

**Investigating the Perceived Effectiveness of Eye Movement Desensitisation
Reprocessing (EMDR) Treatment in Adult Survivors of Childhood Sexual
Abuse and the Impact on Neuropsychological, Emotional and Behavioural
Functioning and Quality of Life: A Case Series Analysis**

Halima Bibi

School of Health and Society, University of Salford

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Abbreviations

ACES – Adverse Childhood Experiences
ACT – Acceptance Commitment Therapy
ADHD – Attention deficit hyperactivity disorder
AIP – Adaptive Information Processing
ANAM – Automated Neuropsychological Assessment Metrics
APA – American Psychological Association
BABCP – British Association for Behavioural and Cognitive Psychotherapies
BLS – Bilateral stimulation
BPD – Borderline personality disorder
BPS – British Psychological Society
CAMHS – Child and Adolescent Mental Health Services
CASP – Critical Appraisal Skills Programme
CBT- Cognitive Behavioural Therapy
CCG – Clinical commissioning group
CDI – Children’s Depression Inventory
CFT – Compassion focused therapy
CITES – Children’s Impact of Traumatic Events Scale
CMHT – Community Mental Health Team
COMET – Competitive memory training
COVID-19 – Coronavirus disease 2019
CPD – Continued Professional Development
C-PTSD – Complex-Post-traumatic Stress Disorder
CSA – Childhood Sexual Abuse
CT – Childhood Trauma
CT – Complex Trauma
DBT – Dialectical behaviour therapy
DEAR MAN (Skill) – Describes, Assertive, Express, Reinforce – Mindful, Assertive and Negotiate
DES – Dissociative Experiences Scale
DID – Dissociative Identity Disorder
DoH – Department of Health
DSM – Diagnostic and Statistical Manual of Mental Disorders

EBP – Evidence-Based Practice
ECR – EMDR Consultant Rater
EFRS – EMDR Fidelity Rating Scale
EM – Eye movement
EMDR – Eye Movement Desensitisation Reprocessing
EMDRIA – EMDR International Association
FAST (Skill) – be F-air, don't over/under A-pologise, S-tick to value, be T-ruthful
GAD-7 – Generalized Anxiety Disorder 7
GDPR – General Data Protection Regulation
GIST-T – Initiative for Stress, Trauma Treatment
GIVE (Skill) – be G-entle act I-nterested, V-alidate, use an E-asy manner
GMMH – Greater Manchester Mental Health
GP – General Practitioner
HAT – Helpful Aspects of Therapy
HSCED – Hermeneutic Single-Case Efficacy Design
IAPT – Improving Access to Psychological Therapy
ICD-11 – International Classification of Diseases-11
IES-R – Impact of Events Scale-Revised
ImRs – Imagery Rescripting
IPA – Interpretative Phenomenological Analysis
IRR – Independent Research Raters
IT – Information Technology
MASC – Multidimensional Anxiety Scale for Children
MDMA – Methylenedioxymethamphetamine
MeSH – Medical Subject Heading Terms
MoJ - Ministry of Justice
NATs – Negative Automatic Thoughts
NC – Negative cognition
NCCMT – National Collaborating Centre for Methods and Tools
NHS – National Health Service
NICE – National Institute for Health and Care Excellence
NRES – National Research Ethics Service
OCD – Obsessive compulsive disorder
PANT – PEBL Attentional Network Test

PBE – Practice Based Evidence
PC – positive cognition
PCBT – PEBL Corsi Blocks Test
PE – Prolonged exposure
PEBL – Psychology Experiment Building Language
PFC – Prefrontal cortex
PHQ9 – Patient Health Questionnaire 9
PIGT – PEBL Iowa Gambling Task
PSS – Platinum Standard Scale
PTM – Power Threat Meaning
PTSD – Post-traumatic Stress Disorder
QoLS – Quality of Life Scale
RA – Research Assistant
RCT – Randomised controlled trial
REM – Rapid eye movement
RSES – Rosenberg Self-Esteem Scale
SAPAS – Standardised Assessment of Personality – Abbreviated Scale
SCL-90-R – Symptom Checklist-90-Revised
SENCO – Special Educational Needs Coordinator
SMI – Severe mental illness
SSS – Single Session Summary
STOPP (Skill) - Stop, Take a step back, Observe, Pull back, Practice what works
SUDs – Subjective Units of Disturbance
TA – Thematic Analysis
TF-CBT Trauma-focused Cognitive Behavioural Therapy
TIP (Skill) – Tip the Temperature, Intense exercise, Paced breathing
TPT – Treatment Plan Tracking
UKCP – United Kingdom Council for Psychotherapy
USIR – University of Salford Institutional Repository
VLQ – Valued Living Questionnaire
VoC – Validity of Cognition
WHO – World Health Organisation
WM – Working Memory
WPS-CR – Weekly Problems Rating Scale-Children’s Revised

Abstract

Childhood sexual abuse (CSA) is an ongoing issue (WHO, 2017) with 1 in 20 children annually reported as being abused in the UK (NSPCC, 2019; Radford et al, 2011). Many child survivors are of adolescent or young adult age before they request help from relevant services (HAVOCA, 2021; NSPCC, 2018; Noel, Dogaru, and Ellis, 2015; Flatley, 2017). The aim of this study was to investigate the perceived experiences of six young adult female survivors of CSA of their EMDR treatment as well as an assessment of the changes in the individual trauma stress response. This case series analysis explored (a) neuropsychological, emotional (namely low self-esteem, anxiety and depression), behavioural functioning and quality of life issues using descriptive statistics via outcome measures conducted before, during and after treatment and (b) client perspectives through qualitative interviewing at one-month follow-up to ensure adequate time was allowed to monitor changes using Thematic Analysis [TA]. The study setting was within the Improving Access to Psychological Therapies (IAPT) program framework, established to ensure service users accessing NHS treatment are presented with choice in their treatment.

The triangulation of data in this study allowed for a deeper analysis of the experiences of adult CSA survivors undergoing EMDR treatment beyond an examination of differences in pre and post outcome measures. The descriptive statistics suggested overall positive changes in participant functioning in all measured domains (three positive, two moderate outcome cases and one sceptical no-improvement case; based on independent research rater feedback) however variable differences in neuropsychological processing from pre- to post-treatment. The descriptive statistics were limited in their generalisability because of certain limitations in data collection as inhibited by COVID-19 restrictions and because of the small sample size. Three key themes were identified in the qualitative analysis which contributed to the literature on treatment of adult CSA survivors by identifying which factors the clients identified as helpful and unhelpful to their treatment. These themes were identified as being an 'Unhelpful' process (service time restrictions, fear of the lack of confidentiality, fear of emotional reprocessing), 'Helpful' aspects of therapy (client choice in treatment, therapist interpersonal and professional skills, psychological resourcing, idiosyncratic approaches) and 'Mixed Responses' due to

COVID-19 (face-to-face vs remote working). Overall, this study contributed to the literature about EMDR treatment for adult CSA survivors by shedding insight into the perceived experiences of clients and providing further evidence for the efficacy of this treatment.

Importantly, further research could investigate a potentially larger sample, emphasis on neuropsychological functioning, and within differing settings, to understand deficits within the current study. A qualitative study of the perceptions and experiences of childhood sexual abuse survivors who opt for CBT over EMDR might lead to recommendations for changes in protocol that would make EMDR more acceptable. There is scope to further investigate EMDR as a reliable and valid treatment option within NHS IAPT settings, alongside essential service development in therapist training programmes to support the growing need for treatment of multiple-trauma and/or Complex-PTSD (ICD-11, International Classification of Diseases-11, 2018).

Chapter 1: Introduction and Literature Review

This chapter aims to provide information around evolution of the current research and the current knowledge of the traumatic stress response. Historical underpinnings of both Eye Movement Desensitisation Reprocessing (EMDR) therapy and Improving Access to Psychological Therapies (IAPT) services will be explored in terms of debate surrounding preference in treatment models, founded upon evidence-base, in accordance with the National Institute for Health and Care Excellence (NICE). Equally, consideration of significance in diagnosis, such as Post-traumatic Stress Disorder (PTSD), Anxiety and Depression (APA, 2012), and frameworks to support clinicians when working with survivors of Childhood Sexual Abuse (CSA) will be discussed, alongside the neurobiological correlators of EMDR in PTSD. Finally, an overview of research and guidance surrounding client perspectives, in collaboration of the above-mentioned areas will be amalgamated into the objectives of this study.

