet the inclusion criteria for the

review, after reading the articles thoroughly it became clear that both studies had focussed exclusively on the client experience of the therapeutic relationship within the context of EMDR. Although it was considered probable that themes related to the therapeutic relationship would emerge in the review, the inclusion of these two studies was deemed to potentially increase this likelihood. On balance, the decision was made to exclude these two studies as they were considered unable to answer the review question in its entirety.

Characteristics of included studies

The main characteristics of the studies included in the review are presented in Table 2 and include author, location, aims, methodology, analysis, sample characteristics and key findings. Of the included studies, eight were published in peer-reviewed journals (2,3,7,8,9,11,12,13); three of these were derived from parent studies (2,3,11), three were conducted by one author (7,8,9) with a further two being conducted by another author (11,12). The remaining five studies were unpublished thesis projects completed as part of doctoral-level qualifications (1,4,5,6,10). Nine of the studies were conducted in the USA (1,2,3,4,5,7,8,9,13), whilst four took place in the United Kingdom (6,10,11,12); interestingly all the studies recruited participants from community settings; the implications of this will be considered in the discussion. Most participants were female: five studies recruited female-only samples (2,7,8,11,13), one study recruited a male-only sample of which all had been court-ordered to undergo therapy as part of a sex offender treatment programme (3), seven studies recruited mixed gender samples (1,4,5,6,9,10,12) although even within these studies a higher prevalence of female participants was noted. Participants in all studies were aged between 18-65 years old representing a working-age population, again the implications of this will be considered in the discussion. Within studies, a range of presenting difficulties were reported by participants including depression (10); stress (5); obsessive-compulsive disorder (OCD, 11,12); trauma related to childhood sexual abuse (2,3), domestic abuse experienced in adulthood (13), or other traumatic experiences (1,4,6); and comorbid difficulties related to trauma and addiction (7,8,9). The number of EMDR sessions accessed by participants ranged from 4-20 (2,7,12,13,5,10); some studies reported the mean number of sessions as between 6-11 (6,11,3), two studies did not report the number of sessions (1,8) and one study reported the average length of time that participants had been seen by an EMDR therapist as 3.6 years (9) although how many of these sessions were for EMDR specifically was not reported.

Table 2

Study Characteristics and Key Findings

Study	Author	Location	Study Aims	Methodology	Analysis	Sample Characteristics	Key Findings
1	Schleyer (1999)	U.S.A Community	To describe personal experiences of EMDR; to identify and describe changes occurring after EMDR.	Qualitative – unstructured interviews	Heuristic Analysis	Participants n=7 **Gender** Female (n=5) Male (n=2) **Age*** **Ethnicity***	Six key themes: 1. Set-up for harm 2. Being stuck 3. Willing to risk in spite of 4. Release 5. Movement 6. Ongoing movement
2	Edmond, Sloan & McCarty (2004)	U.S.A Community	To examine survivor perspectives of the effectiveness of EMDR & Eclectic Therapy for trauma symptoms among adult female survivors of childhood sexual abuse.	Qualitative – semi-structured interviews	Thematic Analysis	Participants n=59 **Gender** Female (n=59) **Age** Range 18-51 (mean=35.0 years) **Ethnicity***	Two key themes: 1. Client-therapist relationship 2. Nature of change
3	Ricci & Clayton (2008)	U.S.A Community	To analyse participants' experiences of EMDR and explore underlying processes that may have contributed to outcomes.	Qualitative – transcriptions of treatment sessions, semi-structured interviews, client	Grounded Theory	Participants n=10 **Gender** Male (n=10) **Age**	Seven key themes: 1. Recognition of distorted beliefs 2. Increased participation in group therapy 3. Increased empathy

				self-report and clinical observations		Range 18-52 (mean=37.5 years) **Ethnicity** White	4. Clarification of thoughts 5. Raised consciousness as a self-management tool 6. Self-esteem 7. Emotion recognition and management.
4	Naccarato (2008)	U.S.A Community	To expand the knowledge related to the effectiveness of EMDR from patients' experience of the EMDR process.	Qualitative – semi-structured interviews	Grounded Theory	Participants n=15 **Gender** Female (n=11) Male (n=4) **Age** Range 25-55 (mean*) **Ethnicity***	Two key themes: 1. Transforming suffering 2. Changes in perception
5	Stewart-Grey (2008)	U.S.A Community	The evaluate the lived experience of body sensations, emotions, beliefs, and imagery during EMDR treatment.	Qualitative – semi-structured interviews	Phenomenological Analysis	Participants n=12 **Gender** Female (n=11) Male (n=1) **Age** Range 23-60 **Ethnicity** Euro-American (n=12)	Five key themes: 1. Responsibility 2. Safety 3. Choices 4. Power 5. Value
6	Brotherton	U.K.	To explore clients'	Qualitative -	Interpretativ	Participants n=7	Five key themes:

	(2009)	Outpatient	experiences of receiving EMDR as an intervention for trauma-related symptomatology.	semi-structured interviews	e Phenomenological Analysis	**Gender** Female (n=5) Male (n=2) **Age** Range 29-57 (mean = 44.0 years) **Ethnicity***	1. Living with trauma 2. Doubt & apprehension 3. Making safe and making sense 4. The process of processing 5. Change
7	Marich (2009)	U.S.A Outpatient	To demonstrate the impact of EMDR on a cross-addicted female's overall treatment and initial recovery experience and to explore the case's lived experience with EMDR.	Case study – semi-structured interview conducted at follow-up	Descriptive Phenomenological Psychological Method	Participant n=1 **Gender** Female (n=1) **Age** 44 years **Ethnicity** White	Six key themes: 1. Escape 2. Transformation 3. Addiction recovery as a life-or-death matter 4. EMDR as an important part of addressing past issues 5. A combination of factors necessary for successful treatment 6. Restoration
8	Marich (2010)	U.S.A Outpatient	To explore the lived experiences of women participating in EMDR treatment as part of their addiction continuing care and the impact of the EMDR experience on their lives as individuals recovering from addiction.	Qualitative – semi-structured interviews	Descriptive Phenomenological Psychological Method	Participants n=10 **Gender** Female (n=10) **Age** Range 27-52 (mean=41.7 years)	Four key themes: 1. The existence of safety as an essential crucible of the EMDR experience 2. The importance of accessing the emotional core as vital to the recovery experience 3. The role of perspective

						Ethnicity African American (n=4) Caucasian (n=5) Mixed European-Iranian (n=1)	shift in lifestyle change 4. A combination of factors for successful treatment
9	Wise & Marich (2016)	U.S.A Community	To explore the lived experiences of persons with co-occurring PTSD and addictive disorders who received combined treatment of EMDR therapy standard protocols and addiction-specific protocols.	Qualitative – semi-structured interviews	Phenomenological Analysis	Participants n=9 **Gender** Female (n=6) Male (n=3) **Age** Range 28-60 (mean=43.4 years) **Ethnicity***	Four key themes: 1. Recognition of 2. addictive disorder as related to trauma 3. Integrated treatment as optimal for ongoing recovery from addictive and traumatic disorders 4. Relationship with the therapist is integral to successful EMDR therapy
10	Wood (2016)	U.K. Primary Care	To develop a framework to analyse EMDR therapy from a client viewpoint.	SCED: separated into three studies. The third study utilised semi-structured interviews to collect qualitative accounts from clients.	Framework Analysis	Participants n=13 **Gender** Female (n=8) Male (n=5) **Age** Range 29-65 (mean *) **Ethnicity** British (n=12) European (n=1)	Five key themes: 1. Helpful aspects of EMDR 2. Unhelpful aspects of EMDR 3. Comparison with other treatments 4. Relationship with the therapist 5. Friends and Family Test

11	Marsden (2016)	U.K. Primary Care	To present a series of three OCD cases treated by a single therapist applying one of the EMDR therapy protocols developed by Marr (2012).	Case study: Qualitative – semi-structured interviews	Thematic Analysis	Participants n=3 **Gender** Female (n=3) **Age** Range 18-50 (mean=36.0 years) **Ethnicity***	Three key themes: 1. Role of traumatic experiences 2. Role of shame 3. Importance of the therapeutic relationship
12	Marsden, Teahan, Lovell, Blore & Delgadillo (2018)	U.K. Primary Care	To investigate patients' experiences of the process and outcome of CBT and EMDR.	Qualitative – semi-structured interviews	Thematic Analysis	Participants n=24 **Gender** Female (n=17) Male (n =7) **Age** Range* (mean 31.8 years) **Ethnicity** White British (n=21) Other ethnicity (n=1) Not stated (n=2)	Six key themes: 1. Treatment rationale 2. Preparation techniques 3. Bilateral stimulation 4. Phases of treatment 5. Difficulties 6. Suggestions

13	Schwarz, Baber, Barter & Dorfman (2019)	U.S.A Community	To explore the impact of EMDR as a treatment modality for female clients who experience trauma resulting from sexual or domestic violence.	Mixed method Qualitative – semi-structured interviews	Thematic Analysis	Participants n=21 **Gender** Female (n=21) **Age** Range 20-60 (mean*) **Ethnicity** White (n=12) Latina (n=4) African American (n=3) Asian (n=1) Biracial (n=1)	Three key themes: 1. Accelerated progress and enhanced therapeutic outcomes 2. Decreased depression 3. Enhanced hope and confidence

Note. * indicates that this information was not reported in the study.

Quality of included studies

Qualitative research can be considered ‘good’ quality where it is credible, transferable, dependable, confirmable, and authentic (Guba, 1981; Lincoln, 1995). Good quality qualitative research should also be transparent, and this is important whether the study is published or not (Treharne & Riggs, 2015). When conducting a systematic review the quality of the included studies must be appraised; inclusion of studies which are of poor methodological quality or contain high levels of bias may have serious implications for the results of the review (Drucker et al., 2016). To help reviewers appraise the quality of studies included in systematic reviews a range of guidelines and tools have been developed (Mays & Pope, 2020).

The Critical Appraisal Skills Programme (CASP) qualitative checklist (2018) was used to assess the methodological quality of studies included in this review. The CASP qualitative checklist contains 10 questions and reviewers are asked to answer ‘yes’, ‘no’, or ‘can’t tell’ to each one. The CASP quality assessment for each study is shown in Table 3. With the exception of Marich (2009), it was possible to eventually answer ‘yes’ to each quality assessment question for all studies. Whilst Marich (2009) achieved ‘yes’ for eight questions, there were issues relating to the recruitment of the participant, and the relationship between the researcher and participant; these questions both received a response of ‘can’t tell’. Marich used a case study design, so whilst the recruitment of a single participant was considered appropriate there was no discussion about why this particular participant was selected over any others who might have been eligible to take part. In considering the relationship between the researcher and the participant, Marich declares that the participant was a former client of the researcher but does not discuss any potential issues related to this such as the risk of bias; in the conclusion, Marich briefly mentions that recruiting a larger sample and including clients whom the researcher has not been involved in treating in future studies would help to minimise the risk of bias. However, Marich does not provide sufficient detail to assure the reviewer that either of these issues have been adequately considered.

Interestingly, a distinct difference between the level of detail provided in published and unpublished studies was noted, with unpublished studies containing much greater detail which aided the quality appraisal process. One possible explanation for this is related to the more generous word count afforded to doctoral thesis projects in comparison with peer-reviewed journals. A larger word count allows the author to explore issues in more depth; this was particularly striking when considering potential ethical issues with many published studies simply stating ‘ethical approval was received from a review board’ compared with

several pages of exploration of ethical issues in thesis projects. The reviewer noticed feeling much more confident in the quality appraisal of unpublished studies compared with published ones, this was likely related to the level of detail provided which made determining whether a specific quality criterion had been met much easier.

Table 3

Methodological Characteristics included in the CASP Quality Appraisal

Author	Clear aims	Appropriate qualitative method	Appropriate research design	Appropriate recruitment strategy	Appropriate data collection	Relationship between researcher and participants considered	Ethical issues considered	Rigorous data analysis	Clear statement of findings	Valuable research
Schleyer (1999)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Edmond et al., (2004)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ricci & Clayton (2008)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Naccarato (2008)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stewart-Grey (2008)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brotherton (2009)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Marich (2009)	✓	✓	✓	?	✓	?	✓	✓	✓	✓
Marich (2010)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wise & Marich (2016)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Wood (2016)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Marsden (2016)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Marsden et al. (2018)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Schwarz et al., (2019)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note. Where the answer to the quality criteria question was 'yes' this is indicated by a ✓. Where the answer to the quality criteria question was 'can't tell' this is indicated by a ?.

Thematic synthesis

The process of thematic synthesis was applied to the 13 studies included in this review; through this process, four super-ordinate themes related to client experience of EMDR were identified: being introduced to EMDR, mechanisms of change, change attributed to EMDR, and the role of the therapist. Within these four super-ordinate themes, 11 subthemes were also identified.

Being introduced to EMDR

The super-ordinate theme 'being introduced to EMDR' was observed in five studies (1,4,6,8,12) and consisted of two subthemes 'initial scepticism' and 'importance of early sessions'.

The subtheme initial scepticism was observed in five studies (1,4,6,8,12) and related to how most clients expressed 'some level of scepticism when…first presented (with) EMDR, ranging from mild hesitation to outright fear' (Marich, 2010, p.502). Clients who were hesitant about EMDR expressed uncertainty about whether the intervention 'would be beneficial or not' (Stewart-Grey, 2008, p.80) with some clients believing that EMDR would not 'do a lot of good' (Brotherton, 2009, p.16). Those who reported feeling fearful described finding EMDR 'frightening and confusing' and said they were 'afraid of it being…very mentally invasive' (Naccarato, 2008, p.89). Initial scepticism appeared largely related to EMDR not being well publicised, with many clients reporting that before starting therapy they had 'never heard of it' (Brotherton, 2009, p.16; Schleyer, 1999, p.59). Clients who had some prior knowledge of EMDR expressed being unsure about the role of eye movements within the therapy which one client summed up as 'I don't know what moving your eyes about would do' (Brotherton, 2009, p.16) whilst other clients reported the method 'seemed kind of silly' at first (Naccarato, 2008, p.89), with clients who were offered EMDR using alternative forms of bilateral stimulation to eye movements finding this 'confusing' (Marsden et al., 2018, p.257).

The subtheme importance of early sessions was observed in four studies (1,6,8,12) and demonstrated how the initial scepticism reported by clients could be mitigated during the early stages of EMDR; once clients were familiarised with EMDR their initial anxieties appeared 'to dissipate as (they) became acquainted' with the therapy (Brotherton, 2009, p.18). Helping clients to understand the rationale for EMDR and the techniques involved was considered an essential first step and could be achieved through 'simple education from the therapist' (Marich, 2010, p.502). Creating a sense of safety within the initial sessions of EMDR was also important with clients needing to feel that they 'had the tools…and…safety nets' in place before embarking on the journey through the active stages of EMDR (Marsden et al., 2018, p.256). These factors were key in reducing the initial scepticism reported by

clients and replacing this with an ‘underlying sense of hope’ about EMDR and how effective it might be in helping clients address their difficulties (Brotherton, 2009, p.17).

Mechanisms of change

The super-ordinate theme ‘mechanisms of change’ was observed in 11 studies (1,2,3,4,6,7,8,9,10,11,12) and consisted of four subthemes ‘recognising past trauma’, ‘getting to the core’, ‘within-session change’ and ‘post-session change’.

The subtheme recognising past trauma was observed in six studies (1,3,7,9,11,12) and related to how EMDR had helped clients to recognise ‘where (their current difficulties) came from’ (Wise & Marich, 2016, p.238). Some clients reported that it was a ‘shock to go back and identify past occasions not dealt with’ (Marsden, 2016, p.99) and see how ‘their traumatic memories were contributing to their symptoms’ (Marsden et al., 2018, p.257). Clients reported that EMDR had enabled them to access past traumas and ‘connect with what had happened to (them)’ (Schleyer, 1999, p.72), after this clients were able to use EMDR to ‘process traumatic experiences’ (Marich, 2009, p.102) which resulted in their memories of traumatic events being less ‘emotion(ally) charged’ (Schleyer, 1999, p.72) and ‘not as traumatic’ (Marsden et al., 2018, p.257).

Related to recognising past trauma was the second subtheme getting to the core which was observed in four studies (2,6,8,10). Clients accessing EMDR often described having ‘deep-seated problems’ (Wood, 2016, p.153) and said that not only had EMDR played a crucial role in helping them to access the core of their problems but that doing so had positively impacted their recovery (Marich, 2010). Clients often used analogies to describe how EMDR targeted the core of their difficulties, for example, ‘instead of working from the outside layers of an onion to reach the core inside as traditional therapy does, EMDR allows you to go straight to the core (and) resolve the issue’ (Edmond et al., 2004, p.267). Clients cited getting to the core of their difficulties as one of the main reasons that they experienced positive change as a result of EMDR.

The third subtheme within-session change was observed in four studies (1,4,6,12) and related to the way clients described experiencing changes within EMDR sessions; these changes ranged from clients feeling more relaxed (Marsden et al., 2018) to feeling ‘totally different’ about themselves (Schleyer, 1999, p.70). Clients often attributed these within-session changes directly to the bilateral stimulation techniques which ‘helped to reduce the vividness and distress associated with (traumatic) imagery’ (Brotherton, 2009, p.21). However, not all the within-session changes experienced by clients were positive, with one client reporting that by the end of EMDR sessions they would be ‘shaking and deeply

frightened and much more agoraphobic than when (they) went in that morning (Naccarato, 2008, p.106).

The fourth subtheme post-session change was observed in eight studies (1,2,4,6,7,9,10,12) and related to the way clients experienced changes that occurred outside the therapy room either between sessions or after EMDR therapy had ended. Some clients simply described leaving EMDR sessions feeling 'better than when (they) went in' and that those improvements continued beyond the session itself (Wood, 2016, p.153), with some clients describing a 'domino effect' of positive changes following EMDR sessions (Brotherton, 2009, p.23). More specific examples of positive post-session changes were described by clients as reductions in the number and intensity of flashbacks (Brotherton, 2009) and as gaining increased levels of insight which continued to occur between sessions (Schleyer, 1999). However, not all post-session changes experienced by clients were reported as being positive; one client reported that after having EMDR they would feel 'really low for a couple of days' (Brotherton, 2009, p.24). Some clients with OCD reported that after having EMDR their 'stress levels (went) up and the checking…got worse' (Marsden et al., 2018, p.257). Other clients reported feeling worse after having EMDR and being 'more symptomatic when (they) were done with the process than at the beginning' (Naccarato, 2008, p.105).

Change attributed to EMDR

The super-ordinate theme 'change attributed to EMDR' was observed in 10 studies (1,2,3,4,5,6,7,8,9,13) and consisted of three subthemes 'transformation', 'symptom reduction' and 'gaining a new perspective'.

The subtheme transformation was observed in four studies (5,6,7,13) and related to the profound level of change clients experienced due to EMDR with some clients describing the therapy as 'life-changing' (Brotherton, 2009, p.24; Stewart-Grey, 2008, p.80). Whilst others described their transformation as being 'freed from (the) victim role' (Marich, 2009, p.103) and as being returned to 'more of who (they) used to be' (Schwarz et al., 2019, p.9). The transformation that clients experienced was aided by the second subtheme symptom reduction which was observed in four studies (2,8,9,13). Clients noted that because of EMDR their symptoms of depression decreased, and they reported not 'feeling as apathetic' or 'as sad about…life' (Schwarz et al., 2019, pp.9-10). One client reported that 'treating…trauma through EMDR eliminated the majority of (her) mental health symptoms, even the traits of (her) borderline personality disorder (Marich, 2009, p.503). Symptom reduction was also supported by clients perceiving less need for additional therapy, with some clients reporting their difficulties felt 'totally resolved' after EMDR (Edmond et al., 2004, p.268) whilst others shared that 'EMDR was one of the most effective forms of therapy they

had experienced' (Schwarz et al., 2019, p.8). Transformation was also aided by the third subtheme gaining a new perspective which was observed in eight studies (1,2,3,4,5,7,8,9). Many clients reported 'some type of perspective shift that happened…as a result of EMDR' (Marich, 2010, p.503). These perspective shifts helped clients to 'face the past and move on' (Marich, 2009, p.103) which was experienced as 'tremendously healing' (Marich, 2010, p.503) with clients doubting that they 'would have gotten the revelations' without EMDR (Stewart-Grey, 2008, p.80).

The role of the therapist

The super-ordinate theme 'role of the therapist' was observed in nine studies (1,2,4,6,7,8,9,10,11) and consisted of two subthemes 'therapist as a person' and 'therapist as a practitioner'.

The subtheme 'therapist as a person' was observed in eight studies (1,4,6,7,8,9,10,11) and related to how clients described the relationship with their EMDR therapist, with several factors being considered important for a therapeutic relationship to develop. Client's described feeling that it was 'really important…to (have) a good connection with (the therapist)' (Naccarato, 2008, p.91) and considered trusting the therapist as important for helping to 'deal with...the things that…come up' during EMDR (Schleyer, 1999, p.61). Clients reported that feeling connected to, comfortable with and trusting their EMDR therapist were important factors required for 'EMDR to progress smoothly' (Wood, 2016, p.156) and for achieving 'good results' in therapy (Marich, 2010, p.502). Overall, clients considered positive therapeutic relationships with their EMDR therapist to be associated with developing a sense of safety and trust which were key for 'successful treatment' (Wise & Marich, 2016, p.239). However, one study (Edmond et al., 2004) found that clients experienced an absence of the therapeutic relationship in EMDR but despite this were still able to achieve positive outcomes, introducing the idea that the therapeutic relationship may play a less critical role in EMDR than in other types of therapy.

The subtheme 'therapist as a practitioner' was observed in six studies (1,2,4,6,8,9) and related to the importance of the therapist being familiar with and competent in EMDR. Throughout therapy it was important for clients to trust that the therapist was competent 'because (EMDR is) in their hands' (Brotherton, 2009, p.17); with trust being closely linked to clients having confidence 'in the (therapist's) ability' (Schleyer, 1999, p.61). The therapist was thought to be the expert in EMDR, and it was considered their role to act as a 'guide or coach' throughout the therapy process (Naccarato, 2008, p.91), with clients who felt they were 'in capable hands with (the) therapist (having) fulfilling experiences of EMDR' (Marich, 2010, p.502). For some clients, the therapist's knowledge of EMDR and their ability to use the skills and techniques within the approach were considered the most important factors for

successful treatment (Edmond et al., 2004); also, it was important for the therapist to be confident enough with the protocols and techniques so that these could be applied flexibly such as when it may be 'necessary to do more talk therapy and resourcing' before starting the processing stage (Wise & Marich, 2016, p.240).

Discussion

As the evidence supporting the effectiveness of EMDR continues to grow researchers have begun to turn their attention to how the therapy is experienced by clients. The use of thematic synthesis in this review has generated valuable insight into what clients perceive the mechanisms of change in EMDR to be; with some of these mechanisms regarded as unique to EMDR. Clients highlighted that 'recognising past trauma' as a factor in their current distress and 'getting to the core' of their difficulties as key components of EMDR resulting in significant improvements in symptomology and positive changes in their lives. Clients credited bilateral stimulation as the mechanism responsible for producing within-session change, supporting the earlier claim that bilateral stimulation makes a distinct contribution to outcomes in EMDR (Kuiken et al., 2010).

The findings of this review broadly support the idea that clients experience positive change resulting from EMDR, a finding shared with Whitehouse (2020). However, this review has also uncovered client accounts relating to negative experiences of EMDR, with some clients reporting having deteriorated because of therapy. Except for one published study (Marsden et al., 2018), all other negative experiences were found within the grey literature; this finding helps to clarify the uncertainty raised by Bisson et al. (2007) and Cusack et al. (2016) about whether negative experiences of EMDR are not reported because they do not exist, or whether they are simply ignored. It seems clear that some clients do in fact have negative experiences of EMDR, yet these experiences are rarely published, thus creating an illusion within the literature that EMDR is a universally positive experience for clients.

Strengths and limitations of this review

There were several limitations of the studies included in this review and these have important consequences for the generalisability of the review findings. Given that all included studies had recruited their samples from community settings the views of other client groups, for example, clients within inpatient settings are not represented and we must be cautious about assuming that clients in alternative settings share the experience of clients living in the community; it is possible that clients may differ on characteristics such as symptom severity, level of functioning, and risk, and that EMDR may not be deemed suitable or acceptable to clients within inpatient settings, however, this has not been explored by the studies included

in this review. A positive skew towards the representation of the female voice was observed in the studies included in this review. Although recovery rates between genders appear comparable (Gavolski et al., 2013), it remains unclear whether gender differences exist in how clients experience therapy itself. Several studies included in the review presented quotations from participants anonymously thus making it difficult to ascertain how much the voice of male participants has been heard within those studies, or indeed in this review. In addition, the client accounts included in this review represent a working age population; recently researchers have begun to explore the use of EMDR with alternative populations such as children, yet attempts to understand whether EMDR is an acceptable treatment option or how children might experience the therapy appear to be absent from both the published and unpublished literature.

The reviewer acknowledges that by working independently at all stages of the review to identify, screen, appraise, and synthesise the included studies, that a potential risk of bias may have been introduced into the review. Although the reviewer adhered to a pre-registered protocol, it is conceivable that the exclusion of peer or supervisory checks at different stages is a limitation of this review.

One of the main strengths of this review is the inclusion of grey literature sources; through the inclusion of unpublished studies, it has been possible to uncover several accounts of negative experiences of EMDR and present them in the review. In doing so, the review provides support for the possible existence of a reporting bias towards positive experiences of EMDR. In addition, the review used wide search terms to ensure that relevant literature was not lost through a restrictive search strategy, even so, it is noted that the included studies represent just 0.53% of the retrieved literature on EMDR (excluding duplicates).

Recommendations

Qualitative research is needed to explore client experiences of EMDR across populations, including clients with intellectual disabilities, children, older adults, and inpatients. In doing so, it may be possible to compare client experiences across these populations in a future systematic review and understand whether there are experiences of EMDR that are consistent across, or unique to, different populations.

Further exploration of the negative client experiences of EMDR uncovered in this review is recommended. The findings of this review clearly show that negative experiences of EMDR do exist; understanding these in more depth and publishing such findings would make valuable contributions to the literature on EMDR.

Conclusions

Overall, the aims of this review have been met; client accounts of their experiences of EMDR have been explored, broadly supporting the notion that positive change is experienced because of the therapy. The review has also provided valuable insight into what clients perceive the mechanisms of change in EMDR to be.

The review has included published studies and grey literature, ensuring that the voices of clients involved in unpublished studies are now represented within the literature. Furthermore, the review has uncovered several client accounts relating to negative experiences of EMDR and incorporated these into the review, ensuring a holistic view of client experience is presented; in doing so, the review supports the possible existence of a reporting bias within the literature towards positive experiences of EMDR. The review concludes by advocating for further exploration and publication of negative client experiences of EMDR.

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Systematic Literature Review Appendices

Appendix A: Justification for Exclusion Criteria

Studies were excluded from the review if they were not available in English; the reviewer is unable to read in any other language and resources were not available to translate papers in this review.

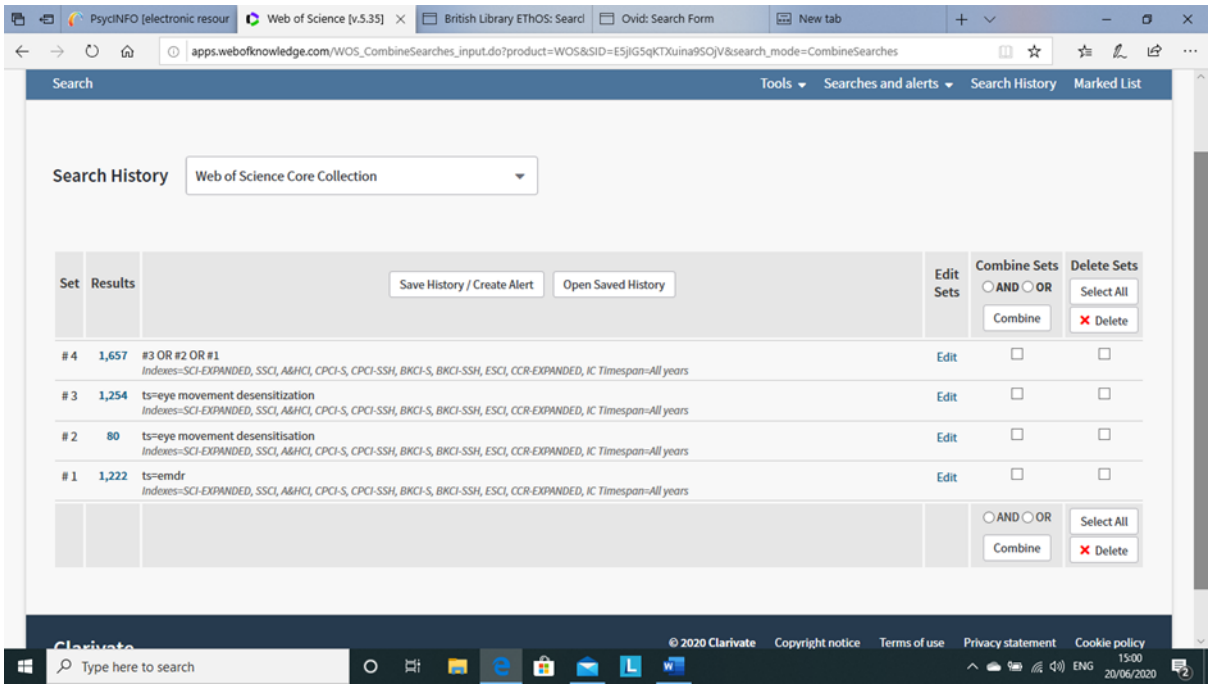
Studies that were unavailable as full-text articles would also be excluded as it would not be possible to analyse the results section as this would not be accessible.

Studies were also excluded if EMDR had been offered to clients as an integrated approach (i.e. EMDR techniques combined with other therapeutic techniques); in cases such as this, it is unlikely that clients would be able to isolate aspects of integrated approaches that solely related to EMDR, also the review question is concerned with how EMDR is experienced as a therapy in its entirety rather than as separate techniques.