OVERVIEW

PTSD is a diagnosis often used in mental healthcare services, internationally, as a prominent ongoing societal issue with 10% of women and 4% of men developing this in the US at some point during their lives (Tracy, 2016). It is also important to mention the normality surrounding strong emotions in response to stress. For instance, during the COVID-19 pandemic some may have incurred feelings of distress, this may have lasted until the circumstance had passed, after which acute stress-disorder or C-PTSD (ICD-11, 2018) may have been present (e.g. for those that have lost loved ones). However, others may exhibit stress alone or collective small 't' trauma resultant of their interpretation of experiences and fear responses, the results of which are yet to be researched in future years. Evidently such experiences leave a detrimental impact on brain development, performance and functioning amongst sufferers due to adaptation of the biochemical stress response system. Research suggests alterations in the sufferers ability to react resourcefully and capably (CWIG, 2009, 2011; NCTSN, 2008; Paquola, Bennett, and Lagopoulos, 2016; Paquola et al, 2017, Wilson, Hansen, and Li, 2011). Accordingly, the focus point within this research was to investigate the influence of the individual traumatic stress response in trauma sufferers, resulting from CSA. This was achieved through

a staged study of behavioural, emotional and neuropsychological utility during IAPT EMDR trauma-focused treatment, which is UK government NICE Guideline compliant (NICE-cg26, 21/10/17).

Trauma-based symptoms are highly recognised as a result of child maltreatment as determined across the Western World (Scher et al, 2004; WHO, 2016). In particular, there is significant inequality in rates of child maltreatment, higher rates of risk are seen in more disadvantaged and impoverished populations, with 71% of child homicides accounted for in low-middle income countries, of which survivors of the male gender account for 60% (WHO Europe Office, 2019). In order to address this global issue many researchers, practitioners and politicians have attempted to tackle concerns leading to the development of numerous psychological interventions, preventative measures and introduction of both short and long-term support services (Colangelo and Keefe-Cooperman, 2012; Sinanan, 2015).

1.2 EVOLUTION OF CURRENT STUDY

PTSD is a term often used in mental healthcare services as a prominent ongoing widespread issue (Kessler et al, 2017) with approximately 1 in 3 people, in the UK, struggling to manage their symptoms following a traumatic incident, potentially resulting in an 'acute stress reaction' (Royal College of Psychiatrists, 2020). Evidently such experiences leave a detrimental impact on brain development, performance and functioning amongst sufferers due to adaptation of the biochemical stress response system, suggesting alterations in the sufferer's ability to react resourcefully and capably (CWIG, 2009, 2011; NCTSN, 2008). Trauma-based symptoms are highly recognised within child maltreatment; this is thought to be linked to (emotional) trauma-specific, (behavioural) task-performance and (neuropsychological) memory functioning (Wilson, 2009; Wilson, Hansen, and Li, 2011). Therefore, research suggests that EMDR has a neuropsychological processing function, consistent with the formulating of traumatic stress.

1.2.1 Relevance of Subject Field

An initial 2017 database search was carried out to refine the subject field (importantly, the main body of systematic review for the current refined research was later conducted in 2018 as seen in the following chapter); numerous searches were run using “MedLine” and “PsycINFO” (covering 8 years, 2009-17) due to broader access around Mental Health topics. Additionally, “Google TRIP database” to gather international research guidance, “CINAHL” nurse index and “Cochrane” to check systematic reviews of EMDR relevant to this research, each more defined than the previous were searched. When searching the various long-term effects of child “maltreatment” (more so when searching “trauma”) incorporating emotional, behavioural and neuropsychological factors, over forty documents were highlighted. However, when introducing the term “EMDR” a much briefer set of results remained.

As seen in the next chapter, with many current studies (consistent with prior research e.g. De Quervain’s, 2006), there appears to be a lack of adolescent sample hence, results can only be generalised to either exclusively the adult or child populace. Therefore, the researcher underwent the task of screening out research looking at treating the child rather than the adult who experienced trauma, as the research aimed to evaluate the treatment of EMDR for adolescent/young adult participants within IAPT services, who had experienced previous childhood trauma; this specifically identified the gap in research. Thus, emphasising the need for more studies when working with adolescence/early year adults when exploring childhood trauma using EMDR. Accordingly, PRISMA guidance (2018) on systematic reviews and meta-analysis was relevant to further structure and investigate this subject as seen in the following chapter. Equally, ethics around working with a young sample (pre-17) was imperative and hence, as seen in the methodology chapter, it was decided that a sample age range of 18-25 would be most appropriate to avoid cross-working between teams and for consensual reasons, which would be too extensive for the scope of this project. It was also envisaged that due to subject sensitivity a much younger sample would be difficult to obtain, potentially deeming the project unachievable.

Upon analysis of the sample and fieldwork demographics, the study of childhood maltreatment was a clearer objective. However, the term ‘maltreatment’ is divided into two key areas: harm, a consequence or action and secondly, people responsible

for the harm (Gough, 1996). It is further defined by the Federal Child Abuse Prevention and Treatment Act as "...any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm (CWIG, 2004)" suggestive that this is collective in relation to its depth. For instance, children may experience various methods of maltreatment (Carter, Weithorn, and Behrman, 1999; Hulme and Agrawal, 2004) as demonstrated in the current research excluded from the literature review for this thesis, as well as prior research in community settings conducted by Bifulco et al. (2002) and Silverman, Reinhherz, and Giaconia, (1996) whereby a large proportion of the sample had experienced differing forms of abuse which made it difficult to differentiate results. Cicchetti, (2007) indicates the need to define such a vast array of categorisation and therefore as opposed to amalgamating the definition, the researcher decided to work solely on childhood sexual abuse in consideration of the literature as highlighted in the following chapter and the current IAPT clientele demographic with which she worked. Minimal research around neuropsychological functioning in young people; COVID-19 restrictions (Lenferink, Meyerbröcker, and Boelen, 2020), IAPT time constraints and invasiveness (e.g. when considering brain imaging) further limited results in the current study.

CSA is usually defined (HM Government, 2015; Gómez, Kaehler, and Freyd, 2014; Irigaray et al., 2013) as the act of having sexual interaction or intercourse with a child (aged between 0-12) and an older individual e.g. in cases of attack whereby the child resists, inappropriate touching, and fondling whilst exhibiting a sexual intent. CSA may affect individuals in various ways e.g. short-term problems, such as a period of self-sabotage (NSPCC, 2000) directly after the experience or alternatively, longer-term adverse physical health issues (Perry et al, 2009), decreased life satisfaction (Fergusson, McLeod, and Horwood, 2013), emotional dysregulation and issues with neuropsychological functioning (Malarbi et al, 2017), persistent nightmares, intrusions, flashbacks, interpersonal issues, and/or ongoing risk issues (Bak-Klimek et al, 2014; Matulis et al, 2014; Norman et al, 2012). Childhood itself is viewed as a social construct across the duration of life and consistently, boundaries of child-adulthood have historically fluctuated (Malarbi et al, 2017; Smith et al, 2016; Gough, 1996). Equally, some survivors might not exhibit any maladaptive symptoms to CSA

dependent upon intensity, duration and age of abuse (Domhardt et al, 2015; Murray, Nguyen, and Cohen, 2014). This may be as brain development in infancy and early childhood plays a significant role in the progression of emotional, behavioural and neuropsychological functioning at later stages in life due to the level of plasticity in change, especially when seeking psychological support following a traumatic incident (Shonkoff et al, 2014, 2015; Shonkoff & Phillips, 2000; Scott et al, 2015; Weems et al, 2015; CWIG, 2011). During early childhood, neural pathways are rapid in learning from repeated experiences however those following trauma are depended upon heavily which slows down the production of other pathways, much required for adaptive behaviour (Ecker et al, 2012; Hart and Risley, 1995; Perry et al, 1995). This is thought to lead to issues with emotional dysregulation, cognitive impairment and attachment later in life (Diamond, 2013; Hase et al, 2017; NICIM, 2000; Shonkoff et al, 2008; 2018).

The effects of exposure to traumatic experiences are displayed in the form of external (e.g. emotional dysregulation such as anger/frustration) and/or internal (e.g. suicidal ideation, depression, self-blame) symptoms (HAVOCA, 2021; Jamshidi, Rajabi and Dehghani, 2020; Goodnight et al, 2019; WHO, 2017; Colangelo and Keefe-Cooperman, 2012; Fergusson et al, 2013; Kaplow, 2007). These may later lead to twenty to sixty three percent of survivors of CSA developing PTSD (Gabbay et al, 2004), with a majority of problems seen in delayed development of complex motor skills, school learning and social relationships (NCTSN, 2008). This may be due to impairment of the brains capacity to shield the neural pathways in an attempt to safeguard and fortify them following trauma (Shonkoff and Phillips, 2000). Similar to childhood, in adolescence the brain again limits unused neural pathways in an attempt to improve efficiency in areas of attention, concentration, reasoning, and executive functioning (Cook, et al, 2005). Abuse during adolescents (e.g. UK secondary school-age onset) can lead to externalising behaviours such as aggression and early childhood onset may cause internalising behaviours, such as isolation, depressive symptoms, self-loathing (Manly, 2001; Kaplow, 2007). It is common that risk may also be presented (e.g. impulsivity, substance abuse, and criminal or challenging behaviour) as reinforcement of neural pathways is resultant in lack of communication between that and other areas of the brain (Chamberlin, 2009;

Wilson, Hansen, and Li, 2011). Although risk-related behaviour may be resultant from a variety of factors, it is equally thought that such behaviour may have been born out of the distress of the traumatic event (Wilson, Hansen and Li, 2011), suggesting that the effects of CSA can be seen in the context of the traumatic stress response.

The development of trauma-focused non-invasive (without need for the client to share detailed accounts of the event) treatments such as EMDR hope to alleviate PTSD type trauma symptomology via Bilateral Stimulation (BLS) of eye movements (Ems) when working with survivors of CSA. During an EMDR UK Annual Conference (12-13/06/20), key speakers including De Jongh and Matthijssen suggested not only its efficacy (Nijdam et al, 2012) however also cost-effectiveness (Mavranouzouli et al, 2020; van den Berg et al, 2014). Importantly, the current research examined how effective EMDR treatment is within short-term services such as IAPT and what the clients' perceived experience of therapy may have been.

1.3 THE TRAUMATIC STRESS RESPONSE

Recent conferences and training events, including NHS Safeguarding Adults and Children training (02/08/18); the 'Complex Trauma' event offered by the British Psychological Society (BPS, 09/05/19) and an EMDR Ego States Workshop (Patterson, 22/09/18) consistently displayed that children who have suffered abuse and similar Adverse Childhood Experiences (Felitti et al, 2019; Centres for Disease Control and Prevention, 2015), resultant in a lack of appropriate support, are more likely to exhibit longitudinal quality of life issues. Such difficulties are outlined as follows; cognitive and social issues (e.g. low self-esteem); negative coping (e.g. reprisal in illicit substances); lower educational attainment; involvement with the criminal justice system; enduring physical and mental health issues (e.g. dysfunctional emotional, behavioural and neuropsychological processing).

The reliving of traumatic experiences as a symptom of PTSD is greatly stressful and can be connected with suicidal ideation, anxiety and particularly depressive

symptomology (Smith et al, 2016; Mills et al, 2016; Kendler and Aggen, 2014; Zeglin, DeRaedt, and Lanthier, 2015; Wood, Ricketts, Parry, 2018). Similar to Van den Bulk et al. (2016), Dannlowski et al. (2012) hypothesised that healthy adults who had previously suffered with childhood maltreatment (including CSA) would exhibit increased amygdala responsiveness to traumatic stimuli alongside decreased hippocampal gray matter volume as generally correlated with both PTSD and depression, findings indicated comparable functional and structural variations. Subjects scoring higher on the Childhood Trauma Questionnaire (Bernstein and Fink, 1997) showed decrease in “gray matter volumes in the hippocampus, insula, orbitofrontal cortex, anterior cingulate gyrus, and caudate” (Dannlowski et al, 2012, p.286), potentially contributing to emotional disorders in adulthood, as identified through morphometric analysis. Hence, the traumatic stress response to an external event (i.e. Criterion A, DSM-V, 2013) is in essence an experience external to an individual’s normal environment which could possibly impair brain development (Perry et al, 1995; Wilson, Hansen, and Li, 2011). In children, this may potentially lead to modification in behaviours, emotional processing and cognitive deficits (Malarbi et al, 2017; Weems et al, 2015; Kathryn et al, 2011; Paquola, Bennett, and Lagopoulos, 2016, Paquola et al, 2017). Schwartz and Perry (1994) link the traumatic stress response with clinical presentation of symptomology as neuropsychological evidence of discrepancies in cognitive functioning, primary functioning and attention in children; this coincides with other research in this area (Van den Bulk et al, 2016; Malarbi et al, 2017; Weems et al, 2015; Dorrepaal et al, 2014; Lazarus and Folkman, 1987; Igloi et al, 2010; Paylor and Royal, 2016). As seen in studies conducted by Wilson et al. (2009, 2011) in children who have suffered maltreatment/abuse, the ‘hypothalamic–pituitary–adrenal axis (which is the connection between organs in both the brain and body) and certain brain regions, such as the amygdala, hippocampus, and prefrontal cortex’ are associated with their impairment in processing emotional and neutral stimuli in later years.

1.4 MODELS OF THERAPY: CONTEXT OF EMDR

It is important to consider models of therapy to help with the deleterious effects of CSA. Although it is thought that numerous diverse models of therapy exist (Cooper

and McLeod, 2010), there are only several key therapeutic domains including Humanistic/Counselling (e.g. Person-Centered), Psychoanalytic/Psychodynamic, Cognitive Behavioural and Integrative; with a large evidence base for Cognitive Behavioural Therapy 'CBT' (Salkovskis and Wolpert, 2012). NICE (2018) guidelines concentrate heavily upon RCTs for CBT vs EMDR however CBT possesses greater provision/funding to continue RCT research due to its profoundly evidence-based status whereas EMDR lacks such provision hence struggles to highlight RCT studies to such an extent. Horst et al. (2017) suggested that CBT and EMDR approaches could be contrasted with EMDR emphasising an exploration of memory and CBT emphasising an exploration of the stimuli that provoked panic. Power et al. (2002) indicate EMDR generally achieves symptom reduction in fewer treatment sessions in comparison to alternative trauma-treatment; EMDR has also been shown to be more successful in achieving sustained symptom reduction (Van der Kolk et al, 2007).

Irrespective of such results, direct marketing of CBT above alternative therapies such as EMDR could perplex individuals who are merely in need of support (Bond and Tyrrell, 2002), especially since the guidance whereby the American Psychological Association (APA) and the NICE (2009) recommend trauma-focused Cognitive Behavioural Therapy (TF-CBT) as a treatment of choice, further limit the choice of alternate therapy available to the general public and may divide an otherwise cohesive workforce. However contrary to these recommendation, a wealth of research is highlighted in the Special Issue of the 'Journal of EMDR Practice and Research' indicating the influence of EMDR across seven countries when working with children and adolescents, presenting with a broad array of trauma symptoms (also see, Karadag, Gokcen, and Sarp, 2020). Moreover, equally the introduction of Information Technology Systems (e.g. self-help programmes often managed by PWP staff) within the NHS also penalises and adds to the sphere of stigma surrounding talking therapies (Vogel and Wade, 2009), further heightening the causation of power struggles between the clinical domains themselves, resultant in an imbalanced professional convergence. Professional conflicts and the availability of self-help services add to clients with traumatic presentations having concerns and being reluctant to seek help (Corrigan and Hull, 2004; Dingfelder, 2009). This section demonstrates the barriers and pitfalls of an occupation that is evolving in turbulence.

1.4.1 Development of EMDR

EMDR was developed in the late 80s by Francine Shapiro (Shapiro, 1989) in her attempt to treat traumatic memories and attached distressing symptomology. The eight-phase protocol with bilateral stimulation (namely horizontal saccadic eye movements) are thought to desensitize the distress resultant from traumatic memories. The purpose of this psychological approach is to attain reprocessing and integration within the client's general biographical memories (Shapiro, 2005). Regardless of the extensive scientific verification of the efficacy of the EMDR protocol in the treatment of pathologies related to traumatic memories (Schwabe, Nader, and Pruessner, 2014; Shapiro, 2012), the psychological landscape for the treatment of traumatic memories or other adverse life events has evolved. More recently research has explored the efficacy of EMDR in the treatment of conditions such as ADHD and Borderline Mental Capacity (BMC) (Kaan et al, 2019), anxiety and depression (Schwarz et al, 2020; Jiménez et al, 2020; Goodnight et al, 2019; Hase, Balmaceda, and Hase 2015), phobias (De Jongh, ten Broeke, and Renssen, 1999; De Jongh, Van den Oord, and Ten Broeke, 2002; De Jongh et al, 2011; 2012), addictions (Markus et al, 2016; Little, van den Hout, and Engelhard, 2016; Little et al, 2017; Schäfer et al, 2017), chronic pain (Brennstul, 2013), obsessive- compulsive disorder (Marsden et al, 2017), self-esteem (Griffioen et al, 2017), autism (Lobregt-van Buuren et al, 2018) and schizophrenia (De Bont et al, 2013). Nevertheless, treating trauma is a key element in its development, especially since its 2005 recognition from the NICE (2005) guidance and further recommendation by the French High Authority for Health (HAS, 2007). Moreover, numerous meta-analysis has examined the efficacy of EMDR in treating PTSD (Benish, Imel, and Wampold, 2008; Bradley et al, 2005; Chen et al, 2015; Davidson and Parker, 2005; Jonas et al, 2013; Seidler and Wagner, 2006; Van Etten and Taylor, 1998) concluding in further identification by the World Health Organization (2013) as a psychotherapy of choice in the treatment of trauma.