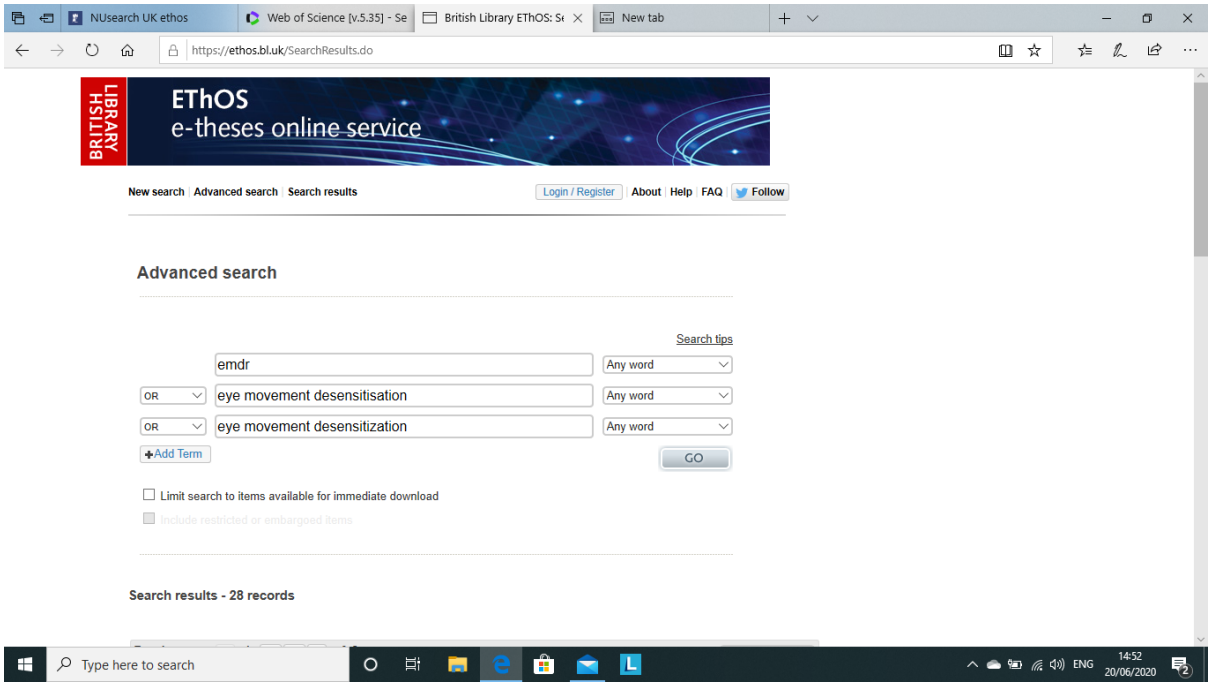
Studies that focussed on a perspective other than the client, or where the client's perspective was presented as entwined with another perspective (e.g. therapist or carer), would be excluded as it would not possible to separate themes from different perspectives.

Appendix B: Example of a Search Strategy

Example of the search strategy used to search the Web of Science online database.



Example of the search strategy used to search the EThOS online database.



Journal Paper

The journal paper has been formatted in accordance with the guidelines for the European Journal of Trauma and Dissociation. Retrieved from: https://www.elsevier.com/journals/european-journal-of-trauma-and-dissociation/2468-7499/guide-for-authors

Exploring Therapists' experiences of using Eye Movement Desensitisation and Reprocessing Therapy with Children and Young People

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Abstract

Background: Eye Movement Desensitisation and Reprocessing (EMDR) therapy is an effective treatment for trauma-related distress and is increasingly utilised as a psychotherapeutic intervention for children and young people. However, within the literature, it is unclear how therapists experience delivering EMDR to this client group. This study aimed to explore therapists' experiences of using EMDR therapy with children and young people and to understand the perceived barriers and facilitators to adapting and implementing the approach with this client group.

Method: A qualitative approach was used within this study; data was collected through semi-structured interviews conducted with therapists offering EMDR therapy to children and young people. All interviews were transcribed verbatim and analysed using Reflexive Thematic Analysis.

Findings: Seven female therapists participated in the study. Therapists worked in public sector and private practice settings and had between one and 15 years of experience using EMDR with children and young people. Two key themes and six subthemes were generated; the key themes were 'Putting EMDR into Practice' and 'Working Systemically'.

Conclusions: Therapists considered EMDR to be an appropriate intervention for children and young people. However, some adaptations to the standard EMDR protocol were required to ensure its developmental appropriateness, enhance engagement, and improve therapeutic outcomes. Supervision was viewed as helpful for therapists when thinking about when and how to make adaptations, as well as providing a space to think about how to work with wider systemic issues.

Key Words: EMDR, Eye Movement Desensitisation, Therapist Experience, Children and Young People, Reflexive Thematic Analysis, Qualitative

1. Introduction

Eye Movement Desensitisation and Reprocessing (EMDR) Therapy was first conceptualised as a trauma-focused intervention by Francine Shapiro in 1989. Shapiro (1989a, 1989b) suggested that trauma-related distress could be effectively reduced by encouraging clients to generate multi-saccadic eye movements, as a form of bilateral stimulation (BLS), whilst concentrating on trauma memories in order to process the experience more adaptively.

Although originally reported to have been discovered by chance, Shapiro later systematically studied the effects of multi-saccadic eye movements amongst large numbers of clients and volunteers, to explore their therapeutic potential (for further information on the development of EMDR see extended paper, section 9.1). Whilst multi-saccadic eye movements have been shown to make a distinct contribution to EMDR outcomes (Jeffries & Davis, 2013; Kuiken et al., 2010; Nieuwenhuis et al., 2013), the original protocol was later updated to also include alternative methods of BLS, including tactile or sensory BLS, such as that elicited through tapping (Beer & De Roos, 2004), as well as the use of auditory tones (Shapiro, 2007).

The theoretical underpinning for EMDR is provided by the Adaptive Information Processing (AIP) model (Shapiro, 2007 – for further discussion of the AIP model see extended paper, section 9.2; for consideration of the AIP model in the context of using EMDR with CYP please see extended paper, section 9.9). According to the AIP model, human beings possess an innate information processing system that is responsible for processing and integrating the component parts of our experiences, before committing these to memory. The AIP model posits that if an individual experiences a traumatic event and their information processing system fails to adequately process and integrate the component parts of that experience then this will result in the dysfunctional storage of the associated trauma memory. Therefore, it has been suggested that if at a later time, trauma memories can be processed and integrated more adaptively, this is likely to reduce any accompanying distress. In EMDR, the adaptive processing and integrating of trauma memories are said to be facilitated through the process of BLS (Jeffries & Davis, 2013; Shapiro & Maxfield, 2002; van den Hout et al., 2001[for further discussion of the proposed mechanisms of action in EMDR see extended paper, section 9.3]).

Since its inception, the evidence base supporting the efficacy and effectiveness of EMDR as a treatment option for adults experiencing trauma-related distress has grown (for further empirical support see extended paper, section 9.4). The findings of a meta-analysis performed by Chen et al., (2014) supported EMDR as an efficacious treatment option which was able to significantly reduce symptoms of post-traumatic stress disorder (PTSD, [g = -

0.662; 95% confidence interval (CI): -0.887 to -0.436]), anxiety (*g* = -0.640; 95% CI: -0.890 to -0.390), depression (*g* = -0.643; 95% CI: -0.864 to -0.422), and subjective distress (*g* = -0.956; 95% CI: -1.388 to -0.525). However, caution was advised when interpreting these findings due to the presence of considerable variation in study design, sample size, and outcome measurement used by the randomised control trials (RCTs) included in the meta-analysis.

Over time, meta-analytic studies have also sought to establish the effectiveness of EMDR and have shown that treatment using this approach can achieve equivalent, and sometimes even superior outcomes, compared with other psychotherapeutic interventions (Bisson et al., 2013; Khan et al., 2018). A meta-analysis of RCTs by Bisson et al., (2013) compared the effectiveness of EMDR as a treatment for PTSD with trauma-focused and non-trauma-focused cognitive behavioural therapy (CBT), other individual therapy approaches (e.g., supportive therapy, non-directive counselling, psychodynamic therapy, person-centred therapy), group therapy, treatment as usual, and waitlist controls. Findings showed that EMDR was equally as effective as trauma-focused CBT in reducing clinician-rated PTSD symptom severity with evidence of superiority over non-trauma-focused interventions at follow-up. However, the authors noted a high risk of bias within the studies included in the meta-analysis and highlighted considerable, unexplained heterogeneity. Many of the included studies were considered to have achieved a small sample size, be underpowered, and have significant methodological flaws. Furthermore, the evidence supporting each of the comparisons between treatment approaches was assessed as being of very low quality with limited follow-up data provided, meaning that longer-term effects could not be reliably established.

Similar conclusions were reached by Khan et al., (2018) in their meta-analysis of 11 studies comparing EMDR with non-trauma-focused CBT as a treatment option for PTSD and associated symptoms including anxiety and depression. EMDR was shown to be better than CBT in reducing symptoms of PTSD and anxiety at the end of treatment, however, there was no evidence to support the superiority of EMDR at a three-month follow-up. Furthermore, no difference was found between the two approaches in reducing symptoms of depression. The authors noted similar limitations to those identified by Bisson et al., (2013) noting that within the included RCTs relatively small sample sizes had been achieved, high levels of bias relating to blinding procedures were present, and limited follow-up data had been reported (for additional limitations see extended paper, section 9.5).

Given that EMDR was developed with an adult population in mind, it is perhaps unsurprising that much of the subsequent research attention has been focused on this client group and therefore has the strongest evidence base. With this evidence in mind, it has been possible for Health Education England to commission the development of a

competence framework for the use of EMDR with adult clients (Roth et al., 2021). The EMDR framework was originally developed to highlight the competences required for the effective use of EMDR as a treatment for PTSD among adult clients accessing primary care settings. However, it was soon recognised that these competences were also applicable to the use of EMDR in the treatment of trauma in the context of a wide range of mental health presentations and would also be appropriate for practitioners working in secondary care services (see section 12 for further discussion of the EMDR competence framework).

More recently, researchers have started to explore the efficacy and effectiveness of EMDR as a treatment option with other client groups, such as adults with intellectual disabilities (Unwin et al., 2019) and children (Moreno-Alcazar et al., 2017), due to recognising the high prevalence of traumatic events experienced by these groups. For children and young people (CYP), there is wide variation in the estimated prevalence of exposure to traumatic events, and the circumstances under which such exposure might lead to the development of PTSD or related symptoms (Alisic et al., 2014). However, exposure to traumatic events during childhood and adolescence has been consistently recognised to have long-lasting, far-reaching implications for individuals throughout their lives (Felitti et al., 1998).

Given that the human brain continues to develop and mature throughout childhood and adolescence (see extended paper, section 9.6 for information about structural brain development and section 9.7 for childhood cognitive development), CYP are particularly vulnerable to developing the potentially life-long consequences of childhood trauma (Moreno-Alcazar et al., 2017). Research suggests that CYP who are exposed to traumatic events are at an increased risk of developing physical health conditions including diabetes, migraines, obesity, and cardiovascular disease (Javidi & Yadollahie, 2012; Nemeroff, 2016). Research also suggests that when the development of a mental health difficulty is related to an experience of trauma, such as is often the case for diagnoses of PTSD, personality disorder, substance use disorders, depression, bipolar affective disorder, and schizophrenia, then the onset of these difficulties is more likely to occur during childhood and adolescence (Luthra et al., 2009; McLaughlin et al, 2012). Therefore, to try and prevent these adverse, long-term effects of trauma, it is paramount that CYP can access fast-acting, effective, trauma-focused interventions (Racco & Vis, 2015). (See extended paper, section 9.8 for a discussion of the impact of trauma on the brain).

In clinical practice, EMDR is steadily increasing in popularity among clinicians and is becoming increasingly accessible to CYP as a treatment option for trauma-related distress (Landin-Romero et al., 2018). Research findings suggest that EMDR is an efficacious treatment option for CYP with a diagnosis of PTSD (Maxfield, 2019; Rodenberg et al., 2009). Further research suggests that EMDR is also effective in reducing the symptoms of anxiety,

depression, and behavioural difficulties (Ahmad et al., 2007; Farkas et al., 2010). Moreover, offering EMDR to CYP is at least as effective as trauma-focused CBT, but capable of producing improvements within a shorter period (De Roos et al., 2011; Jaberghaderi et al., 2004). As a result, the UK National Institute for Health and Care Excellence (NICE) guidelines have recommended EMDR as a treatment option for CYP. It is suggested that EMDR should be considered for those aged between 7-17 who have received a diagnosis of PTSD or who are experiencing trauma-related symptoms, have experienced a traumatic event more than three months ago, and have not responded to or engaged with trauma-focused CBT (NICE, 2018 – for further discussion see extended paper, section 9.4). However, although EMDR therapy is considered an empirically supported treatment option for children and young people experiencing trauma-related distress and has been recommended as a treatment option by NICE (2018), it must be acknowledged that the evidence base is relatively sparse in comparison with that for adults (Maxfield, 2019).

It has been suggested that following the EMDR treatment manual is essential for achieving positive treatment outcomes (Maxfield & Hyer, 2002), however, there is evidence to support that the approach can be adapted when working with CYP and that successful treatment outcomes can still be achieved (Ahmad & Sundelin-Wahlsten, 2008). In clinical practice, the need to make developmentally appropriate adaptations to the standard EMDR protocol, whilst remaining adherent to the fundamental principles of the approach, is recognised as necessary, particularly when working with CYP (Courtney, 2016; Hase, 2021). Therefore, it is important that therapists and researchers alike continue to investigate and develop creative tools to assist the engagement of CYP (Adler-Tapia & Settle, 2008; Gomez, 2013; Malchiodi, 2005; Webb, 2003).

Some suggest that adaptation to the standard EMDR protocol may be required less frequently when working with adolescent clients due to their stage of development, meaning they are often more able to engage with the abstract nature of EMDR than younger children (Courtney, 2016). However, for some CYP who have experienced trauma during childhood, this can result in developmental delays, meaning that they may present as being ‘emotionally off-age’. Therefore, therapists should consider both chronological and emotional age to ensure that developmentally appropriate adaptations to EMDR protocols and processes can be made to engage clients in a meaningful way.

Perhaps one of the most obvious adaptations when using EMDR therapy with CYP is the incorporation of play. Play is a natural method of communication for children and so arguably makes it the best modality for the expression of thoughts and feelings (Gomez, 2013). Moreover, by incorporating play and other creative, developmentally appropriate adaptations into EMDR therapy, therapists have been able to gain enhanced engagement from CYP, reduce resistance to treatment, and decrease the child’s level of stress and

experience of fear associated with processing traumatic memories (Landreth, 1991; Gomez, 2013; Malchiodi, 2005; McNiff, 1992; Ruddy & Dent-Brown, 2007; Webb, 2003). Furthermore, the integration of creative modalities with EMDR therapy can also help to improve therapist confidence when working with CYP, which has also been shown to be related to successful therapeutic outcomes (Adler-Tapia & Settle, 2008; Gomez, 2013). However, it remains unclear how able therapists are to integrate creative modalities into their EMDR practice and whether they are supported and resourced to do this effectively within their clinical roles.

Therapists offering trauma-focused interventions to CYP report facing many challenges in their work, including feeling uncomfortable holding space for traumatic material, having difficulty engaging CYP in the therapeutic process, resistance to treatment, lack of confidence using trauma-informed approaches, not having access to developmentally appropriate interventions, and a lack of experience adapting interventions to improve their developmental appropriateness (Courtney, 2016; Kazdin et al., 1990; Lambert, 1992; Malchiodi, 2005; Purnell, 2010). For therapists offering EMDR therapy to CYP, similar challenges have been experienced, in particular, difficulty engaging them in the EMDR process, avoidance of processing, and the developmentally inappropriate language used within the protocol (Adler-Tapia & Settle, 2008). Moreover, therapists' confidence in using EMDR and their level of understanding of child development have also been shown to be factors which influence their ability to use EMDR effectively with CYP (Adler-Tapia & Settle, 2008). Further understanding of these challenges is therefore needed, as engagement, therapist confidence, and developmentally appropriate adaptations are key to successful therapeutic outcomes when working with CYP (Adler-Tapia & Settle, 2008; Chatoor & Krupnick, 2001; Eisler, 2006; Lambert, 1992; Orlinsky et al., 1994; Simon, 2006). Previous studies suggest that therapists tend to make decisions about how to intervene and adapt the approaches they use based on their expertise (van den Berg et al., 2013), however, at least 40% of therapists using an EMDR approach with adult clients report having difficulty integrating this into their clinical practice due to workplace constraints, lack of appropriate supervision and consultation, and scepticism from colleagues (Dunne & Farell, 2011; Grimmett & Galvin, 2015). There is currently little understanding of whether similar processes occur amongst therapists working with CYP.

At present, very little qualitative research focusing on therapists' experiences of offering EMDR therapy as a treatment option has been published (Dunne & Farell, 2011 - see extended paper, section 9.10 for further rationale). For this study, the researchers aimed to explore therapists' experiences of using EMDR therapy with CYP, including how they might adapt the approach when working with this client group, and to understand the

perceived barriers and facilitators when adapting and implementing EMDR protocols with CYP.

2. Method

2.1 Design

A qualitative approach was utilised in the study to explore therapists' experiences of using EMDR therapy with CYP. By employing a qualitative methodology, it was possible to explore individual experiences of clinical practice as well as consider shared experiences amongst therapists (Hammarberg et al., 2016). Data was collected through semi-structured interviews and analysed using Reflexive Thematic Analysis, following the six stages set out by Braun and Clarke (2006, 2019). Thematic analysis is a flexible approach and can be used with a range of theoretical and epistemological positions (Braun & Clark, 2006) as it allows for the study of multiple perspectives in service of the development of a deeper understanding of a given phenomenon (Barker et al., 2016). (See extended paper, section 10.1 for further information on the study design and epistemological position).

2.2 Sampling and Procedure

Snowball sampling was used to recruit EMDR therapists working with CYP across the United Kingdom (n = 7). Potential participants within the first author's professional network were approached and asked to share the study advert with colleagues trained in and using EMDR with CYP. Study advertisements were also posted on social media platforms with other users being asked to share the advert with their followers. Participants were invited to take part in the study if they met the inclusion criteria: (a) received formal training in EMDR therapy; (b) offered EMDR therapy to CYP under the age of 18; (c) practice in the United Kingdom; (d) speak English. (See extended paper, section 10.2 for further information on sampling and procedure).

2.3 Ethics

The study was granted ethical approval by the Division of Psychiatry and Applied Psychology Ethics Subcommittee at the University of Nottingham. (See extended paper, section 10.3 for further information on ethics).

2.4 Data Collection

Participants were invited to take part in one semi-structured interview, all of which were conducted by the first author. Interviews took place using the virtual platform, Microsoft Teams and were audio-recorded. Interviews lasted for approximately one hour.

An interview schedule was developed based on the research questions and the existing research literature. All members of the research team contributed to the development of the interview schedule, which comprised 11 over-arching, open-ended questions (see Table 4). The questions included in the interview schedule were intended to facilitate an in-depth conversation about: (a) therapists' experiences of using EMDR with CYP, (b) views on adapting EMDR for use with CYP, (c) thoughts on current EMDR guidelines, (d) perceived facilitators and barriers to using EMDR with CYP, (e) perspectives on EMDR in comparison with other therapeutic approaches, (f) considerations when integrating EMDR with other therapy modalities.

Participants were also asked to provide brief demographic information at the beginning of the interview. (See extended paper, section 10.4 for further information on data collection).

Table 4.

Interview Schedule

1.	Can you tell me about your experiences of using EMDR with children or young people?
2.	Can you tell me your thoughts about any guidelines you have come across for

using EMDR with children and young people?

3. Can you tell me about your thoughts on adapting EMDR protocols for use with individual children or young people?
4. Can you tell me about any adaptations you have made to the standard EMDR protocol when working with children and young people?
    a) From your perspective, why were these adaptations necessary?
    b) What was the outcome of making these adaptations?
        I. For the client
        II. For your subsequent practice
    c) What support, if any, did you seek when making these adaptations?
    d) Can you tell me about your experience of involving parents or carers during the intervention?
5. What sorts of things seem to be helpful when you are using EMDR with this client group?
6. What sorts of things do children or young people tend to find difficult when using this intervention, from your perspective?
    a) What adaptations have you considered or made in your own practice to try and address these difficulties?
    b) What was the outcome of making these adaptations?
7. Can you tell me about any barriers you have faced when using EMDR with children and young people?
    a) How did you address these barriers?
    b) What was the outcome?
8. Compared with other approaches, how have you found using EMDR with children and young people?
9. Can you tell me about times where you have integrated EMDR with other approaches as an intervention for this population?

a) From your perspective, why was integration with other approaches necessary?

b) What was the outcome of the integration?

I. For the client

II. For your subsequent practice

c) What support, if any, did you seek when integrating approaches?

10. Are there any other things you think therapists should consider when supporting children and young people when using this approach?

11. Is there anything else you would like to tell me that we've perhaps not talked about, that might be important for me to know?

2.5 Data Analysis

The seven interviews were transcribed verbatim and subsequently analysed according to the six phases of Reflexive Thematic Analysis outlined by Braun and Clarke (2006, 2019). Data analysis was completed manually using a predominantly inductive, semantic approach. (See extended paper, section 10.5 for further information on data analysis).

3.Results

Seven female therapists participated in the study. Therapists had been using EMDR therapy with CYP for between one and fifteen years (M = 4.64, SD = 4.08). They worked in a variety of settings including, the local authority (n = 1), school (n = 1), Child and Adolescent Mental Health Services (n = 2), and private practice (n = 3).

Table 5 shows participant characteristics. (See extended paper, section 11 for further results).

Table 5.

Participant Characteristics

Participant	Gender	Job Title	Length of time using EMDR with CYP
Emma	Female	Therapeutic Social Worker	2 years
Tina	Female	Clinical Psychologist	1 year 6 months
Claire	Female	Clinical Psychologist	4 years
Vicky	Female	Psychotherapist	5 years
Ruth	Female	Integrative Counsellor	4 years
Jane	Female	Lead Clinical Psychologist	1 year
Cora	Female	Counselling Lead	15 years

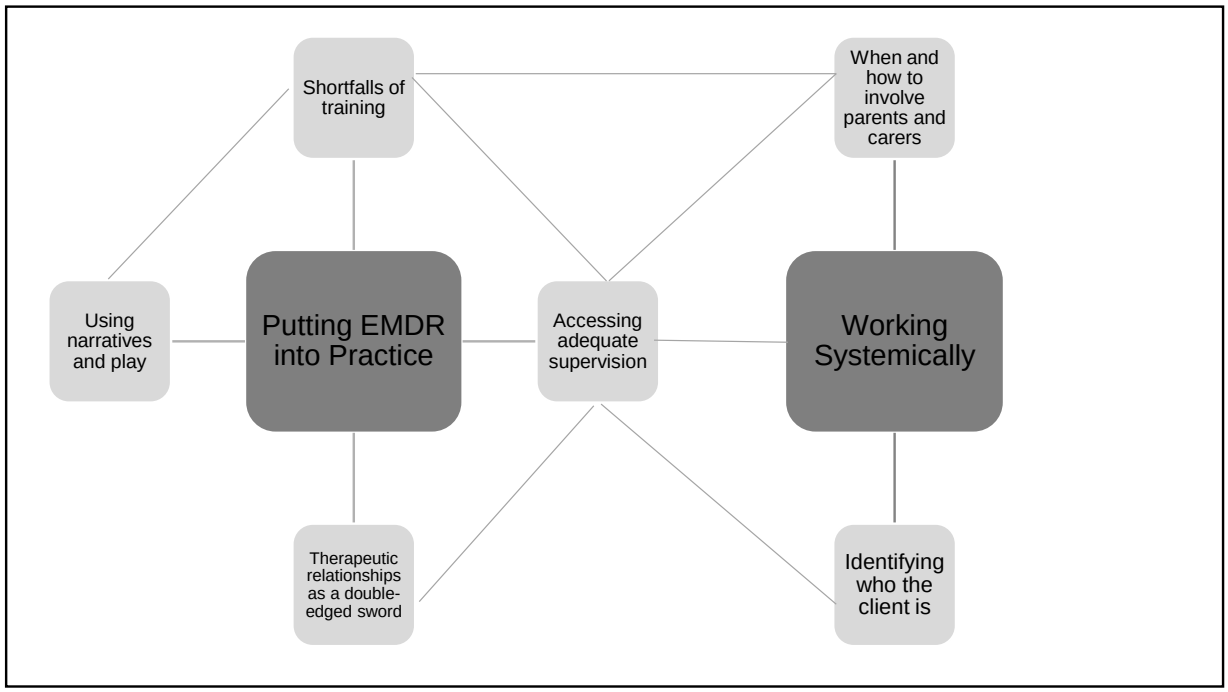
3.1 Key Themes

Two key themes and six subthemes were generated from the interview data. The main themes were ‘Putting EMDR into Practice’ and ‘Working Systemically’. The themes were considered in the context of the research aim of exploring therapists’ experiences of using EMDR therapy with CYP and understanding the perceived barriers and facilitators to implementing and adapting an EMDR approach with this client group (see extended paper, section 11.1 for further discussion of themes).

The relationship between the themes is presented using a thematic map (see Figure 2).

Figure 2.

Thematic Map



Theme 1: Putting EMDR into Practice

Within this theme, the way therapists developed their EMDR practice was explored. Completion of specialist EMDR training was considered necessary, but not sufficient, to begin offering the intervention to CYP, whilst appropriate supervision, use of creative adaptations, and a focus on the therapeutic relationship were thought to be key to developing confidence and self-perceived competence in using EMDR as a psychotherapeutic intervention with this client group. Therapist experiences of putting EMDR into practice were explored within four subthemes: *shortfalls of training, accessing adequate supervision, using narratives and play,* and *therapeutic relationships as a double-edged sword.*

Shortfalls of Training. Generally, therapists had some prior knowledge of EMDR before attending their specialist training. Most reported a first impression of

EMDR as being an ‘odd therapy’, which was both difficult to explain to others and understand themselves, especially in terms of the mechanisms of action.

> ‘’Let's be honest, EMDR looks weird anyway. So, I do think that is a potential barrier that, you know, unless you are super, unless you feel confident, it's hard to sell it….it is hard to explain.’’ (Tina, Clinical Psychologist).

For some, the way EMDR was described during training was considered misleading; therapists reported being taught that there was a specific way to deliver the intervention which, for many, did not translate into their experiences of working therapeutically with CYP.

> ‘’I guess when you do your training, it's like you join a cult and it's like this is the only way to do it. And this is amazing.’’ (Jane, Clinical Psychologist).

As a result, EMDR was initially perceived by some as ‘a doing to someone therapy’ (Claire, Clinical Psychologist), due to the structured, manualised way in which it was presented. And so, for some therapists, this meant that it took ‘a little bit of time to accept EMDR’ (Cora, Counselling Lead) as an appropriate psychotherapeutic intervention for CYP.

Although all therapists had attended the Child and Adolescent EMDR training, many believed this had not sufficiently equipped them for working clinically with this population. In particular, the training provision was considered to lack a detailed focus on how to work with CYP who have experienced complex developmental trauma or where complicating systemic factors are identified.

> ‘’Some of it really felt like, overly basic about teaching you the influence of systemic factors…it just felt really not pitched at the right level.’’ (Claire, Clinical Psychologist).

In summary, completion of the Child and Adolescent EMDR training was recognised as a necessary starting point for therapists planning to use the approach in their clinical practice. However, such training was perceived as overly basic in relation to exploring some of the integral elements of working with CYP, such as the influence of systemic factors. Overall, completion of specialist EMDR training alone was not considered sufficient in preparing therapists for working therapeutically with CYP.

Accessing Adequate Supervision. When working clinically, therapists valued having access to EMDR supervision with someone 'who (knew) more about EMDR than (they did)', (Claire, Clinical Psychologist). Therapists also considered it beneficial to have a supervisor who had experience working with CYP, as well as someone familiar with the service setting they were operating within. Overall, therapists believed that access to a supportive supervision experience was crucial to developing both confidence and competence in using EMDR. However, some therapists believed that 'there are not enough supervisors for…EMDR child therapists', (Cora, Counselling Lead) which made it difficult for them to access the support required to effectively develop their clinical practice.

For some, supervision provided a space to reflect on claims made during training that therapeutic change could be achieved more quickly when using EMDR compared with other psychotherapeutic interventions. For therapists working with CYP who had experienced complex developmental trauma, this idea was particularly challenging, as, within this population, therapeutic change was perceived to take longer and require more sessions than proposed during training or than discussed in the existing literature.

> ''When I first did my training my, you know, standard EMDR, I thought great, you know, going to be able to help people really, really quickly. How wonderful. And then yeah, it became very clear that actually, yeah, that that's

not going to be the case with the population that I work with.'' (Emma, Therapeutic Social Worker).

Amongst these therapists, having access to appropriate supervision was considered vital to ensuring that any need for additional sessions could be explored. Overall, there appeared to be a sense that supervisors were prepared to be flexible about the length of therapy provision offered within the services represented in the sample, however, therapists were aware that this was not always the case. Therapists also cited supervision as a space to consider the frequency and length of intervention sessions, as well as how best to position such sessions in the context of the school day.

''I think you know things like the frequency you know, so you know, especially if you're into processing you want and you're on a target, you know, and then, you know, young people, you know, they're going to school every day, you know, so when do you do it?.'' (Claire, Clinical Psychologist).

For therapists working towards becoming accredited EMDR practitioners, the process of video-recording sessions was thought to help ensure their adherence to the protocol, reflective of how the approach had been portrayed during training. However, outside of these sessions, the need to make developmentally appropriate adaptations within therapy was recognised and supervision was considered a vital resource within this process. Essentially, therapists recognised the need for adaptation in their clinical work and acknowledged that this was not adequately provided for in the standard EMDR protocols, meaning that CYP are often provided with an EMDR approach that is very different to the one presented during training and to some extent that which has been empirically supported within the existing literature.

> ‘’I'm still working towards my accreditation. So, for my videos and things like that, I have to show what I'm doing to meet all the stages of accredited. Umm, but when I'm not doing it for the video, you know, for that I might then talk to my supervisor and think about how we do that differently.’’ (Vicky, Psychotherapist).

In the recent context of the global COVID-19 pandemic, therapists reported that supervision had been crucial in helping them to think about whether it was appropriate to continue to offer EMDR therapy to CYP. And if so, how they might adapt their practice to offer therapy virtually. (See extended paper, section 11.2 for further exploration of using EMDR during the COVID-19 pandemic).

> ‘’So (when you’re working online)…there's been lots of adaptations over this particular period of time and just respecting when it's not been okay to do it really.’’ (Vicky, Psychotherapist).

Overall, access to appropriate supervision was considered key to therapist development; however, given the perceived shortage of child and adolescent EMDR supervisors, accessing adequate support could be challenging for some therapists. Good supervisory experiences were thought to serve a myriad of functions, most often providing a space for reflection and guidance. For many therapists, supervision was an opportunity for discussion which often focused on how and when to adapt standard EMDR protocols to improve their application and therefore, outcomes when working with CYP.

Using Narratives and Play. Therapists discussed how their practice had developed following their initial EMDR training, with many starting from a position of feeling ‘like you’ve got to stick very rigidly to (the protocol)’ (Claire, Clinical Psychologist). Therapists initially reported a sense of safety in having access to a manualised protocol to guide their practice but said that over time, it became possible

to work more flexibly, holding on to the essence of the approach and thinking about the key tasks within therapy. As a result, therapists described an increase in confidence and self-reported competence in the flexible application and adaptation of EMDR protocols. This included the incorporation of creative methods of engagement which particularly appeal to CYP such as the use of stories and elements of play.

> ‘‘I think over time, as you get a bit more relaxed with it and think, well what are you actually trying to achieve? And then applying that and thinking about how you're going to do that, but maybe with a few adaptations.’’ (Claire, Clinical Psychologist).