1.4.2 Functions of EMDR

As previously stated, EMDR was designed to deal with ongoing unprocessed psychological disturbance caused by traumatic memories (Shapiro, 1989). The clinician essentially works with the client to elicit memories of the traumatic event which may not otherwise be willingly processed by the individual, namely as EMDR is non-verbal and does not require clients to articulate all aspects of the traumatic event. The talking aspects of the treatment focus on the beliefs and feelings associated with the event that are unhelpful to the client. The client is encouraged to recall connected bodily sensations and negative cognitions (Shapiro, 2013). At this point, bilateral stimulation (BLS) takes place (e.g. eye movements) in an attempt to desensitise the individual to the stressful image and moreover, reprocess the memory in order to foster adaptation in associated cognitions. The eight stages of EMDR are outlined below:

Phase 1: thorough history-taking and treatment planning take place.

Phase 2: preparation (or 'stabilisation') takes place in the form of installing the relevant resources to cope with the reprocessing of distressing imagery. The therapist and client collaboratively discuss expectations and build rapport.

Phase 3: assessment of the client's target event is identified, alongside emotions, bodily sensations and associated positive (PC) and negative (NC) cognitions.

Ratings of belief in the PC (via the Validity of Cognition (VoC) scale) and the client's level of distress (via the Subjective Units of Disturbance (SUD) scale) are then taken (Logie, 2014).

"The next three phases are known as the 'reprocessing' phases and all involve dual attention bilateral stimulation (BLS). Dual attention BLS activates the client's information processing system while keeping the client anchored in the present moment. Dual attention BLS can be side to side eye movements, sounds, or taps." (EMDRIA, The Eight Phases of EMDR, 2021)

Phase 4: The memory is then processed via BLS to desensitise the client, until SUDs reduce to 0-1.

Phase 5: once desensitisation is complete, the PC is installed whereby the client links the target with a strengthened PC (measured via the VoC), until it feels true.

Phase 6: the therapist checks for residual bodily sensations in the manner of a body scan, detecting any distress from head to toe.

Phase 7: EMDR sessions generally close with this phase, the therapist facilitates resource installation whereby the client returns to a calm state, regardless of the progress of the reprocessing. However, reprocessing is complete if the client reports of a clear body scan, feels neutral when recalling the target, fully believes the PC and the SUDs reduce to 0-1.

Phase 8: the final phase focuses on re-evaluation of the target, in ensuring traumatic memories are integrated into adaptive emotional and cognitive schemas (Chen et al., 2014). Future targets and treatment objectives are then established.

1.4.3 Theoretical Underpinnings

Acknowledgement of the reprocessing function within EMDR led to the development of the Adaptive Information Processing 'AIP' (Shapiro, 2007) model, to hypothesise an explanation of how the reprocessing worked in EMDR. It suggests that new events interlink with existing memory networks. In accordance with this model, the difference in 'normal' and 'traumatic' processing appears to be that generally individuals utilise prior experiences, self- and world- perceptions to acknowledge newly occurring events. However, when 'traumatic' experiences occur the information system appears to accumulate these in a 'frozen' form hence, limiting the individual's ability to appropriately process these to an adaptive resolution. This is seen in cases of hyper-arousal (as a symptom of PTSD), alongside symptoms of avoidance and dissociation.

EMDR is thought to recognise the process of 'dual attention' (eliciting the traumatic memory alongside acknowledgment of the present, via BLS) as a means of allowing the mind to access the dysfunctional deposited event and encourage the instinctive processing system, permitting it to alter the information to an adaptive resolution. Successful processing attempts to integrate relevant preceding information so that unnecessary emotions and somatic symptoms are rejected, and memory structures adequately adapt to any new information. Oren and Solomon (2012) suggest that neurobiological theories of reconsolidation of memory are consistent with EMDR in that the client naturally adapts his/her self-perception during processing (perhaps in

aid of a 'cognitive interweave' if the processing becomes 'stuck') unlike with cognitive therapies which commonly promote challenging, restructuring and re-framing of negative or irrational beliefs. Correspondingly, reduction of pre-existing distressing memories is promoted through exposure therapies whereas in EMDR reconsolidation occurs without the need for eradication of old memories, rather in changing this to a more adaptive form.

In understanding efficacy of EMDR, many theories (MacCulloch, 2006; Propper and Christman, 2008; Nieuwenhuis et al., 2013; Van den Hout et al, 2011, 2012; De Jongh et al, 2013) have been proposed including aspects of 'perceived mastery' when exploring the clients control in managing traumatic memories. Exposure therapies (Ehlers and Clark, 2000; Ehlers et al, 2005) may request the individual to hold concentration in recall of the distressing event to deter avoidance. Unlike EMDR, which allows the client to weave in and out of the memory for brief periods of time; consequently instilling a sense of mastery as the adaptive memory is connected to the networks storing dysfunctional accumulated information (Oren and Solomon, 2012; Bergmann, 2012). Likewise, elements of mindfulness (Siegel, 2007) may play a role during the desensitisation phase of EMDR in allowing the client to 'let whatever happens, happen' and acknowledge what is coming up (Shapiro, 2001), clients are able to then accept their experiences.

1.4.4 Herman's Tripartite Model

Judith Herman (1992a, 1992b) developed a Tripartite Model of Recovery from Trauma where she outlined the stages of recovery as: Safety, Remembrance and Mourning, and Reconnection. Recognised as a leading figure in the field of trauma studies (Suleiman, 2008), her work has been used to promote a decade of neurobiological scholarly on trauma, in which the mechanisms of evidence-based practice, such as EMDR, could be developed (Arnstein, 1996). In a survey conducted by the International Society for Traumatic Stress Studies (Cloitre et al, 2011), 84% of clinicians surveyed supported a staged approach to working with C-PTSD; subsequently leading to a set of guidelines for the treatment of C-PTSD

(Cloitre et al, 2012). However, De Jongh (2016) has started compiling research to demonstrate that stabilisation is not needed in the treatment of complex trauma.

Herman proposed that there is a similar constellation of clinical symptoms experienced by trauma survivors in a number of contexts (e.g. combat, sexual, domestic and political abuse/violence) which were not captured by the PTSD category because they involved a pattern of traumatic events rather than a single event. Herman (1992b) argued, powerfully, that not all traumatic experiences are explained through the PTSD diagnosis and that a new diagnostic category of Complex Posttraumatic Stress Disorder was needed to describe the experiences and consequences of trauma for people who had endured a pattern of traumatic events rather than a single event. This diagnostic category has only recently been incorporated into ICD-11 (2018) and has not yet been incorporated into DSM classifications.

EMDR protocols which have been established to work with common themes of 'threat/safety,' 'self-defectiveness' etc, can be seen as similar to (or influenced by) Herman's initial stage of recovery as being safety, often leading to greater self-fulfilment and sense of control (Herman, 2012; Shapiro, 2002; Shapiro, 2007; van den Hout and Engelhard, 2012). Herman indicated that PTSD is the individuals lingering connection with an incident of threat/danger too overwhelming for their adaptive responses to life, as powerlessness was not only caused by the incapacity to deal with the event (characteristic of the human condition) however also due to 'terror' that circumstances may not change (Herman, 1992a). Neurobiological research (Badenoch, 2008; Cozolino, 2010) suggests that restriction in the ability to act and fear responses to threat are generated by the amygdala, whereby sensation-based memory is stored as the earliest structure, such as the fight, flight or freeze response to perceived threat stimuli; causing an unconscious reaction from the sympathetic nervous system (as per the Polyvagal theory; Porges, 2001, 2009). For instance, heightened physiological responses e.g. heart rate (Applegate and Shapiro, 2005; Van Der Kolk, 2014), are generally evaluated in phase 6 of EMDR. Herman asserted that the longevity of such reactions (on the basis of 'terror') were

observed in behaviours (i.e. dissociation), which is consistent with current studies of Neuroscience, for instance, if the 'low road' (whereby the systems are *amygdala appraised*) response is taken, the thalamus signals the amygdala and if a 'high road' (*cognitively appraised*) approach is taken, the process commences from the thalamus, through the cerebral cortex, and then hippocampus (which controls comparison of prior responses to stimuli via executive functioning), enabling the memory to be stored within an autobiographical framework to understand the context (Le Doux, 1996).

Herman suggested that trauma processing can only effectively arise following thorough understanding of the clients' world (as seen in EMDR phase 1, Shapiro, 2007) and installation of 'Safety' (Herman's phase 1) as the client's experiences of the trauma need to be understood phenomenologically from their viewpoint. For example, something that may be traumatic to one person may not seem to be traumatic to another. However, premature processing is not only relevant to initially undertaking a safety installation – it is also about the pacing of the EMDR and therapy work (Zaleski, Johnson and Klein, 2016). Consistently, the importance of EMDR phase 2 is emphasised whereby safety techniques (e.g. 'calm place,' 'light stream,' 'pendulation' etc) are employed so that the client can access these if imagery becomes too overwhelming (Parnell, 2013) during later phases of EMDR, essentially proceeding with therapy to meet the clients individual needs (e.g. if threat is indicated to a point of dissociation, then safety techniques can be revisited).