When working clinically, the inclusion of narratives within EMDR was considered the main adaptation made by therapists. Many were surprised that so little attention had been given to the construction and use of narratives within the specialist EMDR training they had attended given their widespread use in clinical practice.

> ‘’My narrative aspects of it are probably, is probably for me the predominant adaptation that I use. I would say in the work that I do, that is, that's the biggest adaptation that I do. Yeah, and that's been very helpful.’’ (Emma, Therapeutic Social Worker).

Therapists reported using narratives with CYP in several ways, including to provide information about an experience for which they had no verbal memory, to contain negative cognitions and offer distance from these, to work through complex, saturated stories, to make sense of and find meaning in their experiences, and to help them process and heal from traumatic experiences by pairing a narrative with BLS as a method of desensitisation.

‘’So, there's a bit about writing narratives, but there's a bit of letting them play their story and then seeing if we can do some bilateral stimulation because that’s the bit that desensitises.’’ (Vicky, Psychotherapist).

Moreover, therapists also advocated for the incorporation of play within EMDR therapy as a way of creating the sense of safety required for CYP to meaningfully engage in the therapeutic process. CYP were thought of as being naturally playful and so, introducing play during moments of ‘stuckness’ within therapy was considered a helpful way of moving forward in a non-directive, de-shaming way.

‘’You can't work with young people and not introduce play. They’re not adults. So, they don't, even even the ones, even the ages I work with, they’re very often, emotionally off age and respond really well to, you know, play-based activities and that and it brings a bit of fun as well.’’ (Emma, Therapeutic Social Worker).

Therapists were generally flexible and creative in how they incorporated elements of play within their work, which for many, often involved encouraging movement within the session, for example by using childhood games such as ‘catch’ (Emma, Therapeutic Social Worker), or ‘pattycake’ (Cora, Counselling Lead), or by tapping into a child or young person’s interest in sports (e.g., football). Therapists believed the use of play was even more crucial when working with CYP experiencing developmental delays as a result of trauma. Therapists generally regarded the use of play as a helpful way of introducing and working with concepts such as resource building, cognitive interweaves, and affect change.

‘’And it's (play) quite non-directive and they always play out their issue, whatever their issue is, it always comes out every time. So, you can get the get the buzzers on as well, that sort of helps and you can also introduce

resources into like, I mean resource interweaves into the play.'' (Ruth, Integrative Counsellor).

Working with CYP requires therapists to be flexible and creative in their approach. For those offering EMDR, the developmental appropriateness of the intervention must be considered, with adaptation often being required; the incorporation of narratives and use of play are the most common adaptations used by therapists and their inclusion is thought to enhance meaningful engagement in the therapeutic process and therefore improve outcomes for CYP.

Therapeutic Relationships as a Double-Edged Sword. Therapists discussed the importance of working relationally with CYP when using EMDR, citing the development of a safe and trusting therapeutic relationship as key to achieving positive therapeutic outcomes. Although therapists considered EMDR to be a useful approach for processing and healing trauma, they believed that using EMDR in the absence of a therapeutic relationship would not achieve the desired results and may even risk harm to the child or young person's emotional well-being. Therapists were aware that when working with adult clients there appeared to be less emphasis placed on the development of a therapeutic relationship both within training and the existing literature, instead focusing on specific EMDR techniques to elicit change. However, when working with CYP there was a sense that both the therapeutic relationship and EMDR-specific techniques were needed to achieve positive outcomes.

> **''**The biggest part of the work is within the relationship…and EMDR is an absolute amazing, amazing tool alongside it, it it really touches and heals and settles and moves things on, it's incredible…but I wouldn't want to do it without, with someone I ain't got a relationship with. But I know that, that's how adults you know can work.'' (Vicky, Psychotherapist).

One of the drawbacks to focusing on the therapeutic relationship when using EMDR with CYP was considered in the context of the formal and structured nature of the approach, which therapists thought, at times, influenced how CYP behaved and responded within sessions. Therapists described believing that CYP often viewed EMDR therapy sessions as an extension of their school experiences and that this contributed to them thinking they had to do things in a certain way.

> ‘’They come from a world where they're in that school environment and you've got to be aware of that relationship as well, especially with something like EMDR, which can feel more formal somehow because it's got a structure.’’ (Claire, Clinical Psychologist)

In addition, therapists noted that often by the time they reached the desensitisation phase, they had spent a long time developing a relationship with the child or young person and believed that sometimes this led them to overstate the degree of positive change they experienced as a way of offering validation to the therapist.

> ‘’I think that also happens in that as well because by the time we get to that (desensitisation) stage, you know there's a good relationship. And I also think the relationship impacts a little bit on that possibly, and that they're wanting something to happen for you.’’ (Emma, Therapeutic Social Worker).

The development of a therapeutic relationship when working with CYP was considered key to achieving positive outcomes when using EMDR with this population. However, therapists worried that, at times, developing a therapeutic relationship might serve to increase social desirability and risk the child or young person overstating the improvements achieved, thus leading to therapy being ended prematurely, leaving some difficulties unaddressed.

Overall, therapists who used an EMDR approach in their work with CYP described an ongoing journey of learning and development. EMDR training appeared to provide therapists with a basic grounding in the approach, but clinical experience was considered crucial for therapists to finesse their skills. EMDR training was considered very much a starting point and therapists reported becoming aware of many challenges to putting EMDR into practice when working clinically with CYP that were not adequately addressed through the current training provision, including the need for significant adaptation to the standard EMDR protocol to ensure its developmental appropriateness when working with this population.

Theme 2: Working Systemically

Within this theme, how therapists involved the systems around CYP within EMDR therapy was discussed. Therapists tended to consider parent or carer involvement in therapy to be helpful but recognised the challenges associated with working in this way. Therapist experiences of working systemically were explored within two subthemes: *when and how to involve parents and carers and identifying who the client is*.

When and How to Involve Parents and Carers. Therapists regarded involving parents and carers in the therapy process to be a key element of the approach, but one that required careful consideration. Overall, therapists deemed it inappropriate to include parents or carers in the therapy where they had been involved in the experience of trauma or where attachment difficulties were evident within the relationship with the child or young person. For therapists working in Looked After Children services, placement stability was an important consideration when thinking about the appropriateness of involving foster carers in the therapeutic process. Where parents or carers were not able to be included in therapy for any reason, therapists saw it as their responsibility to act as a resource figure and create safety in the room and the relationship, before proceeding with EMDR, thus prolonging the therapeutic process.

''(When parents or carers cannot be involved) the work with the child is going to be a slower because I have to become the safe space for the child. The safe figure.'' (Cora, Counselling Lead).

However, where a 'good enough' attachment exists between a child or young person and their parent or carer, therapists encouraged their involvement throughout the therapy process, believing that this enhances outcomes. Therapists considered a wide range of ways in which parents and carers might be involved in EMDR therapy both within and between sessions, from writing narratives with, or for, the child or young person and providing extensive information about their background and current presentation, to administering the BLS and acting as a resource figure to provide safety and containment through proximity and touch.

''She was physically using that, you know, to contain her emotions. So, she was turning into Dad and, you know, being physically held. And that's very much a relationship that I trust. And I'm very confident about. It is a secure attachment. And therefore, that's an appropriate use of that. So yeah, that having that parent there to do that role.'' (Tina, Clinical Psychologist).

However, therapists also expressed that, at times, parents and carers might become overwhelmed by the process of EMDR, and that CYP often appeared attuned to this and would attempt to cope alone during sessions as a way of protecting the adult. Overall, there was a sense that sometimes not having a parent or carer present in the room allowed for more open discussion and exploration of traumatic experiences and that CYP should always be offered this as an option.

''They're always allowed that preference, but for a lot of the young people that I work with…they prefer to have a safe space to, because, again, if they're in foster care, even if they have a brilliant relationship with their foster carer,

there is always the fear that whatever they say is reported back because of the procedures and that around it.'' (Emma, Therapeutic Social Worker).

Therapists considered it important to have conversations with parents and carers about the therapeutic possibilities of EMDR, including the types of difficulties the approach could help with and what might be possible in terms of outcomes. Therapists noted that EMDR appeared particularly vulnerable to the idea that it would 'fix everything' and that this was further compounded by the mysterious nature of the mechanisms thought to be responsible for affecting change.

''Particularly with the EMDR, it seems vulnerable to this idea that it's going to sort everything out…I think maybe because it seems quite mystical.'' (Claire, Clinical Psychologist).

Knowing when and how to involve parents or carers in EMDR therapy with CYP was a key consideration for therapists, requiring a great deal of flexibility and careful management. Whilst how therapists involved parents and carers varied widely between therapists there was an agreement about those times when parent or carer involvement would be deemed inappropriate.

Identifying who the client is. Therapists were mindful that offering EMDR to a child or young person often had a ripple effect, highlighting the need for trauma-focused work amongst other members of the system; most often this work was required for parents or carers to address their own traumatic experiences, including recent events such as domestic abuse, or historic events such as childhood trauma. At times, unresolved experiences of trauma amongst parents or carers were perceived to hinder therapeutic progress with CYP, in these situations, therapists were cognisant of the need for parents or carers to access support. Some therapists believed it to be their role to simply signpost or refer parents and carers to services through which they could access appropriate support.

''If I think that there's probably trauma symptoms present in the parent, I would normally meet with them on their own to sort of check that out, and the sort of assess, assess them almost and then refer in to sort of local services.'' (Claire, Clinical Psychologist).

Other therapists were more likely to offer some form of intervention, such as parenting support, to parents or carers alongside EMDR therapy for CYP. Whereas several therapists reported being more inclined to offer EMDR to parents and carers themselves either before or instead of working with the child or young person. Therapists taking this position appeared to believe that working in this way could help to clear some of the negative cognitions and blocks for parents and carers which they perceived as likely to impact the child or young person's progress in therapy.

''With umm social care cases, I did EMDR with the parent or carer, the guardian, prior to working with the child on that, that was the, I suppose the best route forward if the umm, guardian was willing to do that. Umm so that we could clear some of their negative beliefs and trauma so that they could do the sort of nurturing, caring parent role.'' (Ruth, Integrative Counsellor).

There was an awareness amongst therapists that often, systemic factors were the aspects of a child or young person's current situation where change was needed and where any intervention was likely to be most effective. However, in clinical practice, therapists often perceived that they were expected by families to offer EMDR therapy directly to CYP, despite this approach not only being considered ineffective in the absence of systemic change but also one which serves to pathologise the child or young person.

''And you know, when I, with some, then I've suggested maybe there needs to be family therapy or something like that. Because often as I say, there could

be a kind of systemic thing that underlies it a bit.'' (Claire, Clinical Psychologist).

Appropriately identifying who the client is when working in clinical practice is an important step for therapists and one which can greatly impact therapeutic outcomes when working with CYP. Whilst direct therapeutic work with CYP can be helpful, many therapists believed that intervention at the systemic level (e.g., within the wider family system) was often necessary to bring about change.

From the perspective of therapists there appear to be some benefits to involving parents and carers when offering EMDR therapy to CYP, with some believing that parent or carer involvement in the therapeutic process can serve to improve clinical outcomes. However, therapists must be mindful of the fragile systems within which CYP accessing EMDR therapy are often operating within and think carefully about the parameters of the approach and the remit of their service context.

Discussion

Overall, therapists described their experiences of using EMDR with CYP as a journey of learning and development. Initially, therapists described being cautious when using EMDR in clinical practice and valued having a standardised protocol to guide their interventions. When working with CYP, therapists were aware of the need to adapt the standard EMDR protocol to ensure its developmental appropriateness, however, generally, therapists believed that their initial EMDR training had not provided sufficient guidance about how or when to make such adaptations. As therapists became more experienced in using EMDR, they described an increase in confidence and self-perceived competence, meaning that over time, they were able to work with CYP simply by holding on to the essence of the approach, working loosely within the protocol, and making use of a variety of creative adaptations, supporting the idea that the standard EMDR protocol can and should be adapted for use with CYP whilst remaining adherent to the fundamental principles of the approach to enhance treatment outcomes (Hase, 2021).

EMDR is often perceived as a ‘doing to’ type of therapy due to the formal, structured nature of the approach, this can be particularly uncomfortable for therapists working with CYP who have experienced developmental trauma, who have often already had so many experiences of having things done to them without their consent. In these scenarios, therapists were cognisant of the need to empower CYP and to actively involve them in the therapeutic process. Therapists considered making adaptations to the standard EMDR protocol using aspects from other therapeutic modalities such as narratives or play, as one way to foster collaboration with the child or young person, which in practice appeared to help them engage more meaningfully in the therapeutic process, thus supporting previous findings which suggest the use of creative adaptations enhances engagement (Gomez, 2013).

Furthermore, therapists were mindful that experiences of trauma during early life often affected child development. According to Perry (2006), in these circumstances, therapeutic activities should be matched to the child or young person’s developmental stage which may not be consistent with their chronological age. As such, the inclusion of creative adaptations within EMDR therapy such as storytelling and play are particularly important and powerful therapeutic activities. However, creative adaptations alone were not considered sufficient when using EMDR, with therapists believing the inclusion of BLS to be a crucial component that promotes healing and elicits therapeutic change amongst CYP. Perry (2002) suggests that the repetitive nature of BLS serves to quieten and soothe brainstem activity thus supporting the notion that BLS distinctly contributes to the outcomes achieved when using EMDR (Jeffries & Davies, 2013).

When working with CYP, there is a need to recognise and account for the influence of systemic factors (Dummett, 2010). Therapists reported that the child specific EMDR training had not paid enough attention to the influence of systemic factors when using the approach and believed this to be a significant flaw in the training provision. As such, although many therapists believed involving parents or carers in EMDR therapy with CYP

was important, they had difficulty knowing how to or how much to do so. Therapists recognised that at times, the involvement of parents or carers within therapy was not appropriate due to their own traumatic experiences, however by offering EMDR to a child or young person a ripple effect was created within the system often highlighting layers of unresolved trauma that would need addressing before the child or young person could make progress (Kiser et al., 2020). In these situations, for some therapists, signposting parents or carers for support was enough, whereas other therapists found themselves offering therapy before or instead of working with the child or young person. Overall, it seems that to be able to safely offer EMDR, therapists need to develop the skills and knowledge to work both directly, and systemically with children, young people, and families. To do this, therapists require knowledge of trauma and child development, an understanding of systemic factors and how to work with these effectively within therapy, and a broad awareness of alternative approaches to working with trauma, either individually or systemically, before embarking on the Child and Adolescent EMDR training. Furthermore, therapists must be mindful of occasions when direct therapeutic intervention with a child or young person is not currently indicated and consider whether and how interventions might be appropriately sequenced to increase the possibility of a positive therapeutic outcome (Perry, 2006).

The development of a safe and trusting relationship was considered key to successful EMDR when working with CYP, and therapists said they would not attempt to deliver EMDR in the absence of a therapeutic relationship due to concerns about the potential harm this could cause. Therapists were aware that when working with adult clients using EMDR the emphasis is on the technique (Edmond et al., 2004), but for CYP the emphasis must be on the relationship, and both are needed for successful outcomes (Perry, 2006). However, therapists were aware of potential issues created by the nature of developing a relationship, which at times were thought to increase the risk of social desirability on the part of the child or young person and inadvertently encourage them to report more improvement than had been experienced in reality to please the therapist

(Hagborg, 1991). This may be understood at a neurobiological level as the adolescent brain has been shown to strengthen neural pathways under dominant influences such as social cues (e.g., acceptance), as well as a motivation to gain immediate reinforcement (e.g., praise). Over time, as a relationship is developed between the therapist and the young person these neural pathways are consolidated, thus potentially increasing the likelihood of socially desirable responses within therapy (Ford, 2017). Therapists must be mindful of this phenomenon so they can respond appropriately and ensure that therapy is not ended prematurely. (See extended paper, section 12 for further discussion of these points).

4.1 Strengths, Limitations, and Future Research

This study aimed to explore the experiences of therapists offering EMDR to CYP. Therapists who took part in the study represented a diverse range of experience in terms of core profession, service settings, and time spent using EMDR with CYP, thus resulting in the generation of broad, nuanced insights into using EMDR with this population. Within the study, a limited sample size (see extended paper, section 12.1 for further discussion) was achieved and so, data saturation is unlikely to have been reached; this in itself is not necessarily problematic as the concept of data saturation is not considered consistent with the assumptions and values of a Reflexive Thematic Analysis approach (Braun & Clarke, 2021). However, the sample within this study was self-selecting and may only include the views of therapists who have had similar, largely positive experiences of using EMDR with CYP. We know that experiences of EMDR are not universally positive (Shipley et al., 2021) and so must remain mindful that perhaps, more unique, or negative therapist experiences have not been captured and are therefore not represented within this study. It would be important for future research to investigate whether negative therapist experiences of using EMDR exist and to represent these experiences within the literature. Given that therapists within this study supported the involvement of parents and carers throughout the therapeutic process, it would be interesting to explore therapist experiences of using the approach when parents or carers are unable or unwilling to be involved and consider the implications of this

for clinical practice. Furthermore, it would be prudent for future researchers to also explore CYP's experiences of EMDR therapy, so that their views may also be represented (see extended paper, section 12.1 for further future research considerations).

4.2 Implications for Clinical Practice

- Therapists consider EMDR to be an appropriate intervention for CYP. However, some adaptations to the standard EMDR protocol are required to ensure its developmental appropriateness, enhance engagement, and improve therapeutic outcomes.
- The incorporation of narratives and elements of play are key adaptations thought to increase meaningful engagement and encourage collaboration with CYP.
- Developing a safe and trusting therapeutic relationship is vital to good therapy and EMDR should not be attempted with CYP in the absence of this. Investing time to develop a therapeutic relationship is believed to improve outcomes for CYP when using EMDR.
- Therapists must be aware of the likely presence of traumatic experiences in other layers of the system and consider how to work with this in the best interest of the child or young person. It may be helpful for therapists to consider the need for intervention at a systemic rather than individual level, or where both are indicated, consider how to sequence such interventions appropriately.
- There are many ways in which parents and carers can be involved in the therapeutic process when offering EMDR to CYP. However, therapists must be mindful of any ways in which parental involvement may serve to hinder CYP's progress in therapy. Supervision can provide a space for these discussions, ensuring that therapists operate within their sphere of competence and the boundaries of their service setting.
- Access to supervision with someone who is experienced in EMDR, who has experience working therapeutically with CYP, and who is familiar with the service

setting within which the therapist is operating, are important factors in the development of therapist confidence and competence.

- See extended paper, section 12.2 for further implications for clinical practice.

4.3 Recommendations to the EMDR Protocol

According to the therapists who participated in this study, the incorporation of narratives and elements of play were considered key adaptations to the standard EMDR protocol that should be considered when working with CYP. Moreover, therapists suggested that the inclusion of these adaptations may be appropriate at every one of the eight phases of the standard EMDR protocol. Therapists largely agreed that within their clinical practice the inclusion of narrative and play based techniques had been particularly helpful during the early stages of EMDR (i.e., during the preparation phase) but recognised that for some CYP, there may be utility in considering these adaptations throughout the therapeutic process.

In terms of specific recommendations, therapists might consider the use of both directive and non-directive play strategies. For example, during the early phases of the EMDR protocol, (such as assessment and history taking), the use of non-directive play may help the therapist to gather additional information through observation of the child or young person whilst engaged in play; during non-directive play, children and young people may 'play out' their experiences using action figures, through storytelling, or communicate these within their drawings. As therapy progresses, it may be appropriate to introduce more directive play, for example, during the processing phase, play may allow the child or young person to access a particularly evocative memory in a way which does not overwhelm them, therefore allowing for processing of the experience to be explored.

In addition, therapists who took part in this study advocated for the use of movement and games within therapy which was thought to help with both emotion regulation within sessions as well as acting as a viable alternative to the traditional methods of eliciting bilateral stimulation during the processing phase of EMDR. Therapists suggested using

activities which encouraged a side-to-side movement such as playing catch or doing goalkeeping as possible adaptations that were particularly attractive to CYP.

4.4 Conclusion

Through this study, therapists' experiences of using EMDR therapy with CYP have been explored, and two key themes were generated: putting EMDR into practice and working systemically. Within these themes, how therapists approach making adaptations to EMDR therapy when working with children, young people, and members of their system were discussed, as too, were the perceived barriers and facilitators to making such adaptations and implementing an EMDR approach in clinical practice. The findings from this study contribute to the relatively sparse literature base relating to therapist experiences of EMDR (Dunne & Farrell, 2011), however, future research should seek to also grow the qualitative literature surrounding the direct experiences of CYP, as well as parents and carers. (See extended paper, 12.3 for further detail on these conclusions).

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Conflict of Interest

The authors have no conflicts of interest to declare.

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Extended Paper

The extended paper is formatted in accordance with APA 7th Edition guidelines.

9. Extended Background

9.1 The Development of Eye Movement Desensitisation and Reprocessing Therapy

Eye Movement Desensitisation (EMD) was proposed as a psychotherapy intervention by Shapiro in 1989. Shapiro (1989a, 1989b) suggested that EMD therapy could be effective in helping clients reduce the distress associated with traumatic memories. Shapiro proposed that the primary component of EMD therapy was the 'generation of rhythmic, multi-saccadic eye movements while the client concentrates on the memory to be desensitised' (Shapiro, 1989b, p.201).

Initial trials of EMD therapy indicated that the procedure could achieve three main outcomes within relatively short periods (Shapiro, 1989b). Firstly, EMD therapy could desensitise clients to traumatic memories without exposing them to prolonged periods of anxiety. Secondly, the visual representation of the memory could be altered, as could the associated irrational beliefs and negative self-statements. Thirdly, significant changes in client behaviour could be produced. Initial research findings suggested that EMD therapy was an efficacious intervention for the treatment of post-traumatic stress disorder (PTSD). PTSD is classified as an anxiety disorder caused by exposure to an extremely distressing experience (World Health Organisation, 2019). PTSD symptoms include flashbacks and nightmares, which can cause the individual to feel as though they are reliving the traumatic event in the present moment.

Despite initial research findings suggesting that EMD therapy was an efficacious intervention for the treatment of trauma-related distress, these findings were not replicated in clinical practice (Shapiro, 1991b). Feedback from clients and practitioners using EMD therapy suggested that over the course of therapy the traumatic memory appeared to undergo reprocessing by the client. Using this feedback Shapiro (1991b) updated her initial EMD therapy protocol to include the reprocessing element, resulting in the creation of Eye Movement Desensitisation and Reprocessing (EMDR) therapy. An eight-stage protocol for EMDR was later developed as a guide to the intervention and included history taking,

preparation, assessment, desensitisation, installation, body scan, closure, and re-evaluation, with the generation of multi-saccadic eye movements being considered a core element of the therapy (Shapiro, 1995, 2001).

9.2 Theoretical Underpinning

According to Shapiro (1995, 2001), memory for past experiences is pivotal to the development and maintenance of present day social, emotional, and behavioural difficulties. Current symptomology can be thought of as manifestations of past experiences which have either been encoded implicitly by the brain or that have not undergone adequate processing. It has been suggested that implicit encoding and inadequate processing take place when an experience occurs in an individual's life prior to the development of the required brain structures responsible for transferring information into explicit autobiographical memory, or where the experience of trauma and associated dysregulation has impeded the proper functioning of such structures (Cozolino, 2010; Shapiro, 2001; Siegel, 1999; van der Kolk, 1999). For example, if a child experiences abuse, abandonment, maltreatment, neglect, or rejection before two years of age, they are unlikely to have developed the cognitive structures (i.e., hippocampus) necessary for integrating and adaptively grouping the component parts of the experience and accurately locating it in time and space. Therefore, component parts of the child's experience are encoded by the developing brain into implicit unconscious, non-verbal memory (Siegel, 1999). As a result, early experiences of interpersonal trauma and attachment injury remain outside of conscious awareness whilst still serving to shape the child's behavioural and emotional responses to environmental demands (Gomez, 2013).

EMDR is underpinned by the Adaptive Information Processing (AIP) model which builds on a neurobiological explanation of information processing and memory creation, suggesting that all human beings have an in-built information processing system, and that this system is responsible for processing and integrating the component parts of our experience, such as thoughts, images, emotions, and bodily sensations, before committing

them to memory (Luber & Shapiro, 2009). It is suggested that when an individual is exposed to a traumatic event their information processing system fails to adequately process and integrate the component parts of the experience before committing it to memory. It is proposed by the model that this system failure results in the dysfunctional storage of traumatic memories.

From a neurobiological perspective, adaptive information processing and memory creation occurs over four stages (Hill, 2020). Firstly, a sensory stimulus is perceived, and a signal is sent to the hippocampus, the signal is then divided into two parts, each of which is assigned an identical marker. Next, one part of the signal is sent to the prefrontal cortex where it will undergo logical processing, whilst the second part is sent to the limbic system for emotional processing. After these processes are complete, both parts are transferred to the temporal cortex and reunited via the identical markers assigned earlier. Finally, these 'complete' memories are then integrated into pre-existing neural memory networks and stored for future retrieval (Montgomery, 2013; Schore, 2003). For most memories, these four stages happen automatically and often unconsciously (Montgomery, 2013).

In the context of traumatic experiences, when a sensory stimulus is perceived as threatening, overwhelming, and urgent, the adaptive information processing and memory creation process is distorted. When an individual is exposed to a traumatic event their information processing system fails to adequately process and integrate the component parts of the experience before committing it to memory due to the prefrontal cortex being overwhelmed by the incoming traumatic information; the prefrontal cortex is thought to be sensitive to the effects of the neurotransmitters released during times of stress and fear such as adrenalin and cortisol which cause it to halt processing (Schore, 2003).

This notion has also been empirically supported through functional magnetic resonance imaging (f-MRI) studies. For example, Herkt et al., (2014) found an increase in activity in the amygdala and a corresponding deactivation of the prefrontal cortex in the human brain in response to individuals being shown distressing images. In these

circumstances, processing of experience components such as bodily sensations and emotions which takes place within the limbic system is able to continue due to the robustness of this system, meaning that these components can be transferred to the temporal cortex in their processed form. However, the components that should have undergone processing in the prefrontal cortex, typically those elements that relate to chronology, causation, and fact, arrive in the temporal cortex in their raw, unprocessed form. Failure of the brain to reunite and assimilate the different components of the experience result in the dysfunctional storage of traumatic memories which appear to be more easily accessed and re-experienced as happening in the present moment leading to significant distress (Schore, 2003).

The dysfunctional storage of traumatic memories is considered to increase an individual's risk of experiencing symptoms related to PTSD (van der Kolk, 1994), the individual may 'know' that the event happened in the past but still 'feel' in danger in the present and experience the thoughts, images, emotions, or bodily sensations associated with the original traumatic event. The brain continues to try and process the traumatic experience, however due to crucial components of the memory being unavailable, the memory cannot be fully processed until all components of the experience are located and reunited (Montgomery, 2013; Schore, 2003).

The AIP model proposes that the adequate processing of dysfunctionally stored traumatic memories can reduce the associated distress (Solomon & Shapiro, 2008). However, one of the criticisms of the AIP model is that it does not define dysfunctional storage at a neurobiological level, limiting the model's scope (Hase et al., 2017). Furthermore, although broadly accepted within the field of trauma-related research and treatment, the idea that traumatic memories are stored dysfunctionally has also been contested, for example, Porter and Birt (2001) found that memories of traumatic events are typically remembered in higher levels of detail and can be recalled more coherently than other types of memories.

9.3 Proposed Mechanism of Action

It is proposed that bilateral stimulation, such as the multi saccadic eye movements, generated in EMDR therapy facilitates individuals to adequately process and integrate memories of traumatic events resulting in an alleviation of associated distress (Jeffries & Davis, 2013; Shapiro & Maxfield, 2002; van den Hout et al., 2001). According to the AIP model, bilateral stimulation is suggested to facilitate memory processing and alleviation of associated distress by increasing communication between all areas of the brain implicated in memory processing, integration, and storage (Hill, 2020).

According to Shapiro (2017), when specific areas of the brain are activated and focused on an adverse experience, the brain works to locate all parts of the traumatic memory, including those which are maladaptively stored. These parts are then processed by the prefrontal cortex before being sent to the temporal cortex to be stored alongside their associated emotional components. Thus, meaning that all parts of the traumatic memory can now be adaptively integrated into existing memory networks. As a result, the individual can now store the memory of the adverse events within their long-term memory with all of the associated emotional distress being resolved and the experience being understood holistically. Furthermore, once this process is complete, when an individual recalls the previously maladaptively stored memory there is now an absence of associated distress. According to the AIP model and supported by f-MRI research, EMDR is the only trauma-focused intervention capable of achieving a reduction in activity in the anterior cingulate cortex, the brain region responsible for processing conditioned fear responses. This reduction in anterior cingulate cortex activity is thought to explain why, once processed using EMDR, the recall of a traumatic experience no longer causes emotional distress in the present (Boccia et al., 2015).

According to the AIP model, bilateral stimulation is posited to assist adaptive information processing by removing obstacles to memory processing, integration, and storage, rather than by making changes to, or fixing, structures of the brain itself (Hill, 2020).

Furthermore, research findings from f-MRI studies suggest that not only can the use of bilateral stimulation assist in the adaptive processing of traumatic memories, but they can also help to achieve rapid reductions in emotional distress for individuals when recalling a personally traumatic experience (Thomaes et al., 2016), and sometimes within less than 90 seconds of an EMDR therapy session (Smeets et al., 2012). Further studies using Near Infrared Spectroscopy [NIRS]) have also shown that for individuals who experience bilateral stimulation within EMDR therapy, a decrease in sympathetic and an increase in parasympathetic nervous system arousal can be observed (Rimini et al., 2016), thus creating the conditions required in order to adaptively process the memory of a traumatic experience.

Further explanations of the role of eye movements (or alternative forms of BLS) as serving as the mechanism of action in EMDR are based on Baddeley and Hitch's (1974) working memory model, which suggests that memory processing and integration is facilitated through working memory taxation (Maxfield et al., 2008). The model posits that working memory is responsible for consciously maintaining information, in the context of receiving new information or in times of distraction, whilst recognising that working memory has only a limited capacity. As such, in EMDR, the individual is asked to hold a target memory in mind (within their working memory) whilst engaging in eye movements, this is thought to overload the working memory capacity leading to the memory becoming less vivid. According to the working memory theory, the more complex the dual attention task is, the greater the reduction in vividness and associated distress will be (Schubert et al., 2011). However, this proposal has been controversial amongst the research community.

Whilst the generation of multi saccadic eye movements has been shown to facilitate memory retrieval and processing (van den Hout et al., 2001) and as such has been adopted as an integral part of EMDR, findings from two meta-analyses suggest that the use of bilateral stimulation in EMDR therapy is unnecessary and does not contribute to individual treatment outcomes (Cahill et al., 1999; Davidson & Parker, 2001). Also, Sack et al., (2016)

found eye movements produced no significant benefit to clients over asking them to focus on a fixed point in front of them. However, more recently, f-MRI studies have provided further evidence to support the efficacy of eye movements as the mechanism of action in EMDR. For example, Harricharan et al., (2019) found that individuals diagnosed with PTSD underwent reductions in the activation of several brain areas associated with sensed body mapping, emotional regulation, and autobiographical memory processing when EMDR procedures involving horizontal eye movements were used. Notably however, these effects were not observed when procedures involved vertical eye movements or when an individual was asked to focus on a fixed point in front of them.

Furthermore, as EMDR therapy practice and research has expanded, so too have the methods of bilateral stimulation being explored. Alternative methods such as tapping, auditory tones, and the use of tactile devices including buzzers are growing in popularity. There is some research evidence to suggest that although the use of tactile devices can be as effective as the use of eye movements in EMDR, auditory tones are significantly less effective (Nieuwenhuis et al., 2013). One explanation for the observed differential effectiveness between these methods is suggested to be related to similar ways in which the visual and somatosensory systems are both laterally organised, thus meaning that these systems are activated and function in similar ways which are different to that of the auditory system. Overall, there appears to be conflicting evidence in relation to the contribution of, and mechanism of action of eye movements, as well as whether these are any more effective than other types of dual attention tasks or methods of bilateral stimulation (Jeffries & Davis, 2013). However, Schubert and Lee (2009) highlight that a reasonable level of theoretical support exists supporting the inclusion of eye movements and that studies investigating the efficacy of EMDR have included these within their procedures, therefore there does not appear to be any current basis to suggest removing eye movements from EMDR.

9.4 Empirical Support for EMDR

Whilst researchers continue to debate what the mechanisms of action within EMDR might be (Landin-Romero et al., 2018), research supporting the intervention continues to grow. As EMDR was originally conceptualised as an intervention aimed at reducing trauma-related distress there have been a wealth of studies conducted with adult clients experiencing the symptoms of PTSD (e.g., Benish et al., 2008; Bisson et al., 2007, 2013; Bradley, et al., 2005; Chen et al., 2014, 2018; Cusack et al., 2016; Davidson & Parker, 2001; Seidler & Wagner, 2006).

Research has shown EMDR to be of equivalent effectiveness when compared to some pharmacological treatments used for PTSD such as fluoxetine; whilst both interventions were effective in reducing PTSD symptoms, only clients treated with EMDR maintained these improvements at six-month follow-up (van der Kolk et al., 2007).

There is also increasing evidence to support the use of EMDR in the treatment of trauma-related distress trans-diagnostically, including clients experiencing depression (Wood et al., 2018), psychosis (van den Berg & van der Gaag, 2012), obsessive-compulsive disorder (Nazari et al., 2011), generalised anxiety disorder (Gauvreu & Bouchard, 2008), borderline personality disorder (Brown & Shapiro, 2006), and specific phobias (De Jongh et al., 1999). In addition, a recent review by Valiente-Gomez et al. (2017) concluded that EMDR appears to be a safe and useful intervention for clients presenting with comorbid difficulties including PTSD, substance misuse, psychosis, and bipolar affective disorder; this review was particularly helpful in addressing widespread criticism relating to the exclusion of clients with comorbid difficulties from many research studies.

Based on the growing research evidence supporting EMDR as a treatment option for adult clients with PTSD, the World Health Organisation (WHO, 2013) has recommended EMDR and cited moderate evidence to support the intervention's effectiveness; the American Psychological Association (APA, 2017) has also, conditionally, recommended EMDR as an effective treatment option. Whereas the National Institute for Health and Care

Excellence (NICE, 2018) advise that EMDR can be offered to clients: if they request it, if the trauma is not combat-related, and if the symptoms of PTSD have been experienced for three months or more.

9.5 Limitations of the Evidence Base

Whilst evidence to support EMDR as an effective treatment option for clients with PTSD is well established, several limitations to the evidence base must be acknowledged. Firstly, high levels of heterogeneity exist between studies, including participant characteristics, experiences of trauma, length of treatment, symptom and outcome measures used, length of follow-up, and study design (Chen et al., 2014; Chen et al., 2018; Cusack et al., 2016; Davidson & Parker, 2001; Bisson et al., 2007). Secondly, a large proportion of published studies have not reported information relating to adverse treatment effects; it is unclear whether this is due to adverse effects not being experienced, or whether they are simply excluded from the discussion (Bisson et al., 2007; Cusack et al., 2016). And thirdly, although perhaps most importantly, there is a lack of representation of clients with comorbid presentations within the evidence base (Bradley et al., 2005); this limits the generalisability of research findings in clinical practice, especially given the high percentage of clients presenting to services with comorbid difficulties (Hamner et al., 2000). Addressing these limitations in future research would ensure that findings could be confidently generalised into clinical practice and enable clinicians to make more informed judgements about the potential effectiveness of EMDR for the individual client sitting in front of them.

Furthermore, despite numerous studies attesting to the effectiveness of EMDR, research has also shown that of those who complete the specialist EMDR training, many fail to adopt the approach in their longer-term clinical practice (Grimmett & Galvin, 2015).

9.6 Structural Brain Development

It is widely accepted that early experiences of trauma and adversity can have an impact on the developing brain. With this in mind, it is important for therapists offering EMDR to children and young people to understand the ways in which the developing brain might be

impacted, at both a structural and process level, by early experiences of trauma. It would be particularly beneficial for therapists to have an awareness of how the brain structures and cognitive process indicated in memory formation and processing might be affected by early trauma and/or adversity. With such an understanding, it would be possible for therapists to consider the developmental appropriateness of EMDR for the children and young people with whom they work, as well as how the model might be applied differently across the various ages and stages of childhood and adolescence. In addition, this understanding may also help therapists to consider when adaptation may be helpful in order to meet the needs of those who have not only experienced trauma, but who are still developing cognitively.

In general, brain development begins within the first few weeks of conception and continues into early adulthood. Although the basic structure of the brain is established during the prenatal and early childhood phases, formation and refinement of neural networks continues over a longer period (Tierney & Nelson, 2009). The brain is comprised of four anatomically distinct regions (brainstem, diencephalon, limbic system, cortex) which are typically developed in a hierarchical 'bottom-up' fashion, from least (brainstem) to most complex areas (limbic, cortical), with each of these areas developing and becoming fully functional at different times throughout childhood (Perry, 2006). For example, whilst basic sensation and perception systems appear fully developed by the time children reach preschool age, the systems involved in memory, emotion, and decision making continue to develop well into childhood (Tierney & Nelson, 2009).

Although the human brain continues to develop into adulthood, it is generally accepted that early childhood represents a crucial period for the development of a healthy brain, with almost 90% of a child's neural networks being established by the time they reach three years of age (Perry, 2000). The way in which the brain develops in a 'bottom-up' manner means that any impairment in the organisation and functioning of the lower brain may disrupt the normal development and organisation of higher parts of the brain (Perry, 2006). This is significant when considering the effects of early childhood experiences such

as abuse and neglect, as these appear to affect the development of the brain architecture, altering the organic structure and neural pathways of the brain itself, in a way that experiences of similar events later in life do not (Perry, 2009; Tierney & Nelson, 2009).

According to Perry (2009), there are times within childhood when particular brain areas or neural systems are more sensitive to experience than others and this means that children are especially vulnerable to adverse experiences. Even within childhood, due to the 'bottom-up' development of the brain, the timing of an adverse experience such as abuse or neglect, can have very different impacts on 18-month-old children compared with five-year-old children (Perry, 2006). The inescapable conclusion here is that the developing brain of an infant or very young child is more malleable to experience than at any other time in their lives and that such experiences literally alter the way in which the brain develops (Perry, 2009).

9.7 Childhood Cognitive Development

Childhood is considered a crucial period for cognitive development. During childhood, improvements in attentional skills, changes in cognitive capacity, and the emergence of executive functioning are all cited as important factors contributing to the emergence of the more advanced memory strategies, memory accuracy, and autobiographical memory abilities evident in older children, adolescents, and adults (Posner & Rothbart, 2007).

9.7.1 Attention Processes

Changes in attentional skills over the course of childhood have been hailed by many as key to developing some of the more sophisticated human memory abilities (Nelson & Fivush, 2004; Posner & Rothbart, 2007). However, attention is not considered a unified function, rather it is comprised of several sub-processes, namely divided attention, selective attention, and sustained attention.

Divided attention is the ability to switch focus between tasks or stimuli. Young children aged between three and four years of ages have been shown to have considerable

difficulty in dividing their attention between two tasks, although this ability appears to gradually improve for most children from the age of five. However, despite some improvements, five-year-olds have been found to continue to perform below the level of school-aged children, adolescents, and adults on tasks of divided attention (Herrmann & Tomasello, 2015).

Selective attention is the ability of an individual to focus on a single task or stimulus without distraction. Generally, selective attention appears to improve over the course of childhood and has been shown to be influenced by an individual's temperament (Rothbart & Rueda, 2005), the complexity of the stimulus or task (Porporino et al., 2004), and whether the stimulus is presented in visual or auditory form (Guy et al., 2013). It has been suggested that children are better able to selectively attend to visual than auditory stimuli (Guy et al., 2013); children aged four to seven years old appear to find this the most challenging, whereas those aged eight to 11 years of age display similar ability to that of an adult (Jones et al., 2015).

And finally, sustained attention, which is defined as an individual's ability to remain focused on a task for a prolonged period of time. Generally, it is accepted that younger children have more difficulty in sustaining their attention compared with adolescents and adults (Berwid et al., 2005).

9.7.2 Memory Processes

Based on neurological research on memory, several 'types' of memory have been proposed, namely sensory memory, working memory, and long-term memory.

Sensory memory is considered the first stage of the memory system; sensory memory stores sensory input in its raw form for a brief duration, essentially just long enough for the brain to register and begin processing the information. Studies of auditory sensory memory in very young children have shown that it lasts for approximately one second in two-year-olds, two seconds in three-year-olds, more than two seconds in four-year-olds, and

three to five seconds in six-year-olds (Glass et al., 2008). It has been established that the observable differences in auditory sensory memory between very young children, older children, and adults is not due to attentional differences between these age groups, but rather that it reflects a difference in performance of the sensory memory system across developmental stages (Gomes et al., 1999).

The second stage of the memory system is working memory. Working memory is the stage at which current, conscious mental activity occurs, requiring conscious effort and adequate use of attention to function effectively. The capacity of working memory, that is the amount of information that can be held in conscious awareness, has repeatedly been shown to be smaller in younger children compared with adolescents and adults, thus suggesting that the more complex a mental task is, the less efficient a younger child will be in paying attention to, and actively processing, information in order to complete the task (Lally & Valentine-French, 2019). In addition, working memory capacity is proposed to be affected by biological maturation and coincide with neurodevelopmental processes including myelination, axonal and synaptic pruning, changes in cerebral metabolism, and changes in brain activity (Morra et al., 2011). Furthermore, changes in attention and working memory processes are thought to also be affected by changes in executive function. Executive function refers to self-regulatory processes, such as the ability to inhibit behaviour or cognitive flexibility that promotes adaptive responses, these emerge during early childhood and continue to develop throughout adolescence. Like many cognitive changes, brain maturation, especially that of the prefrontal cortex, along with personal experience, influence the development of executive functioning. Researchers have shown that higher levels of executive functioning skills are developed by children who have parents or caregivers that are warm and responsive, use scaffolding to help them solve problems, and provide cognitively stimulating environments (Fay-Stammbach et al., 2014).

The third component of memory is long-term memory, which can be basically divided into non-declarative and declarative memory. Non-declarative memories (or implicit

memories) typically refer to those automated skills that do not require conscious recollection, for example, how to ride a bike, or behaviours that were adaptive and functional during childhood. Whereas declarative memories (or explicit memories) are the memories of facts or events that can be consciously recollected; these can be further divided into semantic and episodic memory. Semantic memories are typically concerned with facts and knowledge that are not date/time specific, whereas episodic memories relate to a specific event and/or period of time. Autobiographical memory is an individual's personal narrative, typically comprised of semantic and episodic memories. Typically, individuals are not able to recall detailed accounts of events that happened during the first few years of their lives, with research suggesting that several factors are necessary in the development of autobiographical memory, including brain maturation, improvement in language, opportunities to talk about experiences with other people, emergence of theory of mind, and the development of a representation of the self (Nelson & Fivush, 2004). Furthermore, research and clinical practice have repeatedly shown that although young children are able to recall personal experiences, they are rarely able to provide a coherent account of the event. For example, whilst two-year old children have shown the ability to recall fragments of personal experiences, with two-and-a half-year-olds have being able to recall considerably more details (Nelson & Ross, 1980), these children still rely significantly on prompting from their caregivers or other adults (Nelson & Fivush, 2004).

9.8 The Impact of Trauma on the Brain

Experiences that might be considered traumatic, such as abuse, neglect, domestic violence, war, and loss, that occur whilst the brain is still developing (i.e., during childhood) can lead to disruptions of neurodevelopment which have been shown to have potentially long lasting, detrimental effects on the human brain (Gomez, 2013). When a child perceives themselves as under threat, their stress response is activated and when this occurs in a prolonged or repetitive manner then the neural networks involved in this adaptive response undergo a 'use-dependent' alteration (Perry, 2001). Essentially, early experiences of

repeated and prolonged stress such as that associated with experiences of interpersonal trauma such as abuse and neglect, actually shape the structure and functioning of the brain in ways that negatively impact all stages of a child's social, emotional, and intellectual development (Cozolino, 2006). Furthermore, when children are exposed to such stressors at the hands of their caregivers, and where this occurs at critical stages of biological and neurological development this may be thought of as complex trauma and lead to additional difficulties such as emotional and behavioural dysregulation, insecure attachment styles, dissociative symptoms, impairment in cognitive and social functioning, and a distorted sense of self (Ford & Courtois, 2009).

9.9 EMDR for Children and Young People

EMDR was originally developed as an intervention for adult clients, and so, it is understandable that the AIP model underpinning the therapy was developed based on one explanation of how memory processes can be impacted by traumatic experiences within the adult brain. However, the efficacy of EMDR has subsequently been demonstrated amongst other client populations, including children and young people (Moreno-Alcazar et al., 2017), and yet there appears to be no discussion about how the AIP model might be differentially applied to aid understanding of how EMDR therapy works within this group.

Although it is generally accepted that differences in brain structure and cognitive processes exist between children and adults, and that the human brain undergoes a process of continual growth and development throughout childhood and adolescence which affects memory processing, integration, and storage capacity, the AIP model does not explicitly discuss these differences or their impact on the EMDR intervention. However, the AIP model is considered to offer some explanation as to how EMDR therapy works for children and young people through its description of the proposed mechanism of action, bilateral stimulation (BLS). BLS is posited to assist in adaptive information processing by removing obstacles to memory processing, integration, and storage, rather than by altering or fixing the affected brain structure itself (Hill, 2020); this may explain why EMDR appears to work

effectively for children and young people as well as adults despite the noted differences in brain development.

Whilst EMDR has been shown to be an efficacious intervention for children and young people experiencing trauma-related distress, it has been noted that significant adaptation to the EMDR protocol is often required when working with this group compared with the adult population (Courtney, 2016; Hase, 2021). As such, it has become the work of clinicians and researchers to both develop and evaluate adapted EMDR protocols and interventions to allow for flexible application of the model for the benefit of children and young people based on what is understood about the developing brain structure, cognitive processes, and the impact of early trauma on these (see section 9.6 – 9.8 for discussion of these processes).

Furthermore, compared with adult clients, children and young people are often reported to require a greater number of intervention sessions to reduce their emotional distress and achieve therapeutic change. Perhaps one explanation as to why EMDR therapy appears to take longer with children and young people may be because the model has not been differentially defined to account for the various ages and stages of childhood and adolescence. It may be that a child or young person, either due to chronological age or the impact of early trauma on their developing brain, has not, at the time of intervention, developed the required brain structures or cognitive processes needed in order to process and integrate their experiences in the ways described by the AIP model, meaning that adaptive processing and storage may not be achievable, even if the obstacles to processing are removed through BLS. This is an important factor for therapists to consider at the point of assessment and one which they should remain mindful of throughout therapy.

Perhaps one of the limitations of EMDR therapy for children and young people is that the interventions theoretical underpinning has not been adapted to account for the differences in brain structure and cognitive processes between children and adults. Furthermore, the model also does not acknowledge that the brain is continuing to develop

throughout the period of childhood and adolescence. Whilst it appears that the explanation of EMDR can be applied to working with children and young people in a broad sense (i.e., memory processes, mechanism of action), how some of the key components of the approach are activated requires therapists to be creative in their delivery and adaptation of the intervention in order to achieve the desired therapeutic outcomes when working with children and young people. As such, there are increasing numbers of adapted EMDR protocols being developed, however, these adapted protocols continue to be underpinned by the principles of the AIP model and can be generally thought of as additive (i.e., advocating for the addition of alternative, helpful methods of engagement that are considered appealing to children) rather than transformative in nature (i.e., they do not challenge the proposed model or suggested mechanism of action).

9.10 Rationale

As with many psychotherapeutic interventions, EMDR was originally developed for use with adult clients. As such, when offering EMDR to children and young people, deviation from the standard protocol is required (Courtney, 2016). Whilst child-specific protocols have been developed, many advocate for further adaptation in order to meet the needs of children and young people, and therefore it is vital to understand how therapists make use of creative adaptations and implement these protocols flexibly in their clinical work (Courtney, 2016; Gomez, 2013).

Furthermore, when therapists are working with children and young people who have experienced developmental trauma, they are more likely to be working with experiences which have happened in the recent past, or with children or young people who may still be living in environments which continue to be unsafe or triggering. Good practice guidance for EMDR therapists advocate that they remain aware of the impact of such factors on the therapeutic process, be attuned to issues relating to child abuse and child protection, and consider their own needs and emotional wellbeing when working in this context (EMDR Association UK, 2018).

In addition, when working with children and young people using an EMDR approach, therapists are more likely to be working systemically in comparison with therapists offering this intervention to clients in adult services. Gomez (2012) advocates for the active inclusion of parents or carers at all eight stages of the EMDR protocol, including the use of parents or carers to facilitate bilateral stimulation amongst younger children. However, although research has suggested that involving parents or carers when offering psychotherapy to children and young people can enhance treatment outcomes (Dowell & Ogles, 2010), the evidence for this is not conclusive. In clinical practice, therapists must consider how and when parental involvement is and is not appropriate, as well as being aware of circumstances where including a parent or carer in the intervention may be detrimental to the therapeutic progress and outcomes for the child or young person; for example, when they are thought to be contributing to or maintaining the child or young person's difficulties (Breinholst et al., 2011), in these situations, therapists must find ways to communicate this information sensitively.

Given the multiple considerations, therapists must hold in mind when working with children and young people, it is important to understand their experiences of offering EMDR therapy to this population, especially given the relatively scarce literature base focusing on this.

10. Extended Method

10.1 Design

The study was approached from a critical realist perspective (Cook & Campbell, 1979) which recognises that several perspectives on truth are likely to exist within society and posits that each one should be treated as equally valid. The critical realist perspective accepts that whilst the real world exists, it can never be known with any level of certainty, especially given that knowledge is a subjective, everchanging social construction (Vincent & O'Mahoney, 2018). Critical realism has its roots in the correspondence theory of truth but moves beyond this to also include coherence and consensus criterion; stating that

knowledge can be considered true if it makes logical sense and is shared by a group of individuals (Hamlyn, 1970).

During the design phase of the study, the research team considered a number of potentially suitable methods of data collection including, semi-structured interviews, focus groups, and the use of open-ended questionnaires. Further consideration was also given to how the study could be safely conducted in the context of the COVID-19 pandemic and remaining post-lockdown restrictions advising against all but essential face-to-face meetings. Firstly, the research team considered using open-ended questionnaires that could be emailed out to therapists offering EMDR to children and young people. The benefit of using this approach was perceived as the relative ease at which a large number of potential participants could be reached. However, the lack of pre-existing relationships between the research team and members of EMDR community proved to be a barrier to accessing potential participants in this way and was therefore discounted.

Secondly, the research team considered the use of online focus groups. One of the benefits to an online focus group was thought to be the ability to bring together therapists from across large geographical areas without the need for travel. Additionally, by bringing together a group of therapists it may have been possible to facilitate a deeper exploration of their experiences of offering EMDR therapy to children and young people by considering their reactions and responses to one another during the discussion. Given the observed differences noted anecdotally in clinical practice, it was anticipated that therapists were likely to have differing views and approaches to using EMDR and whilst this may have provided a rich discussion within the group, it is also possible that some participants may not have felt able to share their experiences if they were quite different to other group members'. As with any group, some members would likely have been more dominant than others and this may have been more difficult for less confident participants to overcome in an online group, therefore meaning that appropriate weight may not have been given to all participants' input.

Ultimately, semi-structured interviews were chosen as the method of data collection within the study as they provided the opportunity to gather information from therapists about their experiences of offering EMDR and adapting the approach with children and young people. Semi-structured interviews allowed for the exploration of pre-determined areas associated with the research aims whilst also allowing therapists to share broader related experiences and perspectives.

At the outset, the research team had considered the use of an Interpretative Phenomenological Approach (IPA). IPA was considered a potentially suitable methodology for this study given that qualitative data about therapists' experiences of, and perspectives on, using EMDR therapy with children and young people was to be collected using semi-structured interviews (Smith et al., 2009). In addition, IPA is considered an appropriate methodology for research which is undertaken from a critical realist perspective (Larkin et al., 2006) as was the case in this study. However, IPA is generally considered appropriate for studies where a small, homogenous sample is to be recruited and where the focus of analysis is predominantly idiographic. Within this study, the research team had hoped to achieve a larger sample size than that eventually recruited and to recruit therapists from a range of clinical backgrounds with the intention of analysing the data collected across the whole sample. Therefore, after much discussion amongst the research team, it was agreed that a thematic analysis approach would be more appropriate on this occasion.

Using a Reflexive Thematic Analysis within the study allowed for flexibility in coding and theme development. A largely inductive, semantic approach was followed throughout, acknowledging that the aim of the study was to explore individual therapists' experiences and bring these together in the analysis to identify and report on those experiences which were shared. Given that none of the research team had experience of attending EMDR training or using the intervention in clinical practice, the inductive, semantic approach to data analysis was believed to be appropriate as it allowed for therapist responses to be

considered ‘at face value’ without needing to be fitted into pre-existing themes or frameworks.

10.2 Sampling and Procedure

Therapists were invited to take part in the study if they offered EMDR therapy to children and young people within the United Kingdom. A snowball sampling method was used meaning that any person who saw the study advert (see Appendix C) or took part in the study could share the details with other therapists who were potentially eligible to take part.

Therapists were recruited via the first author's professional network and study adverts posted on social media platforms including Facebook, Instagram, Twitter, and LinkedIn. A study-specific account was created and used for each social media platform; no study information or attempt to recruit participants was made using the first author's personal social media accounts. On Facebook, the study advert was posted in several relevant Facebook groups associated with EMDR and clinical psychology practice in the United Kingdom, as well as being shared publicly with followers who were asked to repost and share the study details. On Instagram and Twitter, the study advert was shared publicly, and other users were asked to reshare the study advert with their followers.

Any therapists who were interested in taking part in the study were asked to make contact with the first author via email to express their interest. Following this, potential participants were screened to ensure they met the inclusion criteria. For those meeting the specified inclusion criteria, a participant information sheet (see Appendix D) and a copy of the informed consent form (see Appendix E) were shared with the individual via email. Participants were then invited to meet with the first author via an online platform (Microsoft Teams), to discuss the details of the study, the participant information sheet, and to ask any questions about the study and their participation; no participants took up this opportunity and instead confirmed via email that they were happy to take part in the study alongside returning the informed consent form which they had completed and signed electronically. A

copy of the consent form and participant information sheet was retained by all participants and a copy of the signed informed consent was retained by the first author.

Once participants had agreed to take part in the study, they were invited to attend one semi-structured interview conducted by the first author. The semi-structured interviews were guided by an interview schedule (see Appendix F) developed by the research team. All interviews were arranged to take place at least 24 hours after the informed consent form had been returned to allow participants the opportunity to change their minds about taking part in the study, should they wish to. None of the participants changed their minds prior to taking part in the interview and no one requested to withdraw their data at a later time. Most participants took part in the semi-structured interviews within two weeks of returning their informed consent forms.

10.3 Ethics

The study was granted ethical approval by the Division of Psychiatry and Applied Psychology Ethics Subcommittee at the University of Nottingham; project ID 2860. A letter from the Division of Psychiatry and Applied Psychology Ethics Subcommittee granting a favourable ethical opinion was received on the 8th of March 2022; a copy of this letter is included in Appendix G.

10.4 Data Collection

Participants were invited to provide qualitative accounts of their experiences of using EMDR with children and young people, which is regarded as the unit of analysis.

All data was collected from participants via one semi-structured interview conducted by the first author and facilitated using the virtual platform, Microsoft Teams. The first author conducted the interviews from home; all participants were made aware of this prior to the commencement of the interview. Immediately before the interview, participants were given an opportunity to ask any questions, provide verbal consent for the interview to go ahead, and were reminded of their right to withdraw. Participants were also asked to provide verbal consent for the interview to be audio-recorded using a Dictaphone and/or the recording

function built-in to the Microsoft Teams software; one participant requested their interview be audio-recorded using only a Dictaphone, and the remaining participants consented to the recording via Microsoft Teams and a Dictaphone.

Interviews were conducted with one participant at a time and transcribed approximately one week after being conducted to allow time for participants to exercise their right to withdraw their data from the study. One interview was transcribed by the University of Nottingham's automated transcription service, whilst the remaining six interviews were transcribed using the transcription feature in the Microsoft Teams software. All transcripts were then checked thoroughly by the first author against the interview recording for accuracy and any necessary amendments were made to the transcripts to ensure these reflected the audio-recorded interviews verbatim. All transcripts were then anonymised.

10.5 Data Analysis

All participants were asked for written and verbal consent prior to taking part in the study to allow for anonymised extracts of their interview transcripts to be included in the written report containing the study results; all participants were happy for this to take place. Once all interviews had been transcribed, they were analysed using Reflexive Thematic Analysis according to the six stages set out by Braun and Clarke (2006, 2019).

The initial phase of the reflexive thematic analysis required familiarisation with the data. The first author began by reading the interview transcripts and noting down any initial thoughts, the research team then met together approximately one week later to discuss these initial ideas (see Appendix H).

Within the second phase, initial codes were generated so that the interview data could begin to be organised in a meaningful way. An inductive coding approach was used in this study as it allowed for codes to be created based on the interview data itself. In order to code the data, a 10-minute sample from the beginning of each of the seven interviews were used. The first author read through each of the transcripts, highlighted key parts of the text, and began to generate initial codes using the participants' own words (in vivo coding). Once

the samples had been coded, these were shared with the research team and discussed. Once the team agreed that the initial coding of the sample was representative of the data, the first author continued to code the remainder of the seven interview transcripts in 10-minute segments, each time applying existing codes and developing new codes where necessary, this process was repeated until all of the interview data had been coded. An example of the initial coding of an interview transcript is included in Appendix I. Through this process a large number of initial codes were generated. The text of each interview transcript was given a different colour so that once the initial codes were extracted, they could still be traced back to individual participants. For ease of reference, all initial codes were transferred into an Excel spreadsheet so that they could be viewed within one document. An example of the Excel spreadsheet is shown in Appendix J.

During the third phase, the initial codes were examined and grouped to form potential overarching themes This phase of the analysis involved a number of in-depth discussions amongst the research team and as a result, 14 potential overarching themes were identified. These 14 themes were: adaptations, barriers, benefits, challenges, child factors, helpful aspects, integration, other factors, pandemic, parent factors, support, therapeutic relationship, therapist factors, therapist development, and training. Within each potential overarching theme, a number of subthemes were also identified. An example of the subthemes initially identified under the overarching theme of ‘Adaptations’ is provided in Appendix K.

The 14 potentially overarching themes and their associated subthemes were then checked for accuracy against the coded extracts and original transcripts by the first author. These were then reviewed and further refined by the research team through discussion; where themes were considered to represent similar concepts (e.g., barriers and challenges) or be closely related to one another (e.g., support, training, therapist development), these were merged together. This resulted in nine overarching themes remaining which were further checked against the coded extracts and original transcripts to ensure they represented the data accurately. On further exploration, the research team agreed that

several overarching themes may be more appropriately placed as subthemes, further refining the number of overarching themes from nine to five, with 21 interrelated subthemes (see Appendix L).

After taking some time away from the data the fifth phase of the reflexive thematic analysis was undertaken. Within this phase each theme was further defined and refined to ensure that, as far as possible, each represented the essence of the overall meanings evident within the data. Taking time away from the data made it possible to identify that some of the existing subthemes were simply the opposite of one another (e.g., involving parents and carers, and excluding parents and carers) and in such circumstances it made sense to combine these, resulting in the subtheme 'when and how to involve parents and carers'. Similarly, the subthemes of 'why', 'how', 'narratives', and 'play' were combined to form the subtheme 'using narratives and play'; on inspection of the coded datasets it became clear to the research team that each of these previously separate subthemes were in fact representative of the ways in which therapists used EMDR creatively when working with children and young people. The final step in phase five was to give a name to each theme and subtheme which captured their essence. The final themes are shown in a thematic map which also depicts how each theme and subtheme are related to one another (see Appendix M).

Finally, during the sixth phase, a study report was written using direct quotes from the interview data to support the themes and subthemes identified during the data analysis phase. The written report was then submitted to the University of Nottingham in partial fulfilment of the requirements for the Trent Doctorate in Clinical Psychology.

11. Extended Results

Despite having representation amongst the sample of both public sector and private practice experiences of using EMDR with children and young people, none of the therapists who participated in the study had worked in inpatient settings.

11.1 Key Themes

The prevalence of each subtheme within the data is shown in Table 6 below.

Table 6.

Subtheme prevalence

Theme/Subtheme	Prevalence
Putting EMDR into Practice	
Shortfalls of training	6
Accessing adequate supervision	6
Using narratives and play	7
Therapeutic relationships as a double-edged sword	5
Working Systemically	
When and how to involve parents and carers	7
Identifying who the client is	5

Theme 1: Putting EMDR into Practice

Shortfalls of Training. Therapists working in public sector organisations described the overall training experience offered to delegates as somewhat narrow due to the perceived limited nature and type of clinical experiences held amongst EMDR trainers. Some public sector therapists perceived that a hierarchy exists within the EMDR world, whereby, in order to attain positions, such as that of an EMDR trainer, one must be using EMDR as the main component of their clinical work. Furthermore, most trainers were thought to work (or have worked) predominantly in private practice settings and so there was a sense amongst some that broader experiences of contexts, such as the NHS and the associated pressures and services constraints, which impact treatment provision, were not acknowledged, or explored within the training context.

> ‘So, what's happening there then is you're missing out on this whole pool of people who've got experience and those of other areas and do a bit of EMDR alongside who maybe don't quite get to those positions.’’ (Claire, Clinical Psychologist).

Therapists reported that in clinical practice, much more adaptation to the standard EMDR protocol was required than had been discussed within the training they had attended. Moreover, therapists did not think that the training they attended had spent enough time focusing on how and when to make adaptations to the therapy, leaving them feeling apprehensive about doing so in their clinical work.

Accessing Adequate Supervision. A further consideration within supervision when working with children and young people was the appropriate timing of sessions. Session timing was considered both in terms of the time of day and how EMDR sessions might fit around the school day, as well as other time factors associated with working with children and young people such as exam periods. Therapists considered these time factors to be generally associated with working with children and young people and thought they were important considerations to hold in mind when thinking about the most appropriate time to offer an intervention.