Herman's concept of 'terror' is conceptualised as being held in the right brain hemisphere, central to autonomic and unconscious processing (Gainotti, 2012), as seen in the hypothalamic-pituitary-adrenocortical (HPA)-axis's reaction to trauma via the 'low-road,' as opposed to via the 'high-road.' Hence, the individual has no conscious control of their choice in levels of distress (Siegel, 1999). However, if the event is viewed as non-threatening by the memory, HPA systems 'constrain' the sympathetic nervous system and employ the parasympathetic system. Though, when the system dysregulates, as thought to be the case in trauma, this leads to a cycle of hyperactivity, intrusions (flashbacks), and prolonged constriction (dissociation); Herman proposed that understanding of these three dialectical aspects is key in treating trauma. These elements are explored through reprocessing

of the hippocampal memory and neocortex assimilation of the trauma (Herman's phase 2, 'Remembrance and Mourning') – as per EMDR phases 3-8 in which the therapist requests that the identified target memory is matched with the negative cognition during BLS, and checks for a subjective measure of (optimally reduction) in distress and validity of cognitions (VoC) to interchange negative with more consistently positive beliefs, before body scan and self-control protocols are installed to ensure no distress in the body, thoughts and emotions remains (Gomez, 2012). Herman then suggested phase 3 in her model 'Reconnection' or reintegration with the outside world whereby the client "faces the task of creating a future" (Herman, 1992a, p.196), similar to the third prong of EMDR i.e. future template (Shapiro, 2001; De Jongh and Logie, 2014).

1.4.5 EMDR: Significant Hypotheses of Mechanism

During Shapiro's (1989, 2001) initial theory around EMDR, Shapiro indicated that the metrical, multi-saccadic eye movements (Ems) work as a brain-constraining mechanism to decrease anxiety when linked with the traumatic memory, similar to information emerging when dreaming is desensitized by rapid eye movement (REM). The REM theory was further enhanced by Stickgold (2002), suggesting that the horizontal Ems in EMDR create a mind-state comparable to that formed during REM sleep, which consequently fulfills numerous adaptive functions, delivering numerous adaptive functions such as memory and more importantly, a decrease in trauma-related indicators by changing emotionally charged auto-biographical memories into an indiscriminate semantic structure (Born, Rasch, and Gais, 2006; Stickgold and Wehrwein, 2009); in the same way that EMDR is thought to encourage the restructuring of traumatic imagery, decreasing the potency of the traumatic episodic memories, facilitated by the connected negative emotion (processed by the amygdala, Van den Bulk et al, 2016) and the hippocampus (Stickgold, 2002, 2008, partially evidenced by Elofsson et al., 2008; Sondergaard and Elofsson, 2008). However, in the previous two decades, three main hypotheses of mechanism have been formed to examine the role of eye movements:

- 1) Ems are unwarranted (Davidson and Parker, 2001; MacCulloch, 2006) as PTSD is an anxiety disorder and hence 'recall only' would suffice; in a former

meta-analysis of thirteen studies (Davidson and Parker, 2001) results were indicative of Ems making little if any contribution to the efficacy of EMDR, raising questions around physiological and neurological changes happening during BLS. Later research (Lee and Cuijpers, 2013) however highlighted methodological issues with the prior study hence a literature review of two key categories was conducted as follows; (a) fifteen clinical trials comparing the effects of EMDR with and without eye movements, with moderate and significant effect size for the additive effect of eye movements in EMDR treatment studies and (b) eleven laboratory trials that explored the effects of eye movements during participants eliciting distressing memories vs. the same technique minus the eye movements in a non-therapy setting, with a large and significant effect size, the soundest difference of which being for vividness measures, indicating the necessity of Ems.

- 2) There is a suggestion (Propper and Christman, 2008) that recovery of interrupted memories is developed by Ems managing associative memory processing and episodic memory retrieval via augmented 'interhemispheric communication' through the corpus callosum; partially based upon a prior functional imaging study resultant in saccadic Ems creating greater frontal cortical activity in comparison to smooth pursuit eye movements (O'Driscoll et al, 1998). Varying conditions/direction of Ems have been researched with saccadic horizontal Ems shown to enhance memory retrieval while considerably reducing false memories (Christman et al, 2003; Christman, Propper, and Brown, 2006; Propper et al, 2007; Brunyé et al, 2009; Nieuwenhuis et al, 2013).

However, Gunter and Bodner (2009) found that though vertical eye movements are not proven to improve interhemispheric communication, they exhibit equal efficacy to horizontal movements in the reduction of memory emotionality. They indicated that Ems enhance communication amid the left and right brain hemispheres, improving the capacity to recall an aversive event while not being negatively stimulated (Gunter and Bodner, 2009); many sensory channels can be utilised to arouse interhemispheric interaction (e.g.

tapping, eye movements, beeps), however that they should be alternating metrically left-right.

- 3) The volume of long-term memory (storing inactive memories and knowledge) is significant, in comparison to that of Working Memory (WM, active stored information utilised to perform cognitive tasks) (Baddeley, 1998) hence when concurrently doing two tasks (recalling a traumatic memory whilst moving the eyes), they compete for the WM; subsequently the memory becomes less vivid and emotional (Andrade, Kavanagh, and Baddeley, 1997). It is thought that events during recall effect how the memory is 'reconsolidated' and also future recall, as when the individual attempts recall the original memory becomes more vivid and realistic; from a WM perspective this should result in 'imagination deflation' (Van den Hout et al, 2011, 2012). WM theory suggests that Ems are thought to toll working memory, regardless of direction, unlike the 'interhemispheric communication' theory (above) averse to vertical eye movements. Empirical evidence of the 'working memory' theory is indicative that Ems and visual imagery significantly rely upon restricted-capacity visuospatial and central executive working memory sources, hence the anthology formed by any dual tasks which require attention (including calculating out loud (Kemps and Tiggemann, 2007); auditory shadowing (Gunter and Bodner, 2008); playing computer games (Engelhard et al, 2010); mental arithmetic (Van den Hout et al, 2010; Engelhard, Van den Hout and Smeets, 2011); copying a drawing (Gunter and Bodner, 2008); mindful-breathing (Van den Hout et al, 2011) will damage imagery causing it to become less emotional and vivid in comparison to 'recall only'; as similarly outlined in analogue studies (De Jongh, Ernst, Marques, and Hornsveld, 2013). This hypothesis indicates that all emotional memories eventually decrease in vividness when taxing WM during recall; research (Van den Hout et al, 2001; Engelhard, Uijen, and Van den Hout, 2010) suggests that equally; negative memories will become less unpleasant and enjoyable memories less enjoyable. Interestingly, Hornsveld et al. (2011) found that the taxing the WM with Ems twinned with positive activation leaves such thoughts less vivid and less enjoyable (consistent with WM theory), regardless of the direction in

movements, deeming this element in the standard EMDR protocol as unproductive.

Research is ongoing for the above theories however it is hypothesised that the role of Ems, unique to EMDR, may be a contributing factor in its success, studies carried out by van Veet et al, (2015) indicate Ems result in slower response times in comparison to no Ems during reprocessing, suggesting that they tax working memory and have been found to reduce the intensity/emotionality of historical memories in both this and earlier studies (Barrowcliff et al, 2004; Kavanagh et al, 2001; Maxfield, Melnyk. and Hayman, 2008; Van den Hout et al, 2001). They are thought to develop cognitive plasticity (Goodnight et al, 2019; Kuiken et al, 2001–2002) and if strong enough, the orienting nature of Ems (linked with induction of the brainstem's threat-scanning motion) may also create a 'bump' in the tectum map (which controls visual and auditory responses) in producing saccadic Ems (Panksepp, 2013). This consequently influences the tegmentum ('second brainstem' which controls mood, sleep attention and physiological responses - specifically within the periaqueductal gray (PAG), which is known to regulate emotional pain) hence, regulating general functioning and autonomic arousal (Panksepp and Biven, 2013). However, findings from a recent literature review (Kenchel et al, 2020) suggested that Ems did not reliably affect exposure to misinformation, nor seemed to improve memory, however that they did appear to increase spontaneous false memories. In the current study, Ems were not systematically used due to the COVID-19 pandemic and therefore, the impact of changes in BLS medium (e.g. EM's to tapping) were minimally explored.