> ‘’I think you know things like the frequency you know, so you know, especially if you're into processing you want and you're on a target, you know, and then, you know, young people, you know, they're going to school every day, you know, so when do you do it? Do you do it in the morning? But then they got to go to school afterwards. And, well, that's what's that going to be like. Or do they come at the end of the day when a so appointment times and scheduling I think is difficult because you want to obviously have that regularity of of of sessions, especially when you're into processing, you know we are quite often have a lot of young people because there's so many other issues as

well. They'll come after a school day and just not in a place where they feel they can access it.'' (Claire, Clinical Psychologist).

However, more specifically for EMDR, these time factors were thought to require careful consideration, particularly when considering the processing stage of EMDR to ensure children and young people have the capacity to manage this stage of therapy. For example, some children and young people were observed to have difficulties with concentration which was thought to impact their ability to engage for lengthy periods of time during sessions. Therapists tried to work flexibly wherever possible and adapt the length and frequency of sessions, however, service constraints sometimes made this difficult.

''Just holding (in) mind, the young person's cognitive capacity and concentration stuff…Like I mean, I just find you know, a lot of them even after half an hour of processing got quite tired. And so, you know, in an ideal world, I guess you'd try and do it more frequently, shorter times maybe. But again, it's fitting that in, in the CAMHS context, you know our service isn't really geared up for it to be delivered in that way.'' (Claire, Clinical Psychologist).

Therapists were also vigilant around occasions where time factors appeared to serve as a way for the child or young person to avoid the processing stage of EMDR therapy.

''I'd say that's another barrier, possibly, I guess just to you know, when is it avoidance and when is it actually just not (the right time), you know, there's that fine line, isn't there?'' (Claire, Clinical Psychologist).

Therapists talked about making use of supervision to explore these scenarios and seek guidance about how to approach these topics sensitively with parents and carers. Therapists also considered supervision to be a helpful space to think about times when, in these circumstances, working directly with the child or young person

using EMDR might not be effective or may even serve to pathologise them and their experiences.

Using Narratives and Play. Many therapists reported working slowly and cautiously, due to concerns that they may cause harm to the child or young person by going too quickly to later eventually feeling confident enough to experiment with the approach and make creative adaptations.

> ‘’That’s the part, you know, not just through the narrative, it’s how we know through the polyvagal and through our nervous system, how eye movements, how bilateral stimulation in some way (desensitises).’’ (Vicky, Psychotherapist).

Therapists were able to give a variety of examples to showcase the creative ways in which they had incorporated play into their clinical work with children and young people.

> ‘’I've done it in football, you know? Goals. That way, goals that way, goals that way. Dive that way, you know. So, I would, you know, play, you know, it's like I would, you know, you you have to be creative as well with how you bring it in. If I was to say to that child, let's do some EMDR, you'd forget it. I ask them to do anything, forget it. But play football, do goals, and think about what's going on. I can get them moving and get get their system moving.’’ (Vicky, Psychotherapist).

> ‘’We've got two light soft balls and we play a game of catch and if you drop the ball you have to go down one leg and then if you drop it again the next leg, right? And we do that for a bit.’’ (Emma, Therapeutic Social Worker).

> ‘’Tossing a teddy around and moving around.’’ (Ruth, Integrative Counsellor).

So, you almost have to be, you know, in those times I'll be playful. So, I might have two puppets and go. No, they don't want that. They no, they don't. And they'll be watching me. But that'll be going no. I know they don't want it. What? You know, I'll be talking to my two puppets.'' (Vicky, Psychotherapist).

> ''So, what you do is you ask them to draw a picture of it, okay? Or maybe in the sand or something, and then you'd turn the picture over on, or you'd cover it in the sand with the sheet of paper or something. And then you do something fun.'' (Emma, Therapeutic Social Worker).

Also discussed were some of the challenges therapists faced when putting an EMDR approach into practice in their clinical settings. There was a sense amongst therapists that, particularly in public sector services, there were several challenges, which although not specific to EMDR, felt more noticeable when using this approach. For example, lack of access to appropriate therapeutic spaces which could be personalised and where sessions could take place uninterrupted, as well as little access to alternative technological aids, particularly for BLS as a substitute for eye movements or buzzers.

> ''I'm trying to think what other barriers really the usual things again are very common to the NHS. Having a room (where you've) not got someone bashing and bashing around outside or interruptions… but they're normal, aren't they… I guess in EMDR it's more noticeable.'' (Claire, Clinical Psychologist).

> ''Being the local authority, I'm not lucky enough to have equipment, EMDR equipment, they won't pay for it yet.'' (Emma, Therapeutic Social Worker).

Theme 2: Working Systemically

When and How to Involve Parents and Carers. Overall, therapists believed it to be inappropriate to use foster carers as resource figures where the placement was not stable and where a placement move was likely during the course of therapy as this was likely to destabilise the child or young person and undermine their therapeutic progress.

> ‘’That's dependent on the placement stability. Because you cannot use a foster carer as a resource figure if they're not going to be around. Because we're just, you know, saturating the losses for the child.’’ (Emma, Therapeutic Social Worker).

Therapists working in private practice reported a perceived trend toward parents and carers not being involved in EMDR therapy with children and young people. Therapists noted that often the child or young person would be ‘dropped off’ at the therapist’s office and the parent or carer would leave them there and go to work; therapists were of the opinion that this was unhelpful and often served to strengthen narratives around the child or young person needing to be fixed or ‘sorted out’ which was considered pathologising, particularly in circumstances where systemic factors were thought to be contributing to and/or maintaining the child or young person’s difficulties.

> ‘’In private practice, it’s a lot harder to insist that the parents do the work because they can just go, they're not going to, and I'll go find somebody else who’s actually going to do what I want with the kids.’’ (Jane, Lead Clinical Psychologist).

Therapists deemed those times when parents or carers were not willing or able to be involved in the child or young person’s therapeutic journey or make the necessary systemic changes required in order to create the conditions for change, to be areas of careful consideration. Some therapists considered times when parents

and carers were not willing or address to address identified issues to constitute potential safeguarding issues, thus rendering it inappropriate to offer direct EMDR therapy to the child or young person at that time.

> ‘’And if I felt strongly that actually, the young person needed the parent, and the parent wasn't able to do it because of their own trauma, and then the parent wasn't accessing their own help, even if that had been advised, you know, then you're in kind of safeguarding realms, aren't you about a young person? Not, not, not having access to what they need.’’ (Claire, Clinical Psychologist).

11.2 EMDR in the COVID-19 Pandemic

Given that this study was conducted during the aftermath of the COVID-19 pandemic which has impacted the way in which EMDR therapists have operated in clinical practice since March 2020 in the United Kingdom, it is important to acknowledge this context within the research. Due to the COVID-19 pandemic, therapists reported a change in the way they delivered EMDR therapy to children and young people. During the initial phases of the pandemic, government guidelines advised that face-to-face appointments should be kept to a minimum which for many therapists, resulted in EMDR therapy being ‘put on hold’. In cases where therapists were not able to offer face-to-face appointments for EMDR therapy, this was considered another experience of the child or young person not having access to what they need.

> ‘’I've had a couple of young people who have really missed having in person sessions, missed the EMDR and just can't do it online and and yet have really, really missed it. So, I feel like I've I've not been able to offer what they've needed. So I feel like I've I've got alongside their lack and their lack of, you know, an adult giving, you know, understanding their needs.’’ (Vicky, Psychotherapist).

It was also important for therapists to recognise when offering virtual EMDR to children and young people was not appropriate. Therapists recognised that often, by the nature of being at home, children and young people were being asked to engage in therapy whilst in the very environment thought to be contributing to, or maintaining, their difficulties.

> ‘’If you're doing online work and they're at home, you know, they’re at home with the people who are maintaining and or who have caused or who have who are in some way related to what, what on earth is going on with you and they need to be allowed to be somewhere else.’’ (Jane, Clinical Psychologist).

Therapists described issues with technology as being an ongoing challenge to offering virtual EMDR. For example, access to a reliable internet connection and screen freezing on devices were considered to impact therapists’ ability to safely offer virtual EMDR interventions. In addition, therapists noted that the intensity of the EMDR intervention appeared to deepen when offering this virtually and this was felt to be difficult for children and young people to tolerate.

> ‘’I think COVID was because I think quite a few of them didn't want to do it online and then it would freeze. And you know all of the, you know, you know, so it wasn't, you know, really not okay to do it in some points because I couldn't decide if someone froze or have I froze? And so, it made me sort of develop the relationship of sort of saying I would never switch off. And if things happen, I've got the phone here. Mum's got her phone or if it was a teenager, you've got your phone. I am going to be messaging you. Like, I'm not gonna leave you. So, I was always mindful about who had got an even sometimes I'd have the best connection, it would go boom, you know? So. So I feel like that had an impact.’’ (Vicky, Psychotherapist).

> ‘’So, I feel like there was something about (the online) work, acknowledging that intensity for young people and knowing how evocative EMDR therapy is.’’ (Vicky, Psychotherapist).

12. Extended Discussion

Since its inception, there has been extensive debate surrounding EMDR, firstly in relation to the intervention's efficacy, which has now largely been established through a host of RCT and meta-analytic studies for both adults (Chen et al., 2014) and children (Maxfield, 2019). And secondly, about how EMDR actually works, specifically in relation to the proposed central role of multi saccadic eye movements as facilitating the adaptive processing and integration of memories for adverse or traumatic experiences (Jeffries & Davies, 2013; Shapiro & Maxfield, 2002; van den Hout et al., 2001). A number of published studies have suggested that the inclusion of eye movements in EMDR therapy is unnecessary and that they do not serve to enhance treatment outcomes (Cahill et al., 1999; Davidson & Parker, 2001; Sack et al., 2016). However, more recently, through the use of f-MRI research, multi saccadic horizontal eye movements, such as those used in EMDR, have been shown to distinctly contribute to reductions in activity within the specific brain areas indicated in PTSD, including emotional regulation and autobiographical memory processing, thus resulting in lower levels of emotional distress being experienced by individuals following the intervention (Harricharan et al., 2019).

As EMDR practice and research has expanded, so too have the methods of bilateral stimulation being explored. Alternative methods such as tapping, auditory tones, and the use of tactile devices such as buzzers are growing in popularity, especially when working with children and young people (Gomez, 2013). There is some evidence to suggest that the use of tactile devices is as effective as the generation of multi saccadic eye movements within EMDR, however, the use of auditory tones has been shown to be significantly less effective (Nieuwenhuis et al., 2013). Overall, there appears to be conflicting evidence in relation to the contribution of, and mechanism of action in relation to eye movements within EMDR, as well as whether these are any more effective than other methods of bilateral stimulation or dual attention tasks (Jeffries & Davis, 2013). However, despite this ongoing debate within the literature, Schubert and Lee (2009) highlight that there is a reasonable amount of theoretical

support for the inclusion of eye movements and that studies investing the efficacy of EMDR have included these within their procedures, therefore, at present, there appears to be no basis to remove eye movements as a core feature of EMDR.

Given that similar treatment outcomes can be achieved in EMDR therapy using multi saccadic eye movements as when alternative methods of bilateral stimulation are used, it has been suggested that the mechanism of action in EMDR may be more accurately understood as the inclusion of a dual attention task, rather than any unique effect of eye movements per se (Shapiro & Laliotis, 2015). For example, asking a client to focus on a trauma memory whilst engaging in an external task such as focusing on the therapist's finger to elicit multi saccadic eye movements is said to reduce the vividness of the trauma memory and result in lower levels of emotional distress in the same way as if the individual was asked to focus on the trauma memory whilst using alternating buzzers or engaging in self-tapping movements. When working with children and young people, therapists are thought to be more likely to offer alternative forms of bilateral stimulation or dual attention tasks. Within the sample of therapists who participated in this study, the use of buzzers and self-tapping were particularly popular choices. Furthermore, therapists in this study also advocated for further creative adaptation to the ways in which children and young people were encouraged to elicit bilateral stimulation, for example, through the use of wobble boards or other forms of movements such as goalkeeping. In principle, the generation of bilateral stimulation through such methods makes sense and is likely to connect with a child or young person's interests (Perry, 2009), however, there is little research-based evidence confirming the impact of such modifications on the efficacy and effectiveness of EMDR, which some argue may threaten the integrity of the intervention and undermine its empirically supported status (Kemel Kaptan & Brayne, 2021).

With emerging evidence supporting the notion that dual attention tasks may serve as a mechanism of action within EMDR (Shapiro & Laliotis, 2015), it is important to be aware of the potential implications of this when working with children and young people. If the dual

attention hypothesis is correct, then younger children are likely to achieve poorer outcomes in therapy, as well as require substantial adaptations due to their age and the related deficits in divided attention ability. Young children aged between three and four years of age have been shown to have considerable difficulty in dividing their attention between two tasks, with this ability gradually starting to improve for most children from the age of five. However, despite some improvement, five-year-olds have been found to continue to perform below the level of school-aged children, adolescents, and adults on tasks of divided attention (Herrmann & Tomasello, 2015). In addition, participation in EMDR requires the individual to be able to sustain their attention on both the trauma memory and an external stimulus for specific periods of time, requiring well developed abilities in sustained attention processes. Generally, it is accepted that children have more difficulty in sustaining their attention compared with adolescents and adults (Berwid et al., 2005). Therefore, children are thought to be more likely to find it difficult to remain focused on tasks during EMDR sessions and as such, there is a need for therapists to find creative, engaging ways to keep children interested, as well as working flexibly to meet the child's needs in terms of session length. As a result, it is considered likely that younger children will require significant adaptation to EMDR therapy processes and procedures in order to enhance engagement and treatment outcomes, a notion that appears to be increasingly acknowledged in clinical practice as well as in the more recent developments in EMDR protocols for children and young people (Gomez, 2013).

From neuroscience research it has been well established that both working memory and sustained attention abilities improve with age. For example, the capacity of working memory, that is the amount of information that can be held in conscious awareness, has repeatedly been shown to be smaller in younger children compared with adolescents and adults. This suggests that the more complex a mental task is (i.e., the more information that is required to be held in conscious awareness), the less efficient a younger child will be in paying attention to, and actively processing, the information required in order to complete the

task (Lally & Valentine-French, 2019), conversely meaning that adolescents are likely to perform at a level similar to adults. In EMDR, this likely means that due to similarly developed cognitive abilities in working memory and sustained attention between adolescents and adults, that the underlying mechanisms proposed to facilitate therapeutic change when using the intervention with adult clients are likely to also apply to the use of EMDR with adolescents.

Although the underlying processes may be similar here, broadly speaking, adolescents are more likely to be closer to the traumatic experience in terms of length of time since its occurrence and are more likely to be continuing to exist within environments or systems where trauma is either still occurring or at least where significant triggers remain. Therefore, it could be argued that although theoretically the process and understanding of EMDR for adults may be appropriately applied to adolescents, there are likely to be relevant differences in the systemic factors operating within an adolescent's life. Such systemic factors may serve to maintain distress and may be different than, and potentially less within the adolescent's control, compared with adults.

In addition, working memory is proposed to be affected by biological maturation and coincide with neurodevelopmental processes such as myelination, axonal and synaptic pruning, changes in cerebral metabolism, and fluctuations in brain activity, meaning that working memory ability peaks, for most people, during adolescence (Morra et al., 2011). With this in mind, and if the working memory hypothesis of EMDR is correct, then adolescence could be considered the ideal time to treat early life trauma using EMDR as the intervention may be more efficient at this stage. However, empirical studies seem to suggest that in reality this is not usually the case, with therapeutic change for adult clients being achieved more swiftly and within fewer sessions, a result that is rarely replicated for children and adolescents (Gomez, 2013). One possible explanation for why such rapid therapeutic change has not been observed for children and adolescents within EMDR therapy may be related to the ways in which the developing brain has been impacted by their experience of

trauma at both a structural and process level. This often means that for young people who have experienced early life trauma, whilst they may be considered to be an adolescent by nature of their chronological age, their cognitive and developmental stage may not be congruent as they are continuing to undergo neurobiological changes.

Typically, individuals are not able to recall detailed accounts of events that happened prior to the age of two years, with research suggesting that several factors are necessary to facilitate the development of autobiographical memory, including brain maturation, language skills, opportunities to talk about experiences with other people, theory of mind, and the development of a sense of self (Nelson & Fivush, 2004), all of which are thought to be negatively impacted by early life experiences of trauma (Perry, 2009).

In both research and clinical observations, young children have repeatedly shown that although they are able to recall their personal experiences, they are rarely able to provide coherent accounts of such events, which is likely due to not having developed the cognitive structures (i.e., the hippocampus) required for such a task (Siegel, 1999). For example, whilst two-year old children are able to recall fragments of personal experiences, two-and-a-half-year-olds are able to recall considerably more details (Nelson & Ross, 1980), although these children still rely significantly on prompting from their caregivers (Nelson & Fivush, 2004). This is potentially problematic in the context of trauma therapy for children and young people who may have either experienced a traumatic event early in life, prior to the development of the cognitive structures necessary for the development of autobiographical memory, or where such structures have been impeded by experiences of trauma (Cozolino, 2010; Shapiro, 2001; Siegel, 1999; van der Kolk, 1999).

Within EMDR therapy, children and young people are asked to generate specific cognitions in relation to their experiences and the meaning they have attributed to these; children and young people often find this task difficult, particularly when the trauma occurred prior to the development of some specific cognitive and language abilities, meaning that the experience has been encoded at a purely sensory level. In these scenarios, in order to

process the child or young person's experience to adaptive resolution, therapists will often ask parents of caregivers to provide a narrative of the experience (Gomez, 2013). However, there are potential ethical issues which must be considered here, for example, whether it is possible for parents and caregivers to provide narrative accounts of the child's experience that are factually accurate and truly free from any personal bias or meaning. It has been suggested that where a narrative is provided which is not factually accurate, it is possible that the child may simply 'go along' with such an account, resulting in the creation of a false memory (Brainerd et al., 2002). This suggestion has implications for EMDR treatment as it is possible in such situations that key target memories are not identified and therefore remain unprocessed, meaning that even after treatment a child may continue to display signs of emotional and behavioural distress. On the other hand, it is increasingly being shown that children are actually less likely to acquiesce with 'facts' presented to them with which they do not agree and that they may be less susceptible to external influence than adults (Otgaar et al., 2019), perhaps suggesting that false memory creation and processing may not be such a significant issue within EMDR for children and young people, but one that therapists should remain mindful of nonetheless.

The AIP model underpinning EMDR recognises the influence of early life events on an individual's subsequent functioning and therefore, theoretically, supports EMDR as a helpful intervention for children and young people experiencing trauma-related distress (Kemal Kaptan & Brayne, 2021), albeit with some adaptations being required in order to ensure the developmental appropriateness of the intervention (Hase, 2021). Given the impact of trauma on the developing brain, clinicians cannot rely solely on a child's chronological age to determine whether adaptation to the EMDR intervention is required. Experiences of trauma during childhood have been shown to interfere with brain development. The brain structure and its associated processes develop in a 'bottom-up', hierarchical fashion, and therefore, for children and young people who have experienced trauma, may continue to be experiencing trauma, or at least remain in environments with

significant trauma triggers, their brain development is likely to be impacted. With this in mind, the neurosequential model of therapeutics (NMT) developed by Bruce Perry (2006) aims to help therapists explicitly consider the principles of neurodevelopment when working with children and young people.

Incorporation of the NMT is thought by some to address the theoretical shortcomings of EMDR as applied to use with children and young people and is said to enrich all eight phases of the intervention, although it is seen as perhaps most important during the preparation phase (Gomez, 2013). When using EMDR with children and young people, a critical element of successful treatment is to ensure that all included interventions are matched to the child or young person's developmental stage, keeping in mind the effects of trauma on the developing brain. For example, when a child or young person who has experienced trauma is triggered, the amygdala 'hijacks' the higher areas of the brain (McLean, 1990); to enable an individual to access the higher parts of their brain as required for the processing and integration of trauma memories, first the lower parts of the brain need to be regulated (Perry, 2006). Given that the brain develops in a hierarchical fashion, if trauma occurred early in a child or young person's life when the brain circuits responsible for regulation and survival were developing, the long term function of these systems is likely to be compromised (Perry, 2006), therefore it is important that brainstem regulation occurs early on in EMDR therapy and continues throughout all eight phases of the intervention when working with children and young people. Alternatively, therapists might consider sequencing interventions intended to help with sensory integration and regulation, followed by play based approaches before introducing the idea of EMDR therapy at all.

Despite the recognised need for creative and developmentally appropriate adaptation to the standard EMDR protocol when working with children and young people, there is relatively little research-based evidence confirming the impact of such modifications on the efficacy and effectiveness of the intervention, which some argue serves to threaten the integrity of the intervention and undermine its 'empirically supported' status (Kemal Kaptan &

Brayne, 2021). However, research focused on how therapists using other evidence-based treatments with children and young people approach making creative adaptations is promising; Racine (2006) found therapists who used their clinical experience and expertise to adapt therapy often reported a higher degree of ownership over, and continued use of, the intervention. Yet, research has highlighted the need to distinguish between therapist adaptations which represent innovative engagement which is intended to enhance treatment outcomes and those which could be considered 'slippage' and may detrimentally impact outcomes (Stirman et al., 2015). Of the therapists who participated in this study, all of them recognised the need for and potential advantages of making developmentally appropriate adaptations to the standard EMDR protocol when working with children and young people, however, therapists also confirmed that they adhered to all eight phases of the standard protocol which was seen as offering a sense of safety to both themselves as a therapist and to their clients, which has previously been considered essential for successful EMDR therapy (Whitehouse, 2021).

For some, EMDR is considered a distinct psychotherapeutic approach which requires extensive, specialist training (Dunne & Farrell, 2011), however, for many therapists who participated in this study, they did not consider the EMDR training they had received to be sufficient, particularly with respect to the adaptations required in order to successfully implement the approach with children and young people or with regards to working with complex developmental trauma and the multi-faceted systemic factors often involved in this type of clinical work. Views of the therapists who were involved in this study echoed the opinions of those who participated in Dunne and Farrell's (2011) study concerned with how clinicians integrated EMDR into their clinical practice, with many believing the EMDR training provision to not consider adaptation and integration nearly as much as would have been helpful.

All therapists who took part in this study discussed their use of supervision and recognised this as playing an important role in their journey toward becoming confident and

competent EMDR practitioners. However, some therapists spoke to the lack of availability of EMDR supervisors, echoing the findings of Dunne and Farrell (2011) who suggested that problems with the availability of effective supervision restricted opportunities for EMDR therapists to develop the required competencies to practice as an effective EMDR practitioner. Over the course of the COVID-19 pandemic, therapists considered that having robust supervision had been an even more vital element of their practice, especially given the isolated nature of working from home experienced by many. Therapists also considered the limited research evidence supporting the efficacy and safety of offering EMDR as a virtual intervention and discussed the need for further adaptation to the standard EMDR protocol to not only account for the child or young person's developmental stage, but also the online context of the work. With regards to offering EMDR to children and young people during the COVID-19 pandemic, therapists reported being initially reluctant to offer therapy virtually due to the lack of research evidence; a systemic review by Lenferink et al., (2020) found only one study examining the effects of online EMDR therapy for children and young people. That study, conducted by Spence et al., (2013) investigated the effectiveness of internet-delivered combined CBT and EMDR therapy on the symptoms of PTSD and found a reduction in clinician-rated symptom severity between pre- and post-intervention scores. However, overall the systemic review by Lenferink et al., (2020) cautioned against the premature delivery of internet-based EMDR due to a lack of research evidence, something which therapists within this study were mindful of.

Specialist child and adolescent EMDR training in the United Kingdom is accredited by the EMDR Association (Europe; International; UK & Ireland). One of the responsibilities of the EMDR Association is to provide guidelines to ensure the safe and effective training in, and use of, EMDR with children and young people. For example, the EMDR UK and Ireland Child and Adolescent Committee (2019) set out that any professional offering EMDR to children and young people must: complete level one of the standard EMDR training, be trained in using EMDR with children and adolescents by an accredited EMDR child trainer to at least level one, have completed subspeciality training to work with children and young

people, have at least 12 months of current clinical experience working in the field of child and adolescent mental health, be in receipt of supervision from an EMDR consultant whose work is predominantly with children and young people, and have access to peer support from other colleagues trained in EMDR.

In addition to providing guidance to professionals, the EMDR Association is also responsible for accrediting EMDR trainers and monitoring the content of the training they offer to ensure it meets the required standards for quality and safety. There are two levels of specialist EMDR training available for professionals intending to use the approach with children and young people; for those wishing to apply for Accredited EMDR Practitioner status, both level one and two must be completed. Unfortunately, information about accredited status was not routinely collected from therapists who participated in this study.

It is acknowledged that some differences exist between EMDR training providers in terms of the curricula they offer at both level one and two; this allows scope for trainers to tailor the content on offer based on their individual areas of competence and expertise. What this means is that in practice, although courses are all accredited, they are not necessarily offering the same content. The benefit to this is that therapists are afforded a degree of choice when considering which training provider to choose. However, the drawback of this means that not all therapists access the same content and even, at times, undertake different hours of training further increasing the likelihood of variation between therapists and how they translate training content into their clinical practices. One limitation of the current study is that therapists were not asked to provide details about their trainer and/or training provider; therefore, how far the findings in relation to the shortfalls of training identified in this study can be generalised is affected by this. For example, if all of the therapists who participated in this study had reported completion of their training with the same trainer and/or provider, it may have been possible to conclude that some of the shortfalls of training identified could be attributed to the trainer themselves (i.e., not having specific experience in a particular area). However, if therapists had reported accessing their EMDR training through different trainers and/or providers but all shared similar shortcomings of the training

offered, then it may be more appropriate to attribute these shortcomings to the training content itself rather than individual trainer factors. On this occasion it is not possible to conclude definitively on this matter.

More recently and intended to be used in conjunction with the guidelines set out by the EMDR Association to drive safe and effective practice, a competence framework for EMDR was commissioned by Health Education England (Roth et al., 2021). The EMDR competence framework consists of six skill domains (see Figure 3), all of which are considered necessary for the delivery of safe and effective EMDR therapy.

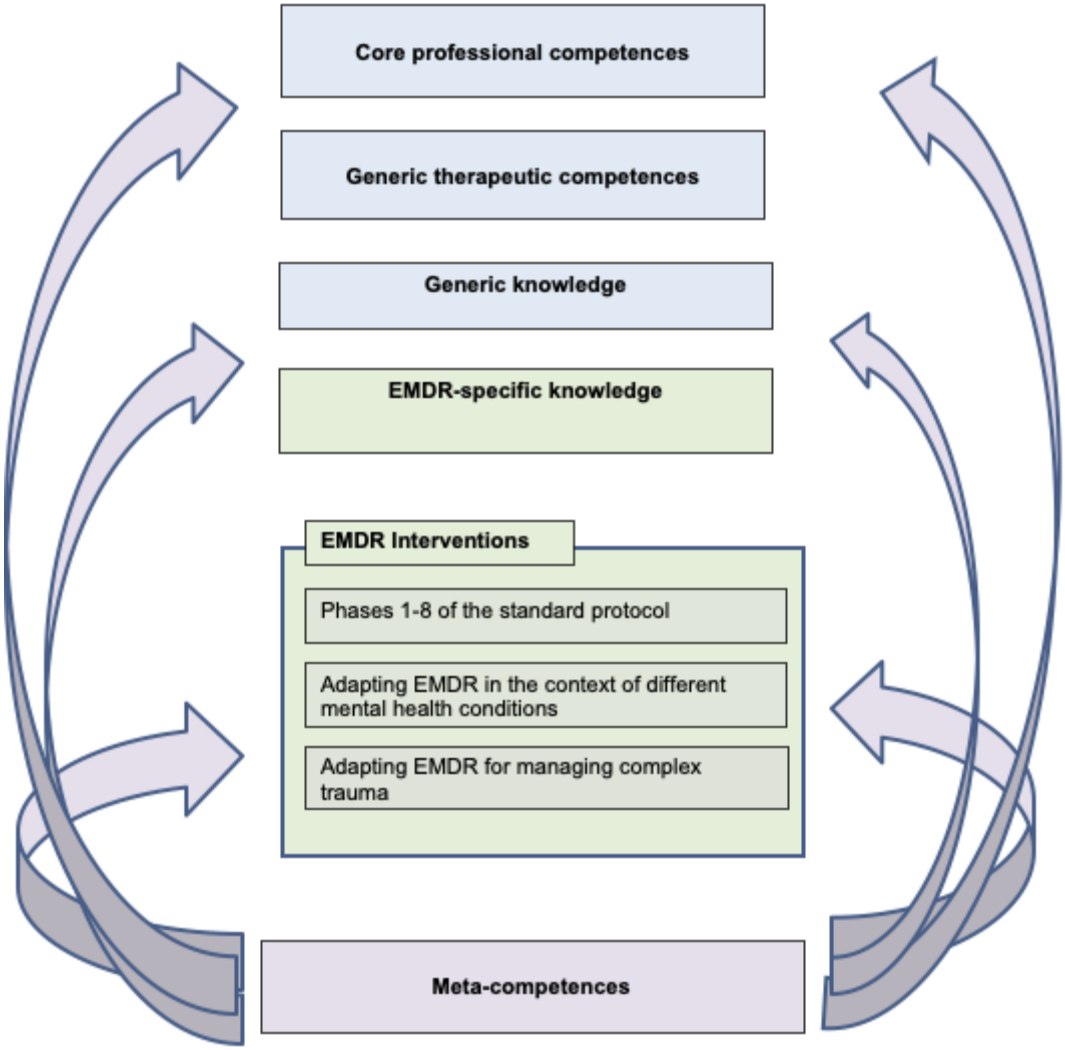
Whilst the EMDR competence framework has been useful for clinicians working with adult clients, for those working with children and young people, additional competences must be included. For example, in addition to EMDR specific knowledge, clinicians working with children and young people must also have an understanding of child development as well as how this can be impacted by experiences of trauma. Some therapists who participated in this study believed that more could be done within the training provision to cover key aspects of attachment, child development, and the impact of trauma to ensure that therapists were not only equipped with the knowledge and skills required to work effectively, but also to reduce the risk of re-traumatising children and young people. In addition, although recognised within the Good Practice Guidelines (EMDR Association UK, 2018), children and young people often present to services with complex needs which require interventions in addition to EMDR; in this study, many therapists felt that these issues had not been adequately discussed within the training they had attended. Therefore, there may be scope to expand the EMDR competence framework to specifically consider working with children and young people with the findings of this study offering some ideas about the additional skill domains required.

Furthermore, the EMDR competence framework highlights the importance of supervision in maintaining fidelity to the EMDR model, however to ensure that the differences between using EMDR with adult and child or adolescent clients are recognised, it would be helpful for the framework to include the use of supervision as a space to think

about how and when to make developmentally appropriate adaptations to EMDR therapy whilst ensuring fidelity to the model when working with children and young people. One potential strength of the framework is that, used alongside the Good Practice Guidelines, it may be a useful tool to help improve the quality of supervision for EMDR therapists. For those working with children and young people, the importance of having a supervisor with significant experience of working with this client group is advocated, however, in this study, some therapists believed that there were not enough EMDR supervisors available with child and adolescent experience. With the competence framework, Good Practice Guidelines, and the findings of this study in mind, it may be beneficial for EMDR accreditation bodies to consider how they might increase the number of appropriately trained and experienced supervisors available to child and adolescent EMDR therapists.

Figure 3.

Outline model for the competence framework for EMDR (Roth et al., 2021).



12.1 Strengths, Limitations, and Future Research

One of the key strengths of this study was the inclusion of therapists from a diverse range of professions, service settings, and length of experience using EMDR as a psychotherapeutic intervention with children and young people, which has enabled a broad variety of perspectives and experiences to be explored. However, noticeably, within the sample there is no representation of the perspectives and experiences of therapists working with children and young people in acute mental health settings such as inpatient services; this lack of representation mirrors the lack of published literature on the use of EMDR within inpatient settings more generally (see Hase et al., 2015 and Proudlock & Peris, 2020, for discussions of the use of EMDR in adult acute services). Research evidence suggests that

EMDR is an effective treatment for adult clients experiencing acute mental health difficulties and can be safely used as an intervention within acute mental health settings (Proudlock & Peris, 2020). However, it is not clear from the sample within this study whether therapists working in the equivalent services for children and young people are using EMDR in their clinical practice. With this in mind, it would be important for future research to explore the use of EMDR therapy within child and adolescent acute services to establish whether, and how the intervention is delivered within these settings. With the aims of this study in mind, it would be of interest to speak with therapists working in acute settings to explore their experiences of adapting EMDR for use with children and young people in the inpatient context and to consider any barriers and facilitators to implementing the approach within such settings.

Although a range of therapist experiences of using EMDR with children and young people have been captured within the recruited sample, it is also prudent to acknowledge that some information that could have been helpful in contextualising the sample, their experiences, and perspectives on adapting EMDR when working with children and young people, was not collected and therefore limits the generalisability of the study findings.

Firstly, information about the length of time therapists had been working clinically was not collected, and therefore interpretations about the influence of this on a therapist's confidence and self-perceived competence in both using and adapting their EMDR practice when working with children and young people, could not be made. It has been suggested that therapists with fewer years of clinical experience may be more likely to make adaptations to evidence-based approaches than their more experienced counterparts, indicating that, perhaps, novice therapists have greater motivation to adapt therapy to meet the needs of their clients (Lau et al., 2017). However, within the sample of therapists who participated in this study, some believed that after completing their initial EMDR training they had tended to follow the protocol more rigidly, and that only after they became more familiar and experienced in using the approach, did they feel confident enough to begin exploring

how to adapt this for use with children and young people. However, by omitting to collect information about therapists' pre-EMDR clinical experience, it is unknown whether they had trained in EMDR early in their clinical careers or came to the approach much later, having trained in other therapeutic modalities previously.

Secondly, information was not collected in relation to the range of therapeutic modalities and/or theoretical orientations therapists were aligned with; it is therefore not possible to comment on how closely matched the principles of EMDR were to each therapist's usual approach to psychotherapy. This is an important point given that research has shown that when a therapist trains in a new therapy (e.g., EMDR) which is not aligned with their usual therapeutic and/or theoretical approach, they are more likely to make adaptations to the newly acquired therapeutic modality (Gaudiano et al., 2011) which may involve augmenting with elements taken from their existing repertoire or removing elements of the new modality which are not consistent with their usual approach (Allen & Crosby., 2014; Lau et al., 2017). Furthermore, by neglecting to gather information about both the number and type of therapeutic approaches therapists were trained in (in addition to EMDR), it is not possible to offer conclusive comments about the key adaptations identified by therapists within the study. For example, therapists reported the use of narratives and play as the main adaptations to the standard EMDR protocol they used; if information about which approaches therapists were trained to use had been collected, it may have been possible to conclude that these appeared as the two main adaptations because all therapists had also received training in narrative and play therapy. Without this information, it is not possible to conclude whether the types of adaptations most commonly reported within the study are a result of them being the most developmentally appropriate adaptations to the standard EMDR protocol or whether these appear more popular due to a bias within the sample in terms of previous training experiences.

Thirdly, demographic information relating to therapist ethnicity and cultural background was not collected and therefore it is not possible to consider the study results

through such a lens. During the development of the interview schedule, the research team debated about collecting information on therapist ethnicity but could not find evidence within the existing literature to justify inclusion of this. On reflection, this omission may be considered a missed opportunity as currently, there is potentially a whole host of research data not being considered through a cultural lens, with the continued non-collection and non-reporting of this information perpetuating the problem. Within the study, six therapists came from white backgrounds, however, one therapist shared during her interview that she had been born, raised, and clinically trained outside of the UK and believed that this had greatly influenced her approach to clinical work. On this occasion, further exploration of the influence of cultural differences on using and adapting EMDR have not been explored but would be important to consider in future research. And finally, although demographic information was collected in relation to gender, all therapists who participated in the study identified as female and it may be of interest to future researchers to explore whether those who identify as male report similar experiences of using and adapting EMDR when working with children and young people.

The main limitation of this study may be considered the sample size that was achieved. Although Braun and Clarke (2013) suggest that for small projects a sample size of between six and 10 participants is sufficient, the achieved sample of seven in this study is unlikely to have resulted in data saturation being achieved, as is often the measure of sample size sufficiency in qualitative research. Although the first author attempted to recruit participants using a variety of channels, it is possible that none of the research team being trained in or using EMDR in clinical practice limited opportunities to reach a wider participant pool; at the time of study conceptualisation, the first author's primary supervisor was working as a senior clinician offering EMDR to children and young people in a service where most other professionals were also trained in and using the approach, however, after this supervisor stepped away from the project there was no longer a point of contact or existing relationship that could be used to access therapists working in that service. As such,

recruitment has relied heavily on a self-selecting sample recruited through social media advertising, which by its very nature serves to exclude any therapists who do not access social media or who were not members of the specific groups in which the study advert was posted. Furthermore, although a snowball sampling method was used, this did not appear to aid recruitment, with only one participant being recruited in this way. Overall, it must be recognised as possible, that if additional participants had been recruited that alternative experiences may have been uncovered. For example, we know from client-focused research that not all experiences of EMDR are positive (Shipley et al., 2021) and therefore one must assume that some therapists may also have negative experiences of delivering the intervention. Future research should try and actively seek out therapists who have had some negative experiences using EMDR as a way of ensuring a balanced perspective is offered within the literature.

With regard to future research, whilst both narrative and play therapy have been cited in this study as helpful approaches when considering how to adapt EMDR for children and young people, it would be interesting for future researchers to consider conducting an additive study to establish the degree to which each of the included components (i.e., EMDR specific techniques, narrative adaptations, inclusion of play) offer a distinct contribution to clinical outcomes. Furthermore, it is acknowledged that existing researchers and clinicians are working to develop alternative, adapted protocols that can be used to guide EMDR interventions when working with children and young people. Whilst it will be important for these protocols to be rigorously tested to ensure their efficacy and safety, it would also be of interest to compare the effectiveness of these newly developed protocols with the standard EMDR protocols both with and without the narrative and play therapy adaptations suggested by this study. Any such research within this area should seek to determine whether there is parity of clinical outcomes between newly developed and adapted standard EMDR protocols when working with children and young people.

Moreover, it would be important for future researchers to consider the experience of children and young people being offered EMDR therapy and to gain their perspectives on the acceptability of the intervention. Many of the trauma-focused interventions that are offered to children and young people have been adapted from protocols that were originally developed to meet the needs of adult clients (Greyber et al., 2012), and EMDR therapy is one such intervention. It is well established that for an intervention to be recommended for use in clinical practice that it must be shown to be both efficacious and effective, as has been demonstrated for EMDR therapy. However, there is increasing recognition of the importance of considering the acceptability of an intervention (Milosevic et al., 2015). It is suggested that when an intervention is deemed acceptable by a client, they are more likely to adhere to and benefit from it (Fisher, et al., 2006; Hommel et al., 2013), furthermore, when the acceptability of an intervention is low then this may, in part account for higher levels of treatment attrition (Milosevic et al., 2015).

The acceptability of EMDR therapy for children and young people does not appear to have been explored. Ensuring that trauma-focused interventions offered to children and young people are acceptable is an important consideration for clinicians. Acceptability has been shown to be related to treatment adherence, outcomes, and attrition (Fisher et al., 2006; Hommel et al., 2013; Milosevic et al., 2015); observations in clinical practice support that some difficulties with adherence and engagement with EMDR within CAMHS populations exist. In addition, it has also been suggested that experiences of therapy during adolescence may influence the likelihood of the individual seeking help for difficulties in later life (Watsford & Rickwood, 2014). Ensuring that the interventions offered to children and young people are not only efficacious and effective but also acceptable is likely to be an important factor in the future trajectory of their mental health difficulties and their help-seeking behaviours in adulthood.

12.2 Implications for Training and Clinical Practice

- Therapists reported valuing the opportunity to discuss and reflect on their experiences of using EMDR therapy with children and young people and believed this to aid their professional development. However, given that some therapists reported difficulty accessing adequate supervision due to a lack of available EMDR supervisors for those working with child or adolescent clients, therapists may benefit from considering alternative or additional ways to gain supervision. For example, therapists may benefit from accessing local peer supervision or special interest groups or setting these up in their locality where they do not already exist.
- Given that child and adolescent EMDR therapists are more likely to be working with clients whose traumatic experiences occurred in the more recent past, and that the experience of delivering EMDR can be evocative, therapists may benefit from having access to formal support structures over and above clinical supervision. Some therapists reported having ongoing personal therapy and cited the benefits of doing so; it may be helpful for therapists to consider this for themselves as a proactive means of looking after their own emotional well-being in the context of delivering trauma-focused interventions.
- The accounts shared by therapists in this study have provided valuable insight into the experiences of those working in a range of service settings offering EMDR therapy as an intervention for children and young people. These accounts have provided much-needed qualitative data about EMDR and the experiences of those delivering the intervention, including to highlight areas of need within training provisions (e.g., offering further guidance about adaptations). The findings of this study may help those considering adding EMDR to their therapeutic toolkit or those more recently trained consider how to adapt the intervention in clinical practice and encourage newly trained therapists to look into other modalities that appear to integrate well with EMDR such as narrative and play therapy to gain an

understanding of how to utilise some of these techniques to enhance outcomes in their own clinical practice.

- Within the Child and Adolescent EMDR training, it would be important for providers to focus more explicitly on why adaptation to the standard protocol may be necessary and to teach delegates how to do this in their clinical practice without undermining the empirically supported status of EMDR. With the findings of this study in mind, training providers may consider incorporating guidance on how to use elements of narrative and play therapies within the standard EMDR protocol when working with children and young people with a focus on when such adaptation might be appropriate as well as how to do this practically. Particularly for therapists who have not received formal training in narrative and/or play based approaches, the inclusion of these potential adaptations within the EMDR training curricula may serve to bolster therapist confidence and competence in making such adaptations. Furthermore, by providing guidance to delegates about specific narrative and play therapy adaptations that appear helpful when working with children and young people, it may be possible to standardise some of the ways in which EMDR is adapted, meaning that there would be less variation in the approach each child is offered. With this in mind, it would be important for the outcomes of any such additions to EMDR training provisions to be evaluated, both in terms of therapist confidence and competence, but also how this translates in terms of outcomes for children and young people in clinical practice (Lau et al., 2017).
- The findings of this study suggest that EMDR therapists working with children and young people should spend a significant amount of time building a safe and trusting therapeutic relationship. By investing in the therapeutic relationship therapists may be able to improve treatment adherence and outcomes and provide children and young people with a positive experience of therapy (Shirk & Karver, 2003). Providing individuals with a positive experience of therapy during adolescence has been shown to increase the likelihood of the individual seeking help for any difficulties they might

experience in the future (Watsford & Rickwood, 2014).Therapists reported that as they became more confident in using EMDR they began to feel more comfortable in adapting the approach to meet their individual client's needs and encourage collaboration from the child or young person accessing therapy. This is an important consideration when working with children and young people who have experienced an early life trauma, finding a balance between supporting and empowering them to make decisions that are right for them. Encouraging individual choice and person-centred care is an important consideration and is a requirement set out by the Care Quality Commission (CQC) and the NICE Guidelines.

12.3 Conclusions

Therapists broadly considered EMDR therapy to be a helpful intervention for working with children and young people, particularly in the context of trauma-related distress. EMDR provides a structured protocol and process that can help both therapists and clients experience a sense of safety within the intervention, with safety being considered an essential component for successful outcomes in EMDR therapy. Therapists were mindful of creating a safe and trusting therapeutic relationship with children and young people but noted that this could be hindered if therapists stuck too rigidly to the standard EMDR protocol. Instead, therapists advocated for the use of creative adaptations throughout the therapeutic process to ensure the developmental appropriateness of the intervention and enhance engagement among children and young people; two adaptations that appeared popular amongst therapists were the inclusion of narratives and the use of play. However, therapists noted that relatively little attention had been paid to how one might adapt EMDR therapy for use with children and young people during their child-specific EMDR training and reported this to be a significant flaw of the training provision, leaving them feeling somewhat unsure about how and when to make adaptations when putting EMDR into practice in their clinical roles.

Therapists were also mindful of wider systemic factors when working with children and young people, and were particularly aware of the potential benefits and pitfalls of

involving parents and carers in the EMDR process. Parents and carers were thought to be able to fulfil a range of roles, including providing detailed background information, supporting with stabilisation and resourcing exercises, and even administering the BLS when appropriate. However, at times, parents and carers were thought to become overinvolved in therapy and at these times their involvement tended to hinder the child or young person's therapeutic progress. In addition, therapists reported that often a ripple effect occurred when EMDR was offered to children or young people, highlighting the presence of trauma within other layers of the system which would benefit from being addressed. At times, a parent or carer's own experience of trauma was thought to be a block to successful therapy with the child or young person. Overall, it seems that further guidance within EMDR training provisions about when and how to involve parents and carers in therapy may be helpful for therapists.

Overall, therapists were cognisant of the fact that working with children and young people using an EMDR, often in the context of trauma-related distress, presented complex and multi-faceted issues which needed careful consideration to promote positive outcomes for children, young people, and their families. Therapists tended to make use of supervision as a space to reflect on and seek guidance about the complexities they faced in their clinical work and considered this key to developing confidence and self-perceived competence in using an EMDR approach with children and young people.

13. Critical Reflection

13.1 The Research Team and Reflexivity

Reflexivity refers to the continuous process of reflection through which researchers examine their own assumptions, beliefs, and practices. Reflexivity is important throughout all stages of the research process and can help reduce the risk of bias in data collection, analysis, and interpretation (Haynes, 2012). Throughout the study process, the subjectivity of both the researchers and participants has been recognised, and it is acknowledged that the researchers' personal views and experiences will have influenced the way in which the data collected has been analysed (Fletcher, 2017). The research team for this study consisted of a trainee clinical psychologist (first author) and two experienced clinical psychologists. Although none of the research team had received training in EMDR therapy or used the intervention in their clinical practice, all had previous experience of working with children and young people, and of delivering trauma-focused interventions.

The main author is the only member of the research team with an interest in, and knowledge of using EMDR as a psychotherapeutic intervention, although she has not completed the EMDR training or used the approach in clinical practice. However, the main author intends to complete EMDR training during the post-qualification period and use this as an approach in her clinical work. It is therefore important to recognise that the main author's pre-existing views on EMDR are largely positive, seeing the intervention as a helpful and beneficial approach to working with trauma-related distress.

During the data analysis process, the researchers met regularly to reflect on the influence of their existing assumptions and biases, including their perspectives on EMDR therapy and their personal experiences of working with children and young people. A reflective journal was kept throughout the research journey as this is suggested to enhance transparency and improve the trustworthiness of findings (Nowell et al., 2017).

13.2 Experience of the Research Process

Acting as a scientist-practitioner is a key element of the Clinical Psychologist role (Carter, 2002) and one which all trainees are encouraged to develop over the course of their clinical psychology training. On the Trent programme, trainees were asked to introduce a colleague by talking about their intended thesis research project on the very first day of the course, thus setting the scene for the credence given to the research element of the programme.

For me, I was lucky enough to have quickly identified several potential research projects which fitted with my interest of working with children and young people, and after meeting with a potential primary supervisor was able to narrow this down to a qualitative project exploring young people's perspective on the acceptability of EMDR. Initially, given that I had relatively little previous experience, I felt incredibly anxious at the prospect of undertaking such a large piece of research, especially in the context of the multiple other demands placed on me in terms of academic assignments, clinical practice, being a mum, and very soon, a global pandemic. However, I was able to develop a positive relationship with my primary supervisor and perceived her to be compassionate, supportive, and knowledgeable, all of which were qualities that served to reduce my experience of research-related anxiety. As a result, the initial planning stages of the research project progressed without issue.

The original project idea centred around exploring young people's perspectives on the acceptability of EMDR as this area within the literature was severely lacking; I have always felt strongly about actively involving children and young people in their care and seeking their feedback on any therapeutic experiences, it was therefore uncomfortable for me to realise that EMDR therapy had become so widely available in clinical practice with very little research having been published detailing their experiences of the therapy. Throughout the first year of the training programme, I worked diligently to present the initial project idea at various panels of course staff, service user and carer advisory panel

(SUCAP) members, and fellow trainees; on each of these occasions the project was well received by the audience and was given the ‘go ahead’. As a result, it was possible to proceed with making an Integrated Research Application System (IRAS) application, and although this was a lengthy and complicated process, it again went relatively smoothly, with ethical approval being granted by the IRAS review committee in January 2021. However, shortly after beginning the recruitment process, it became apparent that issues relating to the reduction in face-to-face appointments being offered to clients due to the ongoing COVID-19 pandemic had severely affected the delivery of EMDR therapy across child and adolescent services. In addition, despite several Trusts having initially agreed to support the recruitment of participants to the study, clinicians soon stopped replying to emails, undoubtedly due to the busy nature of their roles, which meant that recruitment, and therefore the study came to a halt. On reflection, one of the key challenges during this phase was the lack of pre-existing relationships with clinicians working in the different Trusts, resulting in me remaining a fairly anonymous figure whose research project was fairly easy to put to one side as it was, understandably, not considered a priority in the context of busy services and high job demands. During the recruitment period, two potentially eligible participants were identified, however, after initial screening, one participant did not meet the inclusion criteria, and the other subsequently changed their mind about taking part due to a number of personal factors.

Despite ongoing difficulties with recruitment for the first six months following IRAS approval being received, I was encouraged by my primary supervisor to continue trying to recruit participants for a further three months. At that time, given the effort and resources I had already invested in the project I decided to follow the advice of my supervisor and continue trying to recruit participants. However, my supervisor also advised me at this point that she would be taking extended leave and was no longer able to supervise the project. In hindsight, given that my primary supervisor was the only member of the research team with experience in offering EMDR to children and young people, and the only person with a pre-

existing relationship with other clinicians offering the intervention, it perhaps would have been beneficial to have re-assessed the viability of the project and considered an alternative approach at that point, especially given the external time constraint imposed by the nature of the training programme within which the study needed to be completed. However, I continued to try, unsuccessfully, to recruit participants for a further three months, at which point I was assigned a new research supervisor and we made the decision to end the original project. After many discussions about potential alternative projects, we agreed to alter the focus and explore therapist perspectives on the acceptability of EMDR, however, after meeting with the module convenor to discuss this alternative focus, it was agreed that this project was unlikely to generate novel insights. Eventually, after much discussion amongst the research team, the decision was made to broaden the scope and explore therapists' experiences of offering EMDR therapy more generally as well as how they made use of clinical adaptations when working with children and young people.

The process for obtaining ethical approval from the University of Nottingham was a much simpler one than I had experienced when applying for IRAS approval. As a result, once ethical approval had been granted, I noticed a renewed sense of enthusiasm for the project, which was reinforced by the initial flurry of interested therapists requesting further information about the study. Overall, twelve potentially eligible participants made contact about taking part in the study, although only seven of these eventually completed an interview. However, amongst those taking part in the interviews, all shared incredibly positive views on the project, believing that it would add value to the EMDR community, as well as offering them a space to pause and reflect on their practice. Although I initially found conducting the research interviews anxiety-provoking, these soon came to be an enjoyable and worthwhile experience. There were moments when I was caught off guard when participants made comments regarding my lack of experience using EMDR, which at times left me questioning whether I was appropriately qualified to be investigating this topic. However, on reflection, I think that not having clinical experience of EMDR enabled me to

retain a position of genuine curiosity and not feel constrained or influenced by my own experiences or preconceived ideas about whether participants were doing therapy in the 'right' way. Furthermore, by talking to therapists who worked with children and young people, at a time when I was working clinically with other populations, spoke to my interest and passion for working with children and young people, further helping to transform an initially anxiety-provoking experience into one which I looked forward to. Through the data collection stage of the study, one key learning point which I will take into my clinical practice is the importance of the need to have an understanding and personal experience of EMDR before offering it as a psychotherapeutic intervention, to understand how evocative it can be; this idea really fits with my approach to clinical practice whereby I will not ask someone to do something within therapy that I would not be prepared to also do.

Throughout the research process, it has been important for me to remain aware of my pre-existing views on EMDR, and the potential way in which this, generally positive view of EMDR might influence the analysis and representation of the data. Accessing supervision and keeping a reflective diary have been helpful ways of maintaining an awareness of this potential influence and have promoted objectivity throughout the project. In addition, whilst conducting the interviews and analysing the data, I became aware of a particular affinity towards participants one and four and the ways in which they described their practices and experiences. Throughout both accounts, I was drawn to their reflective and thoughtful nature, the way they described their work with children and young people in such compassionate and respectful ways, and the parallels I drew between their personalities, views, and approaches with those of my own. For these reasons, it was important to acknowledge and monitor the influence of this, particularly during the data analysis and when reporting on the results as I found myself naturally drawn to their quotes, sometimes over those of other participants which meant that, at times, it was necessary to consciously revisit the results and replace some of the quotes from these participants with those from

other therapists to ensure a balanced reflection of all participants experiences was represented within the study report.

13.3 Ethical Dilemmas

In terms of ethical dilemmas, the main point of consideration centres around the change in focus during the research process, from exploring children and young people's perspectives and experiences to exploring those of therapists. For me, personally, I was keen to speak with children and young people to gain their views and represent them in what could currently be considered an incredibly sparse literature base. However, due to the recruitment difficulties experienced within this study, there remains a significant gap in the literature in terms of children and young people's experiences of EMDR therapy. As someone who intends to complete EMDR training in their post-qualification role and who will be working with children and young people, it does not sit comfortably to not have access to the insight from children and young people about their experiences of the therapy. As such, it will be my intention to attempt to gain insight from children and young people on a smaller scale within my own clinical practice, bearing in mind the role of the therapeutic relationship as highlighted in the findings of this study which may prevent children and young people offering honest feedback about their experiences directly to me.

Furthermore, although this project has attempted to add to the relatively sparse literature base relating to therapist experiences of providing therapeutic interventions generally, and the very little that has been written on therapist experiences of offering EMDR therapy more specifically, there remains a sense of disappointment that I have not been able to work towards representing the views of children and young people within the literature base and this is something I would advocate future trainees and researchers to consider, especially now that working practices are beginning to return to a pre-pandemic state and EMDR therapy provision is resumed amongst child and adolescent populations.

13.4 Areas of Learning and Development

Through the research process, one of the most valuable lessons I have learned is to speak up when I do not agree with a decision that has been made. At the time when my original primary supervisor suggested that we continue trying to recruit participants for a further three months despite having no success for the previous six months, it would have been helpful for me to have raised my concerns and advocated for a change of project at that time. However, I did not have the confidence to disagree with the approach proposed by my supervisor and this has been to my detriment as I will not have completed the research component of the programme within the training period and this has financial and time implications, at least in the short-term, for my future career. After being assigned a new supervisor, one of their first comments was that a new project should have been considered several months prior, which validated my position and has encouraged me to speak up for myself in the future. In addition, the change in the supervisory team meant that from that point I was the member of the research team with the most knowledge of EMDR. This was a somewhat difficult position to navigate at first, especially given that I have no working knowledge or clinical experience of the intervention, only what I have read and learned through academic means. However, being in this position was also empowering and freed me up to drive the new project forward, formulating many of my own ideas and using supervision as more of a guiding resource to check things out rather than a directive 'tell me what to do' space. This shift speaks to a development in my confidence that appears to have happened gradually since the end of 2021 and which I believe has been associated with positive and supportive supervisory experiences which have encouraged me to consider and celebrate my strengths and achievements.

In terms of learning needs, I notice that the pressure I put myself under during the final three weeks of training to have the project completed and submitted was counterproductive. During the first week of the study block, I felt overwhelmed by the task ahead of me and found it difficult to make progress. For me, I find working towards a

deadline helpful, but this experience has highlighted the need for deadlines to be realistic and achievable in order to be motivating. Also, during a recent supervision session, I was advised that the data analysis was likely to take longer than I had initially anticipated, something I did not want to hear due to my self-imposed timescale; however, this discussion proved to be one of the most helpful things I could have been told, because indeed, the data analysis took much longer than I had initially expected, but having had that conversation, I was able to avoid the spiral of self-deprecation associated with believing that this was due to my incompetence as a researcher, but rather this was a common experience for many people during the data analysis phase of a project.

Perhaps the biggest learning, and indeed points of validation for me throughout the research process have been that it has reinforced that I am very much aligned with the clinical aspect of my role and that this is the area I am most passionate about. This research experience has not served to convince me that research is an area of my career that I wish to pursue, although the journey has increased my confidence and self-perceived competence in conducting and consuming research in the context of my clinical role as a way to inform my practice, however, I do not feel inclined to involve myself in projects of this scale in the near future. I anticipate that the research skills and confidence I have developed over the past three years will assist me in my practice and are likely to be utilised in smaller avenues such as small-scale research projects within my service setting, which will support me in remaining research active in a manageable capacity, post-qualification.

13.5 Overcoming Challenges

The training journey throughout the past three years has been filled with challenges, firstly the context of the COVID-19 pandemic which has changed the way in which teaching, supervision, placements, and research have operated, resulting for me, in working more autonomously than at any other time in my career. However, whilst this has been a challenging experience, on reflection, this has also served to encourage my personal and professional growth and forced me to have conviction in my decision-making. These are

skills and experiences which I believe will serve me well in the next phase of my career where I will be accountable for my own practice and decision-making.

In the context of my research journey, having to change the project three times and still being in a position to submit my thesis portfolio not too far beyond the end of training has been incredibly stressful and I have felt a great deal of pressure, albeit mostly self-imposed to complete this. The fact that I have worked so hard to achieve this speaks to my dedication and resilience, particularly when achieving this has been in the context of some very difficult personal circumstances. I feel proud of what I have achieved, both in terms of learning and development over the course of training, meaning that I am entering my qualified role as a confident and competent clinician who is able to take on board feedback to further develop and grow my practice for the benefit of the clients I work with.

Overall, my experience of training has been a varied, enjoyable, and challenging one. I have grown to welcome contradictory feedback that has been such a staple of the Trent course and I am leaving training with a greater sense of belief in my ability to assimilate such feedback for the benefit of my development and professional growth. And finally, whilst I am not leaving training with a newfound passion for research, I am no longer anxious about undertaking such roles and I shall endeavour to seek out opportunities to, in some capacity, remain research active post-qualification.

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15. Appendices

15.1 Appendix C: Study Advert

Exploring Therapists' Experiences of using Eye Movement Desensitisation and Reprocessing Therapy with Children and Young People

Do you work with children and young people under the age of 18?

Do you offer EMDR therapy?

If so, you are invited to take part in a research study exploring therapists' experiences of using Eye Movement Desensitisation and Reprocessing Therapy with children and young people.

Why take part?

Eye Movement Desensitisation and Reprocessing therapy (EMDR) is an interactive psychotherapy used to relieve psychological distress associated with difficult memories and/or thoughts. EMDR is often offered to young people, but very little research has been conducted to find out about people's experiences of using this approach. In this study, we are interested in hearing from therapists who work with children and young people and offer EMDR to this client group. We are interested in hearing your experiences of offering EMDR and of adapting the therapy from standard protocols for use with children and young people.

Understanding the experiences of therapists who offer EMDR to children and young people may help us to identify some of the barriers and facilitators to using this approach and make recommendations to support therapists in their practice.

What's involved?

If you are interested in taking part, then you will be invited to meet me to discuss the study and ask any questions you might have. This meeting will be via a video call using Microsoft Teams.

If you decide to take part, then you will be invited to one interview session lasting for a maximum of 60 minutes. The interview will take place via a video call and will be recorded.

Participants must be proficient in English language.

I am a Trainee Clinical Psychologist conducting this study as part of my DClinPsy training. The study has been reviewed by the University of Nottingham Research Ethics Committee. Research Ethics Reference: 2860. If you have any questions, or if you are interested in taking part in this study, please contact me: msxgs10@nottingham.ac.uk.

15.2 Appendix D: Participant Information Sheet

Exploring Therapists' Experiences of using Eye Movement Desensitisation and Reprocessing Therapy with Children and Young People.

Participant Information Sheet
(Version 1.1: 28.02.2022)

Research Ethics Reference: 2860

Title of Study: Exploring Therapists' Experiences of using Eye Movement Desensitisation and Reprocessing Therapy with Children and Young People.

Name of Chief Investigator: Dr Mark Hudson

Local Researcher(s): Miss Gemma Shipley

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear, contact details for the researcher are located at the end of this information sheet.

What is the purpose of the study?

Eye Movement Desensitisation and Reprocessing therapy (EMDR) is a type of psychotherapy used to help people manage distress associated with difficult memories and/or thoughts. In this study, we are interested in hearing from therapists who work with children and young people and offer EMDR to this client group. We are interested in hearing your experiences of offering EMDR and of adapting the therapy from standard protocols for use with children and young people.

Understanding the experiences of therapists who offer EMDR to children and young people may help us to identify some of the barriers and facilitators to using this approach and make recommendations to support therapists in their practice.

Children and young people are defined as those under the age of 18 for the purposes of this study.

This study is being conducted as part of an educational project.

Why have I been invited?

You are being invited to take part in this study because you said that you would like to receive more information. I am asking up to 15 therapists who offer EMDR to young people, to take part in this study.

Do I have to take part?

It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to complete a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What happens if I take part?

If you are interested in taking part, then you will be invited to meet me to discuss the study and ask any questions you might have. This meeting will take place via a video call. After the meeting, you will be asked to decide whether to take part in the study. If you decide to take part then you will be invited to one interview session, lasting for a maximum of 60 minutes. You will be asked to complete a consent form before the interview takes place. In the interview, you will be asked to provide some demographic information including gender, job title, clinical setting, and the length of time you have been using EMDR for. You will also be asked questions about your experience of using EMDR with children and young people, and of adapting the therapy for this client group. The interview will take place via a video call using Microsoft Teams. The interview will be recorded using Microsoft Teams and will include both video and audio recording (if you choose to have your camera on). In addition, interviews will be audio-recorded using a digital dictaphone. You can choose which way you would prefer your interview to be recorded.