1.5 DIAGNOSIS vs. SYMPTOMOLOGY

A wealth of research suggests measurable variance in neuropsychological processing in those presenting with childhood histories of 'complex trauma' (or 'Complex-PTSD' (C-PTSD) as defined by ICD-11 (2018). C-PTSD is thought to be developed following extremely horrific exposure, often to repeated situations where there was no escape (e.g. CSA or being a prisoner of war), causing affect regulation,

diminished beliefs about oneself and difficulty in sustaining relationships during psychological treatment (Goodnight et al, 2019; King et al., 2016; Malarbi et al, 2017; Groves et al, 2015; Paquola, Bennett, and Lagopoulos, 2016, Paquola et al, 2017; Wilson, Hansen, and Li, 2011). The NICE guidelines, in the UK, use the evidence base from both the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases-11 (ICD) to make their recommendations for which interventions they support. It is the NICE recommendations that the NHS IAPT services use as a basis for decisions about which treatments (i.e. CBT or EMDR) are offered for PTSD and C-PTSD.

PTSD was initially established to describe the symptoms experienced by war victims (originally called combat fatigue). There have been some subtle changes in the symptoms listed for PTSD in more recent iterations of the DSM, however in DSM-V (2013), a more radical change emerged in which PTSD was no longer categorised as an anxiety disorder, but became a diagnosis in its own right. Contra, ICD-11 (2018) includes the abovementioned features in maintaining simplicity in diagnostic assessment (Maercker et al, 2013), essentially either diagnosis of 'PTSD' or 'C-PTSD,' which suggests the appropriate treatment (Reed, 2010). Following much historical clinical scrutiny and debate, PTSD has generally been conceptualised, in both the DSM and ICD, as a conditioned fear response (Cloitre, 2020); exposure to particularly threatening event/s which cause issues which predominantly include reliving trauma in the present moment, with sensations of threat and avoidance of triggers. Whereas, C-PTSD (ICD-11, 2018) has been defined as not only symptoms of PTSD however, in addition of problems with emotion regulation, interpersonal issues and self-identity. Acute, recurrent, and lengthy traumas, such as CSA or domestic violence are commonly associated with C-PTSD (Brewin et al, 2017).

Survivors of complex childhood trauma (CT) such as CSA display poorer outcomes in comparison to survivors of single-event trauma as discussed in a recent systematic review (Chen, 2018) of Randomised Controlled Trial's (RCT's) in exploring the efficacy of EMDR on child and adult survivors of CT when working with PTSD symptoms. Findings suggested that EMDR was linked with a decline in trauma symptoms, anxiety and/or depression at post-treatment and follow-up in comparison to alternative treatments (e.g. CBT, individual or group therapy,

medication i.e. fluoxetine) and control treatment (delayed EMDR, therapy as usual, medication placebo, active listening) (Chen, 2018).

However there appears to be an expectation that CSA will meet the criteria of a traumatic event (Mutavi, Mathai, and Obondo, 2017; Ombok et al, 2013), namely as sexual abuse is a threat to the integrity and essence of the child's being however equally, it can be argued that not all survivors of CSA develop PTSD though do experience trauma symptomology and various other health complaints (Allnock, Hynes, and Archibald, 2015; Kamiya, Timonen, and Kenny, 2016) as they are unable to access/engage in psychological support as children, as seen in this study. The 'Medical Model' places emphasis on labels (e.g. PTSD) which the clinician gives to the client hence causing a power imbalance between clinician and client (Moncrieff, 2013; Shah and Mountain, 2007). In their quest to empower the client, therapists who are trained to provide deep and meaningful manualised treatment concentrating on social/holistic constructs may struggle with such a concept (Bohart, O'Hara, and Leitner, 1998); this is exacerbated by the evidence-based practice movement summoning the need for diagnosis before delivery of treatment (Clark et al 2009).

The Power Threat Meaning (PTM) Framework (Johnstone et al, 2018) developed by the British Psychological Society (BPS) was aimed to place an emphasis on how experiences of abuse of power lead to psychological distress, importance was given to understanding symptomatology as a natural response to the abuse of power and to understanding the meaning that people make of their traumatic experiences. Such an approach challenges conventional psychiatric diagnosis by aiming to recognise patterns in emotional distress, unique experiences and challenging behaviours. Interestingly, this can be utilised as a stand-alone approach as there is no particular theoretical notion (i.e. systemic, cognitive or behavioural), nor a specific direction (biological or social) however, it can equally be utilised as a meta-framework alongside current transdiagnostic interventions, such as EMDR. The PTM Framework (Johnston et al, 2018) heavily explores the function of 'power' in individuals lives, various threats experienced when power is incorrectly used and how we have learnt to deal with threat (also more commonly known as 'symptoms' of threat). Once established, the framework identifies an additional element of such

experiences; in which ways does broader society or societal factors (e.g. poverty, discrimination and inequality) exacerbate our emotions (e.g. fear, shame, guilt, self-loathing, isolation). Consequently, it can be utilised to support individuals to create a more positive narrative about their life experiences as opposed to viewing themselves as helpless, lacking in identity, self-worth, meaning or even as 'mentally unwell.' Interestingly and consistent with the current study, this framework can be used to inform service improvements, research and clinical frameworks through highlighting and strengthening already existing non-diagnostic alternatives (Johnston et al, 2018).

1.6 NEUROBIOLOGICAL LINKS OF EMDR OUTCOME IN PTSD

One main premise has been highlighted when exploring the pathophysiology of PTSD is a deficient fear-processing pathway (Milad et al, 2009; Orr, Metzger, and Pitman, 2002; Wurtz et al, 2016) which depends upon the amygdala and prefrontal cortex, PFC (Fullana et al, 2018), both structures are thought to be dysfunctional in PTSD. Interestingly, amygdala volume (Kuo, Kaloupek, and Woodward, 2012; Morey et al, 2012) and functional activation might account for exaggerated fear responses and persistence in excessive activation of traumatic memories together with distorted emotional regulation (Bzdok et al, 2013; Feng et al, 2016). Alongside bilateral amygdala engagement (Hayes, Hayes, and Mikedis, 2012), other regions of the brain may also be significant contributors to PTSD development, including the hippocampus (Bremner et al, 1995; Smith, 2005; Stein et al, 1997; Thomaes et al, 2009; Woon, Sood, and Hedges, 2010), the dorsolateral prefrontal cortex (dlPFC), basal ganglia, insula, precuneus, and thalamus (Aupperle et al., 2012; Herringa et al, 2012; Strigo et al, 2010; Yan et al, 2013). A recent study (Rousseau et al, 2019) investigated the functional brain correlate of EMDR in PTSD; EMDR showed significant improvements in the processing of traumatic memory via a functional reduction in brain regions thought to be disrupted in PTSD, consequently eliciting positive changes in numerous domains including memory, self-perception, fear extinction, REM sleep, reward, and attention.

Three key structures, the precuneus, PCC and medial PFC, in evaluating one's own and others' emotional experiences were less active post-EMDR, suggesting that

EMDR may contribute in reducing negative cognitions which have been associated with increased trauma symptomology (Shahar et al, 2013). Emotion regulation is also a key factor as the amygdala is connected with the PFC, and additional memory or emotional structures (Van den Bulk et al, 2016; Anggletton, 2000), acting as an alarm, crucial for fear learning (Pitman et al, 2012). Hence, a connection between stimuli that interpret reward or punishment (Hampton et al, 2007) to ensure appropriate responses to future danger. The reprocessing phase in EMDR which promotes one's positive self-cognition may be reinstating clients' reward mechanisms (Hopper et al, 2008) and positive outcome information (Sailer et al., 2008) by reducing the activity of the amygdala, mPFC, thalamic, and caudate. Such positive outcomes also highlight the efficacy of EMDR in the treatment of comorbidities, some of which are secondary to CSA, such as low self-esteem (Griffioen et al, 2017) and depression (Goodnight et al, 2019; Nanni, Uher, and Danese, 2012; Jaberghaderi et al, 2004). RCT's have also displayed a decrease in memory-related stress and conduct issues (Soberman, Greenwald, and Rule, 2002).

1.7 EVOLUTION OF IAPT: ANXIETY AND DEPRESSION

Prevalence of the comorbidity of PTSD systematically includes high rates of anxiety and depression (Schwarz et al, 2020; Smith et al, 2016; Mills et al, 2016; Zeglin, DeRaedt, and Lanthier, 2015; Wood, Ricketts, Parry, 2018; Ostacoli et al, 2018; Minelli, Zampieri, Sacco, 2019); with depression being the most common documented outcome of CSA in adults (Mills et al, 2016; Kendler and Aggen, 2014; Zeglin, DeRaedt, and Lanthier, 2015; Wood, Ricketts, Parry, 2018; Putnam 2003).