Expenses and payments

You will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

It is unlikely that you will be negatively affected by taking part in this study.

You will be asked to commit to a maximum of 60 minutes of contact with me overall; we will meet at a time that is convenient for you.

What are the possible benefits of taking part?

I cannot promise the study will help you, but I am interested in hearing about your experiences. By sharing your views, you may be able to help improve other therapists' and young people's experiences of EMDR in the future. By taking part in this study, you are making a valuable contribution to the research into EMDR.

What happens when the research study stops?

When the study is finished, I will write a report about what I have found out. In the report I will use direct quotes from some of the interviews to back up what I have found, these quotes will be anonymous, and you will not be identified in the report. The study report will be submitted to the University of Nottingham as part of the Trent Doctorate in Clinical Psychology. The study is also likely to be published in a research journal.

You can ask to be sent a summary of the study findings; this will likely be available by September 2022. I can arrange to send a summary of the findings by email; you will be asked to give consent for me to send this summary.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk. Please quote ref no: FMHS 2860.

In the event that something does go wrong, and you are harmed during the research, and this is due to someone's negligence then you may have grounds for legal action for compensation against the University of Nottingham but you may have to pay your legal costs.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practices and all information about you will be handled in confidence.

If you join the study, we will use the information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password-protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security), and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move their information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information and read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx.

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

Your interview will be recorded; some interviews will be sent to the University of Nottingham's automated transcription service to be transcribed. The automated transcription service is GDPR compliant. All transcripts will be anonymised.

Your contact information will be kept by the University of Nottingham for one year after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's, and our funders' policies we may share our research data with researchers in other universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified). You will be made aware if the data is to be shared with countries whose data protection laws differ from those of the UK and how we will protect your confidentiality.

Although the information you provide during the study will be treated confidentially, there are certain limits to this. If you tell me anything during the study that makes me think either you or someone else is at risk of harm then I will have to tell someone else about this so that we can keep you, and other people safe.

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

Your participation is voluntary, and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw, we will no longer collect any information about you or from you, but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible.

If you withdraw from the study and no longer wish for your data to be included in the final analysis you must contact the researcher within one week of your interview date to inform them of this decision.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the Trent Doctorate in Clinical Psychology.

Who has reviewed the study?

All research in healthcare is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed by the Division of

Psychiatry and Applied Psychology (DoPAP) Ethics Committee at the University of Nottingham.

Further information and contact details

Researcher:
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15.3 Appendix E: Informed Consent Form

Participant Consent

Interactive form for online consent

STUDENT RESEARCH PROJECT ETHICS REVIEW

Division of Psychiatry & Applied Psychology

Project Title: Exploring Therapists' Experiences of using Eye Movement Desensitisation and Reprocessing Therapy with Children and Young People.

Researcher: Gemma Shipley, msxgs10@exmail.nottingham.ac.uk

Supervisor: Dr Mark Hudson, mark.hudson@nottingham.ac.uk

Ethics Reference Number: 2860

- Have you read and understood the Participant Information?
  ☐Yes ☐No

- Do you agree to take part in an interview that will be recorded, about EMDR therapy?
  ☐Yes ☐No

- Do you know how to contact the researcher if you have questions about this study?

  ☐Yes ☐No

- Do you understand that you are free to withdraw from the study without giving a reason?

  ☐Yes ☐No

- Do you understand that once you have taken part it may not be technically possible to withdraw your data?

☐Yes ☐No

- Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected?
  ☐Yes ☐No

- Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications?
  ☐Yes ☐No

- Do you confirm that you are 16 years old or over?
  ☐Yes ☐No

If you would like a summary of the research findings please insert your email address in this text box

By ticking this 'Yes' button, I indicate that I understand what the study involves, and I agree to take part. I consent to take part in this research study. ☐Yes

15.4 Appendix F: Interview Schedule

Demographic Information

Gender:

Job Title:

Service Setting:

Years of experience using EMDR:

How many of those years are using EMDR with children and young people?

Interview Guide

1) Can you tell me about your experiences of using EMDR with children or young people?

2) Can you tell me your thoughts about any guidelines you have come across for using EMDR with children and young people?

3) Can you tell me your thoughts on adapting EMDR protocols for use with individual children or young people?

4) Can you tell me about any adaptations you have made to the standard EMDR protocol when working with children and young people?

    a) From your perspective, why were these adaptations necessary?

    b) What was the outcome of making these adaptations?
        i) For the client
        ii) For your subsequent practice

c) What support, if any, did you seek when making these adaptations?

d) Can you tell me about your experience of involving parents or carers during the intervention?

5) What sorts of things seem to be helpful when you are using EMDR with this client group?

6) What sorts of things do children or young people tend to find difficult when using this intervention, from your perspective?

a) What adaptations have you considered or made in your own practice to try and address these difficulties?

b) What was the outcome of making these adaptations?

7) Can you tell me about any barriers you have faced when using EMDR with children and young people?

a) How did you address these barriers?

b) What was the outcome?

8) Compared with other approaches, how have you found using EMDR with children and young people?

9) Can you tell me about times where you have integrated EMDR with other approaches as an intervention for this population?

a) From your perspective, why was integration with other approaches necessary?

b) What was the outcome of the integration
   i) For the client
   ii) For your subsequent practice

c) What support, if any, did you seek when integrating approaches?

10) Are there any other things you think therapists should consider when supporting children and young people when using this approach?

11) Is there anything else you would like to tell me that we've perhaps not talked about, that might be important for me to know?

15.5 Appendix G: Ethical Approval Letter

DPAP Committee: 08/03/2022
Supervisor: Dr Mark Hudson
Applicant: Miss Gemma Shipley

Project ID: **2860**

Project: **Exploring Therapists' Experiences of using Eye Movement Desensitisation and Reprocessing Therapy with Children and Young People**

Dear Gemma

A favourable opinion is given to the above-named study on the understanding that the applicants conduct their research as described in the above numbered application. Applicants need to adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved.

If you need to make any changes (for example to the date or place of data collection, or measures used), an

Amendment Form should be submitted. This can be done by the Supervisor in 'Create Sub Form' in the Actions Menu on the left-hand side of the page on the on-line system: Select 'Amendment Form'

Yours

Professor David Daley

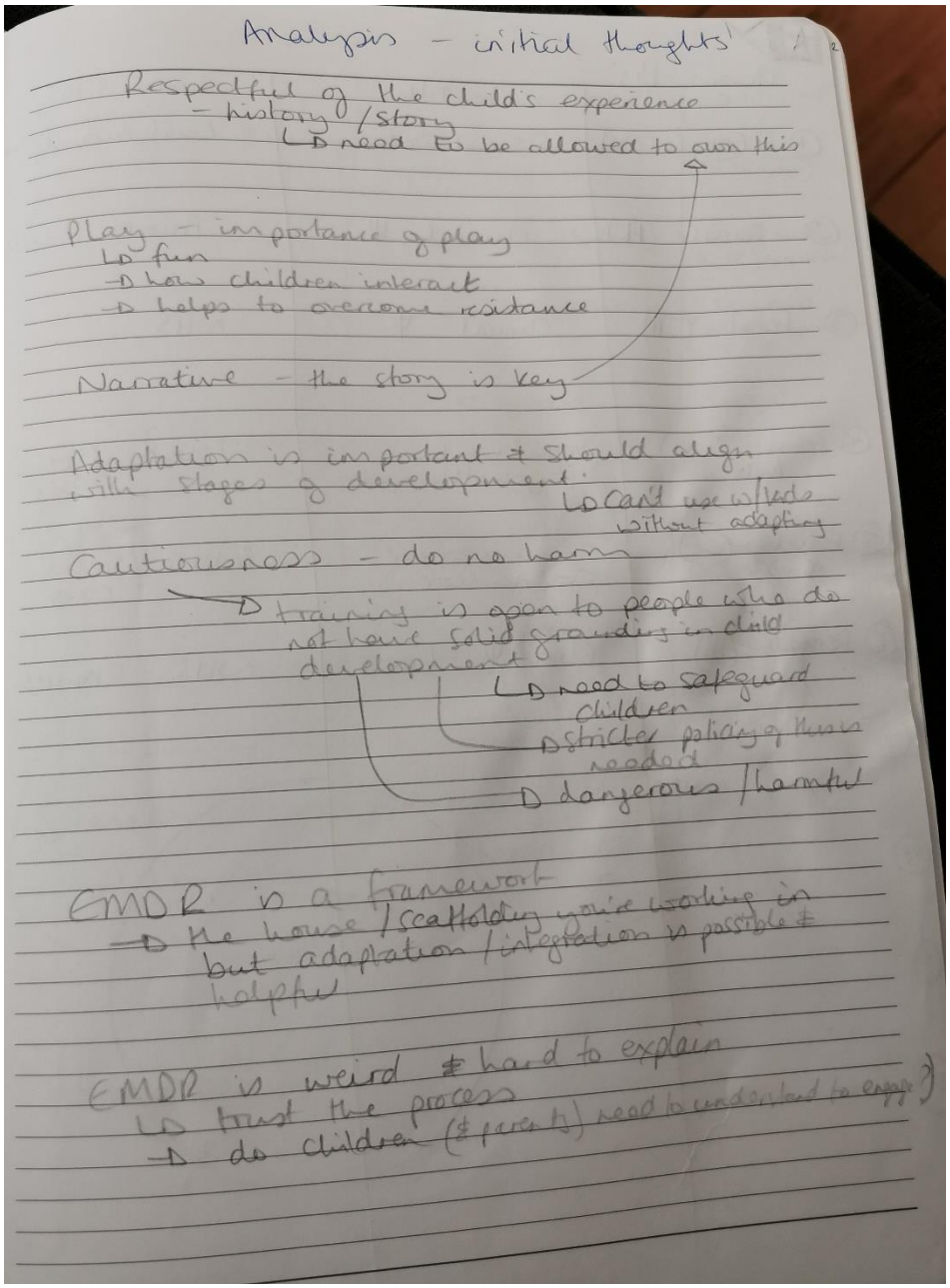
Co-Chair DPAP Ethics Subcommittee

Professor Amanda Griffiths

Co-Chair DPAP Ethics Subcommittee

15.6 Appendix H: Reflexive Thematic Analysis Phase One

The first phase of the reflexive thematic analysis process required familiarisation with the data. This phase involved the first author reading the interview transcripts and noting down any initial thoughts; the research team met together approximately one week later to discuss these. The author's initial thoughts are shown in the image below.



15.7 Appendix I: Reflexive Thematic Analysis Phase Two

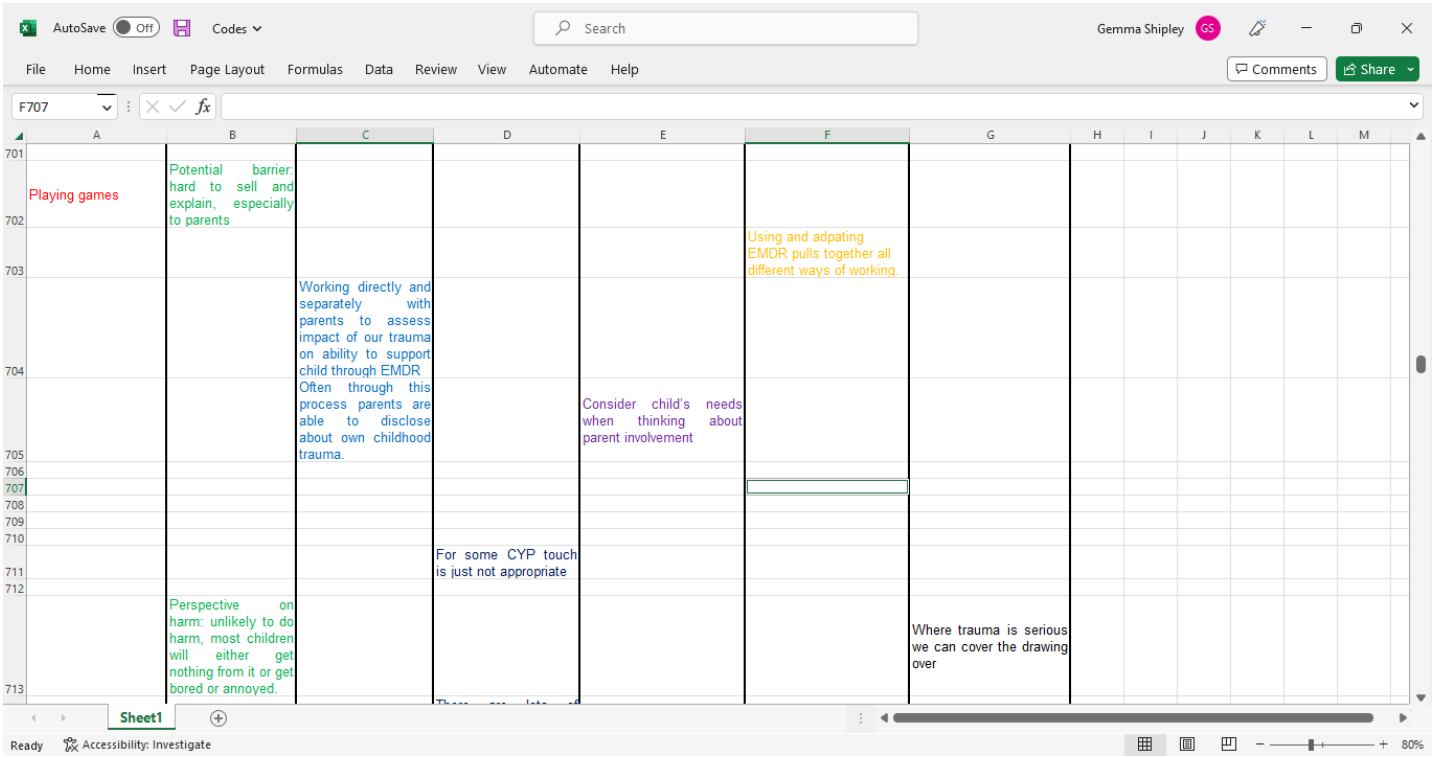
Within the second phase, initial codes were generated so that the interview data could begin to be organised in a meaningful way. An inductive coding approach was used in this study as it allowed for codes to be created based on the interview data itself. In order to code the data, a 10-minute sample from the beginning of each of the seven interviews were used. The first author read through each of the transcripts, highlighted key parts of the text, and began to generate initial codes using the participants' own words (in vivo coding). Once the samples had been coded, these were shared with the research team and discussed. Once the team agreed that the initial coding of the sample was representative of the data, the first author continued to code the remainder of the seven interview transcripts in 10 minute segments, each time applying existing codes and developing new codes where necessary, this process was repeated until all of the interview data had been coded. An example of the initial coding of an interview transcript is shown below.

Transcript	Code
[00:00:03] Speaker 1: So, Emma, can you tell me about your experiences of using EMDR with children and all young people?	
[00:00:11] Speaker 2: Okay, well EMDR is the approach that I used with most of the children that I work with, and I tend to work with children from the age of 11 to 18. That's my preferred age group, so don't have much experience with children younger than that. Yeah, and.	
[00:00:33] Speaker 2: So the children I work with have quite complex needs and they've already got lots of complexities because they're children who are looked after or they adopted, so they have lots of narratives around that, so I wouldn't say that I use standard EMDR protocol with them. It's quite adapted.	Working with children with complex needs: children who are looked after have lots of complexities so I don't use standard EMDR protocols – quite adapted
[00:00:55] Speaker 2: It's not linear.	
[00:00:59] Speaker 2: It definitely doesn't follow the 8 stages in a linear way.	It's not linear
[00:01:06] Speaker 2: Tend to have to use lots and lots of preparation.	Lots of preparation
[00:01:12] Speaker 2: Quite a number of times. It's not. They're not single traumas, so they're not small t traumas	Lots of preparation is needed when working with big T or

that these children have experienced. They're quite large, so lots and lots of preparation in stages one and two and three. [00:01:28] Speaker 2: And. [00:01:32] Speaker 2: Stop.	multiple traumas
[00:00:02] Speaker 2: So one of the hardest things I find with the children I work with is the case conceptualisation for it. And because it's usually lots and lots of memories, so finding the the right memory to work with is sometimes very difficult because they're often very saturated and the memories are very often in clusters.	Challenge: case conceptualisation Challenge: lots of memories, saturated and clustered. Finding the right memory to work with can be difficult

15.8 Appendix J: Reflexive Thematic Analysis Phase Two (Continued)

Through this process a large number of initial codes were generated. The text of each interview transcript was given a different colour so that once the initial codes were extracted, they could still be traced back to individual participants. For ease of reference, all initial codes were transferred into an Excel spreadsheet so that they could be viewed within one document. An example of the Excel spreadsheet is shown below.



15.9 Appendix K: Reflexive Thematic Analysis Phase Three

Next, initial codes were examined and grouped together to form potential overarching themes. This phase of the analysis involved a number of in-depth discussions amongst the research team and as a result, 14 potential overarching themes were identified. These 14 themes were: adaptations, barriers, benefits, challenges, child factors, helpful aspects, integration, other factors, pandemic, parent factors, support, therapeutic relationship, therapist factors, therapist development, and training.

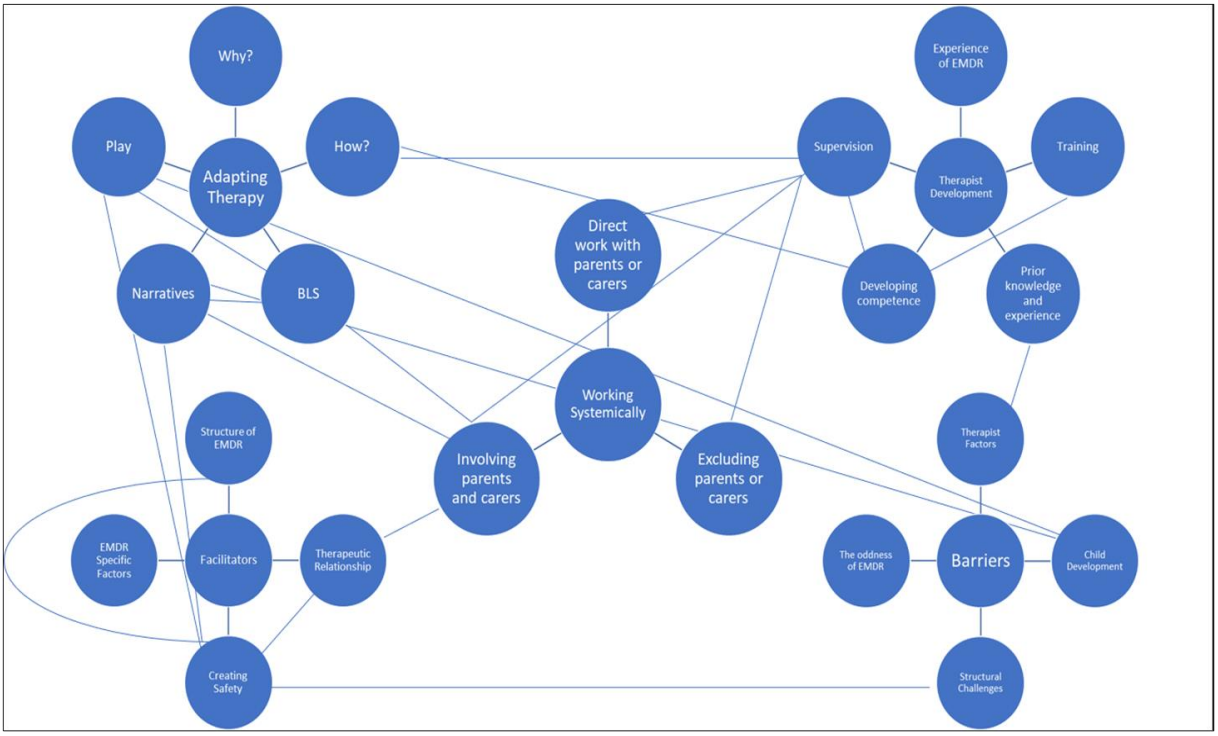
Within each potential overarching theme, a number of subthemes were also identified. An example of the subthemes initially identified under the overarching theme of 'Adaptations' is shown below.

Why use adaptations?	**Ways to adapt.**	**Use of Play**	**Narratives**	**BLS**
Working with children is different – need for different protocols and procedures because children find it more difficult to verbalise and make connections with experiences. Interventions are often developed with adults in mind, so they need to be adapted for CYP – working in CAMHS you get used to that Children need EMDR to be adapted because of their cognitive	Adaptation: session length – making sessions shorter and being flexible with that can be helpful but also increases treatment time overall. Explanation: simplify or make age appropriate, finding language and ways to talk about EMDR and trauma that is accessible for children. Ana Gomez talks about fitting the protocol to the child. Fitting	Play: have to use play with children. Play is non directive and CYP always pay out their issues – can use buzzers (BLS) during this to help and have the opportunity to introduce resources Resource interweaves through play. Try and make adaptations fun: Children are playful. EMDR can be used very playfully with children because there	Use of narratives to give information to the child about what happened when they don't have a memory of it and helping them to move forward. Stories also take pressure off having to think about something. Narratives can be written with parents and then read, updated, and adapted with the child. When writing a narrative, it is important for the therapist to have an understanding of the child's journey and know the child before starting this piece	BLS: can be evocative and children will not do it; allowing them to find their control BLS: proximity can be uncomfortable and kids can feel under pressure BLS is interesting with children in terms of what they can do, often young children can't do eye movements so have to find an alternative. BLS: kids love the tappers. BLS alternative

ability. You have to have an idea of what your aiming for and how to get there but ither than that it's all about adapting.	the protocol to the child means that you might have to adapt the protocols, maybe at every stage but you can bring in different bits without diluting the actual EMDR.	is flexibility in the standard protocol. Movement within the session to help regulate – children don't always need to understand why we do this because it's just fun.	of work. Doing a narrative can take longer than expected but is a good investment – can be a good way of learning about other issues impacting	ways – wobble board, drumming, finding ways to shift between different ways of doing BLS to suit the child Adaptation: butterfly taps

15.10 Appendix L: Reflexive Thematic Analysis Phase Four

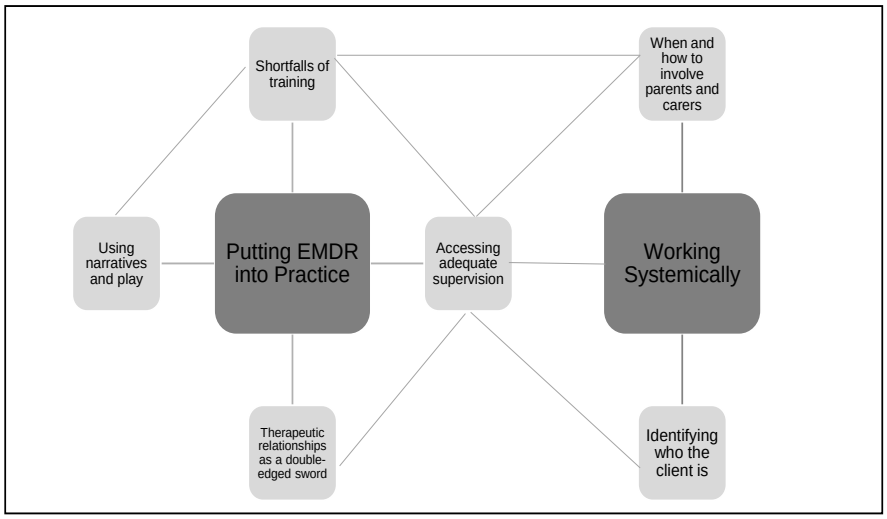
The 14 potentially overarching themes and their associated subthemes were checked for accuracy against the coded extracts and original transcripts by the first author. These were then reviewed and further refined by the research team through discussion; where themes were considered to represent similar concepts (e.g., barriers and challenges) or be closely related to one another (e.g., support, training, therapist development), these were merged together. This resulted in nine overarching themes remaining which were further checked against the coded extracts and original transcripts to ensure they represented the data accurately. On further exploration, the research team agreed that several overarching themes may be more appropriately placed as subthemes, further refining the number of overarching themes from nine to five, with 21 interrelated subthemes (shown below).



15.11 Appendix M: Reflexive Thematic Analysis Phase Five

After taking some time away from the data fifth phase of the reflexive thematic analysis was undertaken. Within this phase each theme was further defined and refined to ensure that, as far as possible, each represented the essence of the overall meanings evident within the data. Viewing the themes with fresh eyes made it possible to identify that some of the existing subthemes were simply the opposite of one another (e.g., involving parents and carers, and excluding parents and carers) and in such circumstances it made sense to combine these, resulting in the subtheme ‘when and how to involve parents and carers’. Similarly, the subthemes of ‘why’, ‘how’, ‘narratives’, and ‘play’ were combined to form the subtheme ‘using narratives and play’; on inspection of the coded datasets it became clear to the research team that each of these previously separate subthemes were in fact representative of the ways in which therapists used EMDR creatively when working with children and young people. The final step in phase five was to give a name to each theme and subtheme which captured their essence. The final themes are shown below in a thematic map which also depicts how each theme and subtheme are related to one another.

Thematic Map



16. Poster

University of Nottingham
UK · CHINA · MALAYSIA

UNIVERSITY OF LINCOLN

Exploring Therapists' Experiences of using EMDR with Children and Young People

Gemma Shipley, Dr Mark Hudson, Dr Anna Tickle
Trent Doctorate in Clinical Psychology, Universities of Nottingham and Lincoln

RATIONALE

Eye Movement Desensitisation and Reprocessing (EMDR) therapy[1] is an effective treatment for trauma-related distress[2,3,4] and is increasingly utilised as a psychotherapeutic intervention for children and young people (CYP)[5]. However, within the literature, it is unclear how therapists experience delivering EMDR to this client group.

AIM

To explore therapists' experiences of adapting and delivering EMDR to CYP.

METHOD

Therapists were recruited via social media platforms and invited to participate in one semi-structured interview. Seven female therapists took part.

ANALYSIS & RESULTS

Reflexive Thematic Analysis[6] was used in the analysis. Two key themes, **Putting EMDR into Practice** and **Working Systemically** were generated. Six interrelated subthemes were also identified.

CONCLUSIONS

Adaptations to standardised EMDR protocols are required when working with CYP.

EMDR training could be improved by including additional guidance for making adaptations; the inclusion of narratives and play appears particularly helpful for therapists working with CYP.

Therapists must be vigilant to systemic factors when working with CYP; supervision is a helpful space to consider the impact of these factors on therapeutic work.

REFFERENCES

[1]Shapiro, F. (1989a). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress, 2*, 199–223. DOI: https://doi.org/10.1002/jts.2490020207; [2]Chen, Y. R., Hung, K. W., Tsai, J. C., Chu, H., Chung, M. H., Chen, S. R., Liao, Y. M., Ou, K. L., Chang, Y. C., & Chou, K. R. (2014). Efficacy of eye-movement desensitization and reprocessing for patients with posttraumatic-stress disorder: a meta-analysis of randomized controlled trials. *PloS one, 9*(8), Article e103676. DOI: https://doi.org/10.1371/journal.pone.0103676; [3]Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews* (12). DOI: 10.1002/14651858.CD003388.pub4; [4]Khan, A.M., Dar, S., Ahmed, R., Bachu, R., Adnan, M., Kotapati, V.J. (2018). Cognitive Behavioral Therapy versus Eye Movement Desensitization and Reprocessing in Patients with Post-traumatic Stress Disorder: Systematic Review and Meta-analysis of Randomized Clinical Trials. *Cureus 10*(9), Article e3250. DOI: 10.7759/cureus.3250; [5]Moreno-Alcázar, A., Treen, D., Valiente-Gómez, A., Sio-Eroles, A., Pérez, V., Amann, B. L., & Radua, J. (2017). Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adolescent with Post-traumatic Stress Disorder: A Meta-Analysis of Randomized Controlled Trials. *Frontiers in Psychology, 8*, Article 1750. DOI:10.3389/fpsyg.2017.01750; [6]Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597, DOI: 10.1080/2159676X.2019.1628806

Small-Scale Research Project

Providing Feedback: A Service Evaluation.

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Abstract

Objectives. The current process for obtaining feedback from trainee clinical psychologists enrolled on the Trent programme was evaluated, and compared with a proposed alternative, the NES Psychology Trainee Survey.

Methods. Trainee clinical psychologists were invited to take part in an online survey consisting of 44 questions in total; 28 questions related to the acceptability, appropriateness, and feasibility of the two feedback processes being compared and were analysed using descriptive statistical analysis. The remaining 16 questions required respondents to provide qualitative comments about their experience of providing feedback to the programme; this data was analysed using thematic analysis.

Results. Descriptive statistical analysis identified that the acceptability, appropriateness, and feasibility of the current feedback process could be improved by providing trainees with the opportunity to give feedback anonymously and by converting the Trainee Evaluation of Placement and Supervision into an online survey. The qualitative analysis yielded four superordinate themes: placement quality is multi-faceted, feedback is an opportunity, barriers to providing feedback, and raising concerns.

Conclusion. Having the opportunity to provide feedback about placement experiences is important to trainees and there are often many areas they wish to comment on. In addition, providing both positive and negative feedback is considered crucial and represents an opportunity to improve the placement experiences of future trainees, however several barriers to providing negative feedback were found to exist.

Keywords: providing feedback, placement experience, clinical psychology training, service evaluation

Introduction

Feedback is conceptualised as the provision of information to an individual about aspects of their performance or understanding that is considered one of the most powerful influences on learning and achievement (Hattie & Timperley, 2007). Often the purpose of providing feedback is to identify the areas of an individual's knowledge, skills, or performance that require further development (Taras, 2005; Thomas & Arnold, 2011) and to encourage the individual to think creatively about how they can improve (Hesketh & Laidlaw, 2002; Liberman et al., 2005). In addition, the importance of highlighting an individual's strengths is also recognised as a vital component of feedback and is key to ensuring that any positive aspects of an individual's practice are reinforced (Thomas & Arnold, 2011). However, although feedback has been identified as having many benefits associated with improving practice, it is also important to acknowledge the possibility that feedback may have a detrimental impact on an individual's development, for example, feedback that is perceived by the receiver to be critical, or that which is not communicated sensitively may result in loss of confidence, demotivation, and a decline in performance (Kluger & DeNisi, 1996).

Whilst much of the available research literature has focussed on how the provision of feedback to individuals occupying the learner role can be effective in enhancing knowledge, skills, and performance (Hattie & Timperley, 2007; Taras, 2005; Thomas & Arnold, 2011), there appears to be a paucity of literature concerned with the provision of feedback by learners to those responsible for providing their learning experiences (Scheeler et al., 2004; Thurlings et al., 2013). However, the real-world value of having learners provide feedback to their teachers, mentors, and supervisors has long been recognised as an integral part of many professional training programmes, including those undertaken by trainee clinical psychologists.