The IAPT programme (2012) was created to address the problem that most people could not access therapy either at all or in a timely manner. The NHS Long Term Plan (2019) supported expansion of IAPT, stating more than 50% of patients who use IAPT 'are moving to recovery, and nine out of ten people now start treatment in less than six weeks.' However, the Mental Health Statistics for England Briefing Paper (Baker, 2020) reported that 1.4 million referrals were received into IAPT in 2016-2017 (equating 1 in every 100 people) and hence, services were under extensive pressure. Consistently, the Department of Health and Social Care figures

(2018) indicated that approximately 2000 mental health professionals left per month, consequently, wait lists had generally increased up to 18 months for low intensity (step-2-care) and 4 months for high intensity (step-3 and 3+ care). Within Central GMMH IAPT this was reported to be somewhat higher for step-3 and over one year for 3+ (GMMH IAPT email; 22/02/21). Further, a report issued by the British Psychoanalytic Council and UKCP (2015), highlighted the significant impact in treatment choice, quality of services and waiting times, all of which deter the public's accessibility to psychological support so greatly needed and on a broader scale, possible risk as individuals are left without suitable treatment due to lack of staff to deal with demand.

1.8 DOMINANCE OF TREATMENT MODELS WITHIN IAPT

EMDR is at times implemented as an intervention alongside CBT however can also be administered as a stand-alone modality of treatment though with the prior ongoing pressure to utilise CBT as the main means of treatment due to its strong evidence-base across numerous clinical trials (NICE, 2018; Butler et al, 2006), EMDR has at times been viewed as lesser advantageous regardless of the Layard Report's (2006) recommendation of service user choice. Hence, real-world IAPT working may be misconstrued when observing NICE guidelines (2009) since service user 'choice' may be diminished by lack of promotion in dissimilar modalities of treatment. Similar to EMDR, CBT is conducted via prescribed methods which lend themselves to RCTs, the 'gold standard' of research evidence, as utilised by NICE and the NHS (NICE, 2018; Beutler and Forrester, 2014). While this is the case for both forms of therapy and regardless of the additional funding in psychological need available within IAPT since 2008, CBT is often the therapy of choice (HSCIC, 2015; NHS Digital, 2016; Platt, 2011) with inclusion of newly employed psychological wellbeing practitioners 'PWPs' and implementation of the 'Counselling for Depression; CfD' approach (Sanders and Hill, 2014) introduced as a counterbalance, causing burnout amongst staff (Westwood et al, 2017) however now also extending to the treatment of trauma as CBT is seen as significant over other trauma-focused therapies such as EMDR (NICE PTSD Guidance, 2018).

1.9 EMDR vs. ALTERNATIVE TRAUMA TREATMENTS

The prevalence rates of the CSA survivor populace must be acknowledged as according to The Office of National Statistics (2019), there were 1,969 adults who reported having experienced sexual abuse before the age of 16, in the year ending March 2019. Consistently, the governments 'Tackling Child Sexual Abuse Strategy' (2021) reports that "the Home Office and the Ministry of Justice have doubled the funding available to national voluntary sector organisations through the 'Support for Victims and Survivors of Child Sexual Abuse fund, to £2.4 million from 2020 to 2022. This funding is enabling...support lines; in-person and remote counselling; online psychoeducation resources; training for professionals working with victims..." (p5). However, despite progression in relevant treatment programmes and funding, according to the Help for Adult Victims of Child Abuse (HAVOCA) Survivor Survey results whereby 10,627 questionnaires had been completed at time of retrieval (02/05/21), answers indicated that only 59% had accessed therapy, with 2206 participants having had 5 or more therapists and 2189 having been in therapy for 6 or more years, a majority of which first told someone about abuse aged 19-25. Consistent with literature review findings, self-esteem, anxiety, depression, suicidal ideation and interpersonal issues were key symptoms.

1.9.1 Studies Investigating the Effectiveness of EMDR

The development of EMDR efficacy can be viewed in three phases; the earliest of which (1989–1998) demonstrated its equivalence to waitlist and delayed treatment controls, large effect sizes pre- to post-treatment were evident, amid six RCTs (conducted, 1994-2007). The subsequent phase (1999) included four RCT's exploring the efficacy of EMDR in comparison to nonspecific treatments for PTSD, again concluding significant effectiveness in treating adult PTSD (Schubert and Lee, 2009). During this phase, nine RCT's also compared the efficacy of EMDR in comparison to alternative trauma-focused therapies i.e. CBT (Devilley and Spence, 1999), exposure (Ironson et al, 2002; Rogers et al, 1999; Rothbaum, Astin, and Marsteller, 2005; Taylor et al, 2003), and exposure with cognitive restructuring (Power et al, 2002) or stress inoculation (Lee et al, 2002). Overall effect sizes were comparable for EMDR and alternative treatments. Though, there is debate

surrounding EMDR in comparison to exposure therapy as effect sizes of both Devilly and Spence (1999) and Taylor et al. (2003) studies were on par with EMDR, whereas other research (Ironson et al, 2002; Lee et al, 2002; Power et al, 2002) suggests greater efficacy of EMDR in the swift reduction of PTSD symptoms and overall need for lesser therapy sessions (van Etten and Taylor, 1998) in comparison to exposure-based treatments. The final phase of EMDR development examines the underlying mechanisms of therapy; three systematic/literature reviews and one meta-analysis were identified during the review for the present study. Chen et al. (2018) systematic review of RCTs and Paylor and Royal. (2016) literature review suggest EMDR's overall effectiveness in comparison to other 'best practice' modalities such as CBT and psychotropic medications. Further, although many studies (Khan et al, 2018; Bisson et al, 2007; Greyber, Dulmus, and Cristalli, 2012) focus on meta-analysis in signifying efficacy when working with adults through use of EMDR and alternative trauma-focused treatments such as CBT; this is equally the case when working with children (Barron et al, 2019; WHO, 2017; Rodenburg et al, 2009).

Further, various crucial components in the difference between EMDR and alternative therapies are presented (Cusak, 2016; Rothbaum, Astin, and Marsteller, 2005), for instance, the length of exposure, EMDR utilises short intermittent bursts of exposures as opposed to blocks of exposure as seen in other exposure therapies, namely as EMDR is not based on habituation. Also, the client's journey in recalling vivid and unsystematic/time-varied memories, and in experiencing these in a third-person tense in comparison to '*reliving*' in first person (as is the protocol for many exposure treatments), is not viewed to be '*avoidance*' as in other therapies however is promoted as productive memory processing within this flexible treatment approach (De Jongh et al, 2019; Lee and Drummond, 2008). For instance, though both PE and EMDR therapy exhibit similarities e.g. direct targeting of trauma memories (Schnyder et al, 2015), there appear to be differences in underlying working mechanisms, from continuous exposure in PE to distraction from traumatic memories in EMDR (De Jongh et al, 2013; 2019).

1.9.2 Advantages of EMDR in Comparison to Alternative Modalities

One major advantage of EMDR in relation to alternative treatments remains to be the discretion in disclosing traumatic events which can be daunting, for example, while clients who receive EMDR are asked only to disclose their traumatic images (if desired) with the therapist – the emphasis is placed on their beliefs about the event/themselves in relation to the events, therefore it is essentially a non-verbal technique, whereas those who receive TF-CBT are often asked to disclose such details (Cohen, 2005; Shapiro and Forrest, 1997) in various formats including written, verbal and pictorial communication. Likewise, EMDR has been branded most cost-effective (Mavranouzouli et al, 2020). The WHO (2017) have also highly recommended EMDR for efficacy when working trauma populations, which builds on their earlier (2013) research exploring four significant differences between the therapies ‘Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework.’ Indicative of better response rates in EMDR due to a lesser degree of exposure and homework’ (Haour, Dobbelaere, and Beaurepaire, 2019). Namely the non-directive approach (Lee, Taylor, and Drummond, 2006) and lack of homework whereby exposure treatments generally issue up to 60 hours of home-based learning (Rothbaum, Astin, and Marsteller, 2005) make EMDR somewhat more appealing (Lee et al, 2002; Marcus et al, 1997; Rothbaum et al, 1997). Though recent studies have combined treatment (Minnen et al, 2020), to date, one significant RCT (Ironson et al, 2002) has explored the variance in treatment time and homework between EMDR and exposure therapies. EMDR participants were issued in vivo homework leading to a significant 70% reduction in PTSD symptoms over a period of three sessions in comparison to the prolonged exposure group, although similar research exists (Stanbury, Drummond, and Lee, 2020; Lee et al, 2002), further studies are required to consolidate such findings. Such unawareness creates a crucial pitfall in studies mindful of the positive association between treatment effect and methodological ‘exactitude’ (Maxfield and Hyer, 2002; Sack, Lempa, and Lamprecht, 2001).