Feedback Processes in Clinical Psychology Training

The British Psychological Society (BPS) set out guidelines highlighting the responsibility of trainee clinical psychologists 'to the programme and to the profession to give feedback to the programme staff about the quality of the placement and the supervision' they receive throughout their professional training journey (BPS, 2010, p. 6). In addition, it is considered important for trainee feedback to also be shared with placement supervisors, and for them to be open and responsive to such feedback in order to maintain or improve the quality of the placement experiences they provide (Anderson et al., 2012). However, an inherent power imbalance often exists within relationships between trainees and supervisors which can make providing feedback difficult for trainees, especially where such feedback may be perceived as negative or critical (Dudek et al., 2016). Yet without trainee feedback

highlighting any negative aspects of placement or supervisory experiences, it is conceivable that programme staff and placement supervisors may assume all is well, meaning that any areas of development for the supervisor are not identified, additional training or support is not offered or sought, and that lower quality placements continue to be offered at the expense of future trainees (Cantillon & Sargeant, 2008).

All clinical psychology training programmes across the United Kingdom (U.K.) have developed processes for obtaining feedback from trainees about their placement experiences and recognise this as a key element of quality assurance (Leckley & Neill, 2001). However, feedback processes are often unique to each of the 30 clinical psychology training programmes operating across the U.K. with no uniform approach to either the topics that trainees are asked to provide feedback about or how such feedback is collected, collated, and disseminated. The purpose of this service evaluation project was to understand trainee clinical psychologists' views on the acceptability, appropriateness, and feasibility of one clinical psychology training programmes current feedback process and compare this with a proposed alternative; brief details of both processes are provided below.

Trent Trainee Evaluation of Placement and Supervision

Currently, trainees enrolled on the Trent Doctorate in Clinical Psychology programme are asked to provide feedback about their placement experiences using the Trainee Evaluation of Placement and Supervision. The Trainee Evaluation of Placement and Supervision is a paper-based form with a broad focus; trainees are asked to provide feedback on the general placement experience including personal experience, support for proficiency development, opportunities for observation, concerns about unsafe clinical practice, and experience of supervision. Trainees are asked to identify themselves and encouraged to share their feedback directly with placement supervisors. In order to gather meaningful feedback from trainees, the form is initially completed at a mid-placement review and repeated at the end of placement review so that any issues can be monitored by the clinical tutor team.

NHS Education Scotland (NES) Psychology Trainee Survey

The NES Psychology Trainee Survey was developed by Millar et al., (2018) at the University of Edinburgh and was considered as a potential alternative to the Trainee Evaluation of Placement and Supervision. The NES Psychology Trainee Survey primarily focuses on trainee experiences of supervision; the survey includes 35 questions in total: 30 related to supervision, three about overall placement experience, and two about clinical tutor support. Trainees are not asked to identify themselves; feedback is provided anonymously via an online survey and is not shared directly with placement supervisors. After three

trainees have provided feedback about an individual supervisor this is summarised and then shared as a report with both the placement supervisor and their line manager.

Rationale

Given the diverse and dynamic nature of the NHS services hosting trainee placements and of clinical psychology training generally, it is important for the processes used to gather feedback about placement experiences to be reviewed regularly to ensure they are fit for purpose (Ramani et al., 2006). An evaluation of the Trent programmes current process for obtaining feedback from trainees was requested by the Supervisor Subcommittee; the subcommittee identified the NES Psychology Trainee Survey as a potentially viable alternative process, however, consultation with trainees was deemed necessary to ascertain whether any modification to the current process was required, and if so, how this could be best achieved.

Aims

The aims of the service evaluation project were:

1. To determine whether current trainees consider the Trainee Evaluation of Placement and Supervision to be fit for purpose, or whether the proposed alternative (NES Psychology Trainee Survey) is deemed more acceptable, appropriate, and feasible.
2. To understand the views of current trainees about which aspects of placement experience they consider most important to have the opportunity to provide feedback on.
3. To understand what current trainees perceive to be the barriers to providing feedback about their placement experiences.

Method

Research Ethics

As the project was a service evaluation, ethical approval was not required. However, the ethical guidelines relating to research involving human participants, set out by the BPS (2014) were adhered to throughout.

Participants

Trainee clinical psychologists enrolled on the Trent programme who were in the second and third year of training were invited to take part in an online survey; at the time of data collection, first-year trainees had only recently started their first placement and had not yet provided any feedback about their experiences and so were not invited to participate. A

total of 20 trainees responded to the invitation and completed the survey, a response rate of 62.5%.

For trainees completing the survey, the total number of placements undertaken ranged from two to six (M = 3.1, SD = 1.25) with respondents indicating that they had completed the Trainee Evaluation of Placement and Supervision on between two and five occasions (M = 2.9, SD = 1.02). Most trainees completing the survey (95%) agreed that overall, their experiences whilst on placement had been positive (M = 4.55, SD = 0.94).

Materials

An online survey was developed based on the Acceptability of Intervention Measure (AIM), Intervention Appropriateness Measure (IAM), and the Feasibility of Intervention Measure (FIM), originally developed by Weiner et al. (2017). The AIM, IAM, and FIM are considered reliable (α = 0.85, 0.91, 0.89 respectively) and valid measures of acceptability, appropriateness, and feasibility (Weiner et al., 2017); each of these three measures were adapted for use in this service evaluation.

Procedure

All second and third-year trainees enrolled on the Trent programme (n = 32) were sent an email inviting them to take part in a short online survey administered via the Qualtrics platform. Trainees were provided with an information sheet attached to the email invitation which gave brief details about the survey as well as the two feedback processes being considered and how these compared with one another (Appendix N). Trainees were also provided with a copy of the Trainee Evaluation of Placement and Supervision and the NES Psychology Trainee Survey.

The survey contained 44 questions in total; 28 questions were concerned with the acceptability, appropriateness, and feasibility of both the Trainee Evaluation of Placement and Supervision and the NES Psychology Trainee Survey, whilst the remaining 16 questions focussed on trainees' experiences of providing feedback to the programme and of raising concerns about unsafe clinical practice within the placement environment. Respondents were asked to indicate their response to each question using a five-point Likert scale with options ranging from strongly agree to strongly disagree. Additional space was provided to allow trainees to also include qualitative comments. The survey was open for responses between 30th October and 31st December 2020. All responses were provided in written form. The full survey is included in Appendix O.

Data Analysis

Descriptive statistical analysis was used to analyse the quantitative data collected using the adapted AIM, IAM, and FIM in relation to the Trainee Evaluation of Placement and

Supervision and the NES Psychology Trainee Survey. In addition, data relating to trainees' general experiences of providing feedback to the programme and associated with raising concerns about unsafe clinical practice, was also subjected to descriptive statistical analysis.

The qualitative responses provided by trainees were analysed using thematic analysis following the stages set out by Braun and Clarke (2006). The process of thematic analysis involved the primary author becoming familiar with the raw data by repeatedly reading the qualitative responses provided by trainees across all survey questions before beginning to generate initial codes. These initial codes were later organised into themes thought to be representative of both prevalent and salient ideas and then checked against the data set to ensure their relevance. Next, themes were named, organised under superordinate headings, and illustrated with direct quotes from the raw data.

Given the context of this service evaluation and the importance of understanding what works in terms of real-world relevance, data analysis was undertaken from a pragmatic paradigm (Creswell, 2003).

Results

Descriptive Statistical Analysis

Of the trainee clinical psychologists who completed the survey, 90% agreed that providing feedback to the programme about their placement experiences was worthwhile, with 94% agreeing that having the opportunity to provide feedback about both general placement experiences and experiences of supervision was important to them. However, based on recent experiences of completing the Trainee Evaluation of Placement and Supervision, 70% of trainees reported being less likely to provide honest feedback about either of these experiences due to a lack of anonymity, believing that if they were to give feedback that was perceived negatively that this would affect the placement outcome.

Acceptability

The Trainee Evaluation of Placement and Supervision was liked by 45% of respondents however, 61% agreed that the Trent programme should consider making some modifications. Overall, respondents indicated that the NES Psychology Trainee Survey appeared to be an acceptable alternative (88%) to the Trainee Evaluation of Placement and Supervision, with 94% indicating that having the option to provide feedback anonymously was particularly appealing.

Appropriateness

The NES Psychology Trainee Survey appeared to be more highly rated than the Trainee Evaluation of Placement and Supervision in terms of appropriateness, with 61% of respondents agreeing that providing feedback anonymously was more appropriate compared with providing identifiable feedback (52%). The NES Psychology Trainee Survey was also rated more favourably in terms of being fit for purpose (83%) compared with the Trainee Evaluation of Placement and Supervision (68%). However, whilst 94% of respondents agreed that the NES Psychology Trainee Survey focussed on topics they wanted to provide feedback on, only half of all respondents indicated that it would be appropriate to change the emphasis from providing feedback on the overall placement experience to focus on supervision specifically.

Feasibility

Whilst respondents generally considered the Trainee Evaluation of Placement and Supervision easy to use (94%) and doable for every placement (84%), all respondents agreed that they would prefer to provide feedback to the programme via an online survey. In addition, 72% of respondents indicated that it appeared more feasible to provide honest feedback using the NES Psychology Trainee Survey given that trainees can complete this anonymously.

Reporting Concerns

All respondents agreed that it was important for them to be able to report concerns relating to any observations of unsafe clinical practice, with 80% agreeing that the Trainee Evaluation of Placement and Supervision provided the opportunity for trainees to identify, and report concerns to the programme safely. Interestingly, for 61% of respondents, the lack of anonymity associated with the Trainee Evaluation of Placement and Supervision did not appear to be a barrier for trainees when reporting concerns about unsafe clinical practice to the programme.

Thematic Analysis

The qualitative analysis yielded four interrelated, superordinate themes: placement quality is multi-faceted, feedback is an opportunity, barriers to providing feedback, and raising concerns. Within these four superordinate themes, five subthemes were identified (see Table 7).

Placement quality is multi-faceted

Trainees considered positive placement experiences to be dependent on multiple factors including, access to varied learning opportunities, integration within the wider staff team, provision of good quality supervision, and consideration of practical aspects (e.g.,

access to IT equipment). Trainees deemed that having the opportunity to comment on the multiple factors associated with overall placement quality as well as the quality of the supervision they received to be of equal importance.

> *'Supervision quality and placement quality are both equally important for the overall experience in my opinion.'* (Trainee I)

The Trainee Evaluation of Placement and Supervision was praised for providing trainees with the opportunity to give feedback on a broad range of factors believed to contribute to the overall placement experience. However, whilst the Trainee Evaluation of Placement and Supervision was considered comprehensive, many trainees believed that some modification was required in order to capture important aspects specifically related to supervision including, the supervisory process, models, styles and skills, the supervisory relationship as experienced by the trainee, and the influence of the supervisory relationship on the overall placement experience and outcome.

> *'I think there can be a little more around the supervision process and being able to be honest in supervision. It would also be useful to be able to provide feedback on the supervisor's style and skills (e.g., warmth, empathy), whether their style matched yours, and whether it felt that the supervisor-supervisee relationship was a good match and if not was not did it impact upon experience and outcome of placement.'* (Trainee B)

Feedback is an opportunity

Generally, trainees welcomed the opportunity to provide feedback about their placement experiences to the programme and viewed doing so as worthwhile.

For learning. Providing feedback was considered by many to represent a valuable learning opportunity for trainees which supports the development of key professional skills that are likely to be required post-qualification.

> *'I think it is a good learning experience to have us provide feedback to our supervisors, positive and negative, e.g., teaching us to be competent and confident practitioners who can go out into the workplace and handle issues that arise. It also maybe teaches us to accept/deal with smaller negative experiences that we don't feel are worth the 'effort' of raising formally, e.g., to handle natural, non-clinically-problematic interpersonal challenges in a professional way.'* (Trainee J)

For Improvement. Trainees highlighted the importance of recognising both positive and negative aspects of placement experiences and considered providing feedback

to the programme on these aspects to represent an opportunity for them to contribute to the improvement of placement quality for subsequent cohorts.

> *'It's about improving the experience for the next person.'* (Trainee J)

> *'(Feedback helps) to identify strengths of the placement and any issues that may be resolved prior to another trainee being placed there, with a view to improving their experience.'* (Trainee N)

Trainees generally considered it important for the programme to be made aware of both 'good' and 'bad' placement experiences so that informed decisions about future placements could be made. Where trainees identified 'good' supervisors, providing positive feedback was thought to boost morale and increase the likelihood of these supervisors offering future placements, whereas trainees hoped that providing negative, constructive feedback to 'bad' supervisors would encourage them to make changes in order to improve the quality of the placement experience they offer to future trainees.

> *'It is important so clinical tutors are able to determine what the placement is like, what type of trainees it would suit (in terms of experience, confidence, ability to work with/without direction etc.). It is also useful for supervisors in guiding what they offer on the placement and their style of supervision. It is also useful for trainees to feel heard on how their experience was.'* (Trainee Q)

> *'Feedback can help to adapt future placements or maintain the quality of these placements. Positive feedback can enhance supervisor morale, particularly if they are hesitant about accepting trainees.'* (Trainee I)

Barriers to providing feedback

Although trainees considered there to be important benefits associated with providing feedback about their placement experiences, many recognised that providing negative feedback was difficult. Three barriers to providing negative feedback were identified: fear of repercussions, relationship with the supervisor, and lack of anonymity.

Fear of repercussions. Trainees highlighted concerns that there may be repercussions for providing negative feedback about a placement or a supervisor, such repercussions were either proximal or distal in nature. Proximal repercussions included being judged negatively by the placement supervisor and/or clinical tutors, the placement experience becoming awkward or being made more difficult for the trainee, and negatively affecting the placement outcome.

'Fear of negative impact and judgement from placement supervisor and clinical tutor. Whilst it is suggested that feedback should be honest it is difficult to do so as there may be repercussions of doing so, which in my experience was the case.' (Trainee B)

Trainees also considered the possibility of distal repercussions associated with providing negative feedback and believed that doing so may have detrimental consequences for future job prospects if seeking employment in the local area post-qualification. Trainees appeared particularly aware of the world of psychology being relatively small so that providing negative feedback about a placement or supervisor could also have potential repercussions for more distant future employment and career progression opportunities.

'The world of psychology is relatively small and as trainees we are likely to be seeking jobs in this area in the coming years and raising something that felt relatively minor during the placement may feel detrimental to your future.' (Trainee L)

Relationship with the supervisor. Many trainees considered the relationship with a placement supervisor to be a barrier to providing negative feedback. Trainees highlighted that it was difficult to give negative feedback about someone with whom they had spent significant time building a relationship; some trainees were concerned that giving negative feedback would risk rupturing the relationship or get the placement supervisor into trouble. Other trainees noted a sense of loyalty to their placement supervisor, recognising the time and effort made to support them, which was deemed to make it more difficult to raise issues or identify areas for development.

'It is uncomfortable to provide feedback which is critical after you have worked with someone for a long period of time, even if they haven't been very supportive. You are also aware that they put a lot of effort into having a trainee so it is hard to be honest if there are things that could be done better.' (Trainee F)

Lack of anonymity. The lack of anonymity afforded by the current process in place on the Trent programme was thought to impede trainees' propensity to provide honest feedback, this appeared to be a greater issue in relation to providing negative feedback about a placement or supervisor.

'I think it (being anonymous) would certainly remove a potential barrier if I were to give negative feedback.' (Trainee P)

Generally, trainees reported that in order receive genuine, honest feedback, the programme should consider offering the option to provide any placement feedback anonymously.

'I think it will be easier to be honest….If an anonymous form is chosen going forward, this would be my preference.' (Trainee B)

Being identifiable to placement supervisors was deemed to be a barrier to providing meaningful feedback, with some trainees having experienced their feedback being directly challenged by supervisors, resulting in them feeling pressured to adjust their feedback and give the illusion of a more positive experience than had been the reality.

'I found a need to censor my final placement evaluation and also re-edit this after questioning by my supervisor. This meant I then rescored my feedback to be more positive than how I felt things were.' (Trainee Q)

Raising concerns

Trainees were generally confident about raising concerns relating to unsafe clinical practice, although there was recognition of often being placed in a vulnerable position as a trainee, with some worrying that raising concerns would have a detrimental impact on the outcome of their placement. Despite these concerns, trainees considered it their 'ethical responsibility' to highlight areas of concern in order to safeguard clients, themselves, and future trainees, with some believing they could have been spared negative placement experiences if previous trainees had spoken up.

'(Raising concerns) is important as we as developing clinicians have an ethical responsibility to do so.' (Trainee B)

Whilst most trainees agreed that concerns about unsafe clinical practice should be raised 'in the moment', the inclusion of a dedicated space to comment on any areas of concern was considered a strength of the Trainee Evaluation of Placement and Supervision. In addition, the inclusion of items relating to raising concerns about unsafe clinical practice served as an additional resource to support trainees and gave the impression that this was an important area of feedback that the programme was interested in receiving.

'I can see the usefulness of including it in the form as I feel it could help trainees access support from the course/clinical tutors in doing so.' (Trainee P)

'The fact this is embedded in the course is crucial and sends the message that it is something we need to be considering from day one.' (Trainee H)

Table 7.

Superordinate themes and subthemes

Superordinate Theme	Subtheme
Placement quality is multi-faceted (11)	-
Feedback is an opportunity (12)	For Learning (5)
	For Improvement (11)
Barriers to providing feedback (16)	Fear of repercussions (13)
	Relationship with the supervisor (8)
	Lack of anonymity (12)
Raising concerns (11)	-

Note. The number of respondents for whom the meaning unit occurred is shown in parentheses.

Discussion

Trainee clinical psychologists are responsible for providing feedback about their placement experiences (BPS, 2010) with doing so viewed by many as worthwhile. Equally, clinical psychology training programmes have a responsibility to gather relevant and meaningful feedback from trainees about their experiences and to act on this accordingly. To ensure that clinical psychology training programmes are able to fulfil their responsibility it is important for the processes they use to obtain feedback from trainees to be regularly reviewed to ensure they remain fit for purpose (Ramani et al., 2006). It is important for trainee clinical psychologists to be able to provide honest, meaningful feedback about their placement experiences so that 'good enough' supervisors and the placements they offer can be recognised and positively reinforced in the hope that this will increase the likelihood of such opportunities continuing to be offered to future trainees. Moreover, where trainee feedback identifies negative aspects of a placement experience or highlights that a supervisor may benefit from further or ongoing training, it may be possible for the programme to offer additional support and in doing so safeguard future trainees from negative placement experiences (Cantillon & Sargeant, 2008; Nel et al., 2012).

Within this service evaluation project, the acceptability, appropriateness, and feasibility of the Trainee Evaluation of Placement and Supervision currently used by the Trent programme was assessed and compared with a proposed alternative, the NES Psychology Trainee Survey. Overall, the Trainee Evaluation of Placement and Supervision was considered fit for purpose, however, trainees thought the process could benefit from

modification by incorporating two key features of the NES Psychology Trainee Survey, namely the opportunity to provide feedback anonymously and via an online survey, both of which were considered more acceptable, appropriate, and feasible.

Overall placement experience was thought to be comprised of multiple factors and having the opportunity to provide feedback on all of these factors was important to trainees, as such the broad focus of the Trainee Evaluation of Placement and Supervision was considered a relative strength. However, some adaptation of the Trainee Evaluation of Placement and Supervision was indicated, with the inclusion of additional questions specifically related to supervision considered necessary to improve the current process. In addition, trainees also appreciated being asked about unsafe clinical practice within the Trainee Evaluation of Placement and Supervision and considered this to be an important area to provide feedback to the programme about; inclusion of items relating to reporting concerns was deemed to provide trainees with an additional resource for those who found themselves in situations where unsafe clinical practice was observed within the placement environment.

The importance of providing feedback about both positive and negative placement experiences was recognised by trainees, and whilst the majority of trainees reported having had positive placement experiences, for those who had not, providing honest feedback about negative experiences was thought to be compromised by the lack of anonymity afforded by the Trainee Evaluation of Placement and Supervision, with many believing that providing negative feedback could have serious repercussions for their career. Having the option to provide feedback anonymously may help to address the power imbalance often experienced within the trainee-supervisor relationship (Dudek et al., 2016) and facilitate trainees in providing honest, meaningful feedback about their placement experiences. However, whilst there is some evidence to suggest that anonymity may help to alleviate the psychosocial pressure associated with providing negative feedback to those in a perceived position of power (Daberkow et al., 2005; Guerrasio & Weissberg, 2012), the overall impact of anonymity in such situations continues to be widely debated with no conclusive agreement on its importance. In addition, in the context of this service evaluation and the recognition of the importance of sharing feedback in the hope of improving placement experiences for future trainees, it is likely to be necessary for feedback to be shared at least with programme staff in a way that identifies the placement and supervisor to ensure that any issues can be addressed and informed decisions made about whether to continue to offer such placements to future trainees; in these instances, anonymity would be neither possible nor beneficial.

Recommendations

The results of this service evaluation project will inform the Trent programmes decision making about how best to gather trainee feedback about their placement experiences in the future. As such the following recommendations are made:

1. Modify the Trainee Evaluation of Placement and Supervision to include more opportunities to comment specifically on experiences of supervision including, the supervisory process, models, styles and skills, the supervisory relationship as experienced by the trainee, and the influence of the supervisory relationship on the overall placement experience and outcome.
2. Offer trainees the option to provide feedback about their placement experiences that is not shared directly with placement supervisors.
3. Develop an online survey to gather feedback from trainees about their placement experiences.

Limitations and Conclusion

There are two key limitations of this service evaluation project. Firstly, the exclusion of first-year trainees has resulted in the views of one-third of the current cohorts enrolled on the Trent programme not being captured and therefore these are not reflected in the analysis. In addition, given the position of the primary author as a trainee clinical psychologist currently enrolled on the Trent programme, it is conceivable that a degree of bias may have been introduced at the data analysis stage which has not been counterbalanced by supervisory checks. Despite these limitations, the aims of the service evaluation have been met. It has been possible to conclude that whilst largely considered fit for purpose, the Trainee Evaluation of Placement and Supervision could benefit from some adaptation to improve the acceptability, appropriateness, and feasibility. It has also been possible to understand which aspects of placement experience trainees consider most important to be able to provide feedback about and highlight that an increased focus on supervision would be welcomed. And finally, it has been possible to understand some of the perceived barriers to providing feedback experienced by trainees which appear most significant when providing negative feedback.

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SSRP Appendices

Appendix N: Survey Information Sheet

Purpose of the Survey

We are interested in hearing your views on the current process used by the Trent DClinPsy programme to gather trainee feedback about placement experiences. We are also interested in hearing your views on a proposed alternative, the NES Psychology Trainee Survey, which has been developed by colleagues at the University of Edinburgh.

Survey Participation

Participation in this survey is voluntary and your responses are anonymous.

Action Required: The survey contains 44 questions. Most questions require a response on a Likert scale whereas some questions provide the opportunity to give a written response.

Time Required: The survey will take approximately 10 minutes to complete.

Survey Link: https://unioflincoln.eu.qualtrics.com/jfe/form/SV_bQSduXtewzYeZxj

How will the survey results be used?

This survey is being conducted as part of a service evaluation. The results of the survey will be presented in a written report and submitted in partial fulfilment of the academic component of the Trent DClinPsy programme.

The results of this survey will also be presented and discussed at the Supervisor Subcommittee meeting taking place in May 2021 and will inform the committee's decision making about how best to gather trainee feedback on placement experiences in the future.

Trent Evaluation of Placement and Supervision form

At present, trainees are asked to complete the 'Evaluation of Placement and Supervision', which allows trainees to evaluate their experience of placement and supervision on placement. In order to gather meaningful feedback from trainees about their experiences, the form is initially completed at mid-placement review and forms the basis of a private discussion with the trainee's Clinical Tutor. The Clinical Tutor discusses strategies for

resolving any difficulties and supports the trainee to share their concerns with their placement supervisor (if it is appropriate to do so). The process is then repeated at the end of placement review so that any difficulties can be monitored by the Clinical Tutor team. The current form is available as a Word document which trainees are asked to complete and send via email to their Clinical Tutor before their placement meetings.

Trainees are asked to record their name on the evaluation so that their feedback is identifiable. Trainees are also encouraged to share and discuss their feedback directly with their placement supervisor.

NHS Education Scotland (NES) Psychology Trainee Survey

The NES Psychology Trainee Survey was developed by Millar et al., (2018) at the University of Edinburgh. The largest component of the survey is a psychology supervision questionnaire which contains 30 items (attached). The other component of the survey contains five items seeking feedback on the trainee's experience of the placement generally; three items seek overall feedback, and two further items seek feedback on the support provided by Clinical Tutors.

The NES Psychology Trainee Survey is administered online and completed at the end of every placement. Trainees are asked to identify their supervisor by name at the start of the survey but are not asked to identify themselves. Feedback is not shared with the supervisor at the end of a placement; instead, supervisors are provided with a summary of trainee feedback after having supervised three trainees (all of whom are required to complete the online survey). In this way, comments or feedback cannot be attributed to an individual trainee, therefore ensuring their anonymity. The feedback summary is also shared with the supervisor's line manager.

Trainees are encouraged to contact their Clinical Tutor if there are specific issues or difficulties during the course of the placement so that these can be addressed.

How do the Trent and NES processes compare?

The Trent Evaluation of Placement and Supervision is a paper-based form with a broad focus; trainees are asked to provide feedback on their general placement experience including personal experience, support for proficiency development, opportunity for observation, and experience of supervision. Trainees are asked to identify themselves and

encouraged to share their feedback directly with their placement supervisor; feedback is not shared with the supervisor's line manager.

The NES Psychology Trainee Survey is administered online. The survey largely focuses on trainee experiences of supervision, asking a total of 35 questions: 30 related to supervision, three about overall placement experience and two about Clinical Tutor support. Trainees are not asked to identify themselves; the feedback they give is anonymous and not shared directly with the placement supervisor. After three trainees have provided feedback about an individual supervisor this is summarised and shared with the supervisor and their line manager.

Appendix O: Service Evaluation Survey

When answering the following questions please consider all your placements since starting the Trent course.

1. How many placements have you completed since the start of your training? *(Please consider FPA and FPB separate placements)*

2. I have had positive placement experience(s)
Strongly Agree Agree Neutral Disagree Strongly Disagree

3. I have had negative placement experience(s)
Strongly Agree Agree Neutral Disagree Strongly Disagree

4. For how many placements have you completed the placement feedback form?

5. The placement feedback I have given has been acted on
Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

6. The placement feedback I have given has not been acted on
Strongly Agree Agree Neutral Disagree Strongly Disagree Unsure

7. I have been kept informed of the actions taken and/or outcomes of my placement feedback
Strongly Agree Agree Neutral Disagree Strongly Disagree

8. I am less likely to give honest placement feedback because the form is not anonymous. If so, why?
Strongly Agree Agree Neutral Disagree Strongly Disagree

9. I believe that providing negative placement feedback will affect the outcome of my placement.
Strongly Agree Agree Neutral Disagree Strongly Disagree

10. Providing feedback on placement experience(s) is worthwhile.
Strongly Agree Agree Neutral Disagree Strongly Disagree

11. The placement feedback form provides opportunities to identify and report unsafe clinical practice.

Strongly Agree Agree Neutral Disagree Strongly Disagree

Please answer the following questions in relation to the current Trent Trainee Evaluation of Placement and Supervision.

Acceptability Measure (AIM)

12. I like the Trent Trainee Evaluation of Placement and Supervision feedback form.

Strongly Agree Agree Neutral Disagree Strongly Disagree

13. I welcome the opportunity to give feedback on my placement experiences.

Strongly Agree Agree Neutral Disagree Strongly Disagree

14. Being able to give identifiable feedback that can be discussed with my supervisor during placement meetings is appealing to me.

Strongly Agree Agree Neutral Disagree Strongly Disagree

15. I approve of the current process of gathering feedback on placement experiences used by the Trent course.

Strongly Agree Agree Neutral Disagree Strongly Disagree

16. Any Additional Comments

Appropriateness Measure (IAM)

17. The use of a non-anonymised feedback form is a suitable method of gathering feedback from trainees.

Strongly Agree Agree Neutral Disagree Strongly Disagree

18. The Trent Trainee Evaluation of Placement and Supervision feedback form is fit for purpose.

Strongly Agree Agree Neutral Disagree Strongly Disagree

19. The questions on the Trent Trainee Evaluation and Supervision feedback form are applicable to my placement experiences.

Strongly Agree Agree Neutral Disagree Strongly Disagree

20. The topics covered on the Trent Trainee Evaluation and Supervision feedback form are a good match for the topics I would like to provide feedback about.

Strongly Agree Agree Neutral Disagree Strongly Disagree

21. Any Additional Comments

Feasibility of Measure (FIM)

22. Providing feedback on a paper-based form for every placement is doable.
Strongly Agree Agree Neutral Disagree Strongly Disagree

23. The Trent Trainee Evaluation and Supervision feedback form is easy to use.

Strongly Agree Agree Neutral Disagree Strongly Disagree

24. Using the Trent Trainee Evaluation and Supervision feedback form makes providing honest feedback about my placement experiences possible.

Strongly Agree Agree Neutral Disagree Strongly Disagree

25. Any Additional Comments

Please answer the following questions in relation to the NES Psychology Trainee Survey.

Acceptability Measure (AIM)

26. I like the NES Psychology Trainee Survey.
Strongly Agree Agree Neutral Disagree Strongly Disagree

27. I welcome the opportunity to give feedback on my placement experiences using the NES Psychology Trainee Survey.

Strongly Agree Agree Neutral Disagree Strongly Disagree

28. Being able to give anonymous feedback is appealing to me.

Strongly Agree Agree Neutral Disagree Strongly Disagree

29. I approve of the proposed changes to gathering feedback on placement experiences made by the Trent course.

Strongly Agree Agree Neutral Disagree Strongly Disagree

30. Any Additional Comments

Appropriateness Measure (IAM)

31. The use of an online, anonymised feedback form seems a suitable method of gathering feedback from trainees.

Strongly Agree Agree Neutral Disagree Strongly Disagree

32. The NES Psychology Trainee Survey seems fit for purpose.

Strongly Agree Agree Neutral Disagree Strongly Disagree

33. The questions on the NES Psychology Trainee Survey seem applicable to my placement experiences.

Strongly Agree Agree Neutral Disagree Strongly Disagree

34. The topics covered on the NES Psychology Trainee Survey seem a good match for the topics I would like to provide feedback about.

Strongly Agree Agree Neutral Disagree Strongly Disagree

35. Any Additional Comments

Feasibility of Measure (FIM)

36. Providing feedback via an online survey for every placement is doable.

Strongly Agree Agree Neutral Disagree Strongly Disagree

37. The NES Psychology Trainee Survey seems easy to use.

Strongly Agree Agree Neutral Disagree Strongly Disagree

38. Using the NES Psychology Trainee Survey would make providing honest feedback about my placement experiences possible.

Strongly Agree Agree Neutral Disagree Strongly Disagree

39. Any Additional Comments

40. If I were not asked about unsafe clinical practice on the placement feedback form, I would:

41. Know how to report it in another way

Strongly Agree Agree Neutral Disagree Strongly Disagree

42. Feel able to report it in another way

Strongly Agree Agree Neutral Disagree Strongly Disagree

43. I am less likely to report concerns about unsafe clinical practice using the placement feedback form because it is not anonymous.

Strongly Agree Agree Neutral Disagree Strongly Disagree

44. If so, why?