1.9.3 Addressing Gaps in Research

As outlined in the literature review, the lack of newer EMDR research with a 18-25 aged CSA survivor population was astonishing, especially when exploring efficacy in realistic clinical settings (e.g. IAPT). Therefore, the current study helped bridge the gap in young adult survivors accessing public services for EMDR. Also, the geographical area and clinical setting in which the research was held allowed for inclusion of a varied demographic i.e. greater ethnic diversity (Census, 2011) and housed two significant Universities, permitting a mixture of home and international students to participate. Triangulation was not generally seen in papers selected for literature review and hence exploration of both descriptive statistics via outcome measures (to identify changes in individual clinical presentations) and qualitative interviewing (to generate rich descriptive data in understanding client perspectives of their therapy experiences) facilitated this case series analysis. Equally, the use of adherence measures, the fidelity scale and a naturalistic sample of clients and therapist styles added transferability to results.

Furthermore, factors identified in other research (Maxfield and Hyer, 2002) discuss the connection between methodology and effect size amid studies; it was concluded that treatment fidelity and a thorough methodology played a key role in achieving a greater effect size for EMDR. The present study aimed to attain such balance through descriptive statistics via outcome measures, as seen in a vast majority of evidence-based research, in supporting qualitative interviews, to identify practice-based learning. This was teamed with utilisation of an EMDR Fidelity Rating Scale 'EFRS' (van der Kolk, 2007) to ensure consistency in therapist technique. To the authors' knowledge, such research with an 18-25 year old sample, within routine clinical/IAPT settings, although greatly needed due to the sheer amount of CSA survivors treated within such services, was severely under-represented. Hence, the current study provides a knowledge base for clinicians in recognising particularly unhelpful factors of therapy and neuropsychological exploration of this sample age range.

1.10 CLIENT PERSPECTIVES

Gaining client perspectives suited the movement toward attaining service user views (Whitehouse, 2019) and involvement in service planning (Allen, 2000); subsequent to the Griffiths Report (DHSS, 1983), suggesting service provider significance in health policy. Such changes in existing affairs have been projected in Health Policy (Department of Health, 2007) although it has been debated that habitually credibility of the somewhat lay population remains contested by positivist notions of knowledge and hierarchies of evidence (Thompson et al, 2012). Kerr, Cunningham-Burley, and Tutton (2007) believed that the public can offer a 'normative' perspective in collaboration with expert knowledge in their own subject area creating a rather amalgam stance that might otherwise be disregarded through a particular specialist lens, hence providing expansive discourse to research and consequently adding value to practice. This is thought to apply to establishing a knowledge base when working with the clients lived experience of therapy (McAndrew et al, 2014; Warne and McAndrew, 2010).

1.11 RESEARCH AIMS

The aim of this study was to investigate CSA survivor (aged between 18 and 25) perspectives of their EMDR experiences via investigation of the changes in the individual trauma stress response. This case series analysis study explored (a) neuropsychological, emotional (namely low self-esteem, anxiety and depression), behavioural functioning and quality of life issues via descriptive statistics conducted before, during and after treatment and (b) client perspectives through qualitative interviewing at one-month follow-up to ensure adequate time was allowed to monitor changes using Thematic Analysis [TA]. The research also briefly explored adaptations in the delivery of sessions incumbent of the COVID-19 pandemic (e.g. how BLS and mediums of delivery were adapted to successfully undertake EMDR reprocessing via remote means).

1.11.1 Research Questions and Hypotheses

Within a case series analysis, the following key areas were considered in relation to treatment change, measured through descriptive statistics via outcome measures

and the perceived overall experiences of participants undertaking EMDR via the qualitative data:

Qualitative interviewing with use of descriptive statistics were utilised to answer the overarching question:

What are the experiences of adult survivors of CSA who undertake EMDR treatment – do their symptoms improve and what are their perceived experiences?

The following points of interest were addressed through mainly descriptive statistics, attained from outcome measures:

- Exploring whether engagement in EMDR results in any changes in emotional and behavioural functioning (in relation to trauma, anxiety and depressive symptoms)
- Exploring whether engagement in EMDR results in any changes in neuropsychological functioning (memory, attention, executive functioning)
- Exploring whether engagement in EMDR results in any changes in quality of life issues
- Exploring whether engagement in EMDR results in any changes in self-worth

Descriptive Statistics: Hypotheses

Hypotheses 1:

Treatment will lead to a reduction of trauma symptomology

Hypotheses 2:

In terms of emotional and behavioural processing, there will be a reduction in low self-esteem, anxiety and depressive symptoms, over the course of treatment

Hypotheses 3:

In terms of neuropsychological processing, there will be an increase in executive functioning, attention and memory, over the course of treatment

The above data were triangulated with qualitative data (one-month follow-up interviews in understanding participant perspectives of their therapy experience) in answering the below questions:

- In what ways was EMDR helpful to adult survivors of childhood sexual abuse?
- In what ways was EMDR perceived as being unhelpful to adult survivors of childhood sexual abuse?

1.12 SUMMARY

Upon completion of this study, it was hoped that a contribution to the field of EMDR therapy would be made in assessing the effectiveness of the model, importantly raising awareness of client views (Lambert, 2007) and informing the therapy profession of factors which are beneficial and unbeneficial in relation to treatment, in order to deliver a platform of guidance to apprise everyday clinical practice. The current study focused upon client choice (through use of idiosyncratic way of working, taking consideration of individual symptomology as opposed to solely diagnosis), questioning whether EMDR treatment had been effective for the client and if so, why, and if not, what were the drawbacks; as opposed to presumption, that proficiency rests with the researcher. The principal researcher utilised a balanced approach between evidence-based practice (as emphasised in IAPT and NICE) and that of practice-based evidence (equally, descriptive statistics and qualitative data to reflect and inform routine clinical practice) to address the research questions more comprehensively in investigating the efficacy of EMDR. Such triangulation of qualitative and descriptive statistics has allowed EMDR therapists to perceive treatment from the significantly alternate dyad to make informed decisions about their client's care.

This research comes at an appropriate time considering the increase in individuals seeking trauma-focused therapeutic help due to the ongoing COVID-19 pandemic (Lenferink, Meyerbröcker and Boelen, 2020) and consequently, the changing face of therapy delivery, especially as NHS England and the NICE have been working closely together “to support a new digitally enabled therapy assessment programme, where up to 14 digital therapy products will be assessed for use” (NHS England and

NHS Improvement website, 2021) in IAPT services by March 2020. The current research is equally important in timing due to the increasing themes in sexual abuse cases (National Crime Agency, 2020), counterbalanced with the restricted modalities of treatment promoted within IAPT, namely CBT and EMDR. As no prior study had considered specifically disadvantageous factors of EMDR, this alone provided an innovative aspect of this research in contributing to the professional practice of EMDR. Mutually descriptive statistics via outcome measures and qualitative methods of enquiry have informed future development of services to cater to individual client needs.

Chapter 2: Systematic Review

The current systematic review investigated the perceived effectiveness of EMDR treatment in adult survivors of CSA.

The aim of this systematic review was to summarise the most important findings when exploring the effectiveness of EMDR via investigation of the changes in the individual trauma stress response on survivors of CSA, aged between 18 and 25, exhibiting symptoms of trauma.

Study methodological quality was assessed with use of the CASP tool (2018) and quality of the evidence was assessed with the Platinum Standard Scale (PSS) (Hertlein and Ricci, 2004). A systematic PRISMA review (Moher et al, 2009) search was carried out on twenty-seven databases in October 2018, identifying nine relevant papers and a further updated PRISMA review (Page et al, 2020, 2021; Rethlefsen et al, 2021) on twenty-four databases (same as previously, except three had been discontinued from the educational institutes library; COPAC, DawsonEra, TRIP) conducted in March 2021, identifying two relevant papers. Therefore, a total of eleven papers were included in this review, all titles and abstracts of which were reviewed and screened by the principal researcher and peer reviewed by two academic supervisors, with any discrepancies being resolved through discussion for accuracy; the automation tool, Mendeley, was also used in the process to manage citations. Additionally, a conscious effort was made to ensure minimal bias in selected literature via the inclusion criteria to cover fundamental ideas hence, an objective view was taken.

Interpretation of results suggested that EMDR therapy treats survivors of CSA effectively when delivered by appropriately trained professionals. Eligible outcomes were broadly categorised as namely neuropsychological, emotional, such as low self-esteem, anxiety and depression, behavioural functioning and quality of life issues. Meta-analyses could not be undertaken due to the heterogeneity of interventions, settings, study designs and outcome measures. The systematic review provides comprehensive knowledge of the subject field and recognition of any gaps

in research to further explore these areas (Brettell and Grant, 2003). Overall, future research should explore how adaptations can be applied to treatment protocols and delivery to enhance acceptability, feasibility, and effectiveness in treating CSA.

This study is registered on ClinicalTrials.gov, number NCT03966963. No funding was sought for this study. There are no declarations of interest.

The search strategy will be explained (full details of databases searched, and inclusion and exclusion criteria will be outlined in this chapter). This will be followed by a critique of the reviewed literature, current guidance and clinical implications (including the British Psychological Society; 'Power, Threat, Meaning' – BPS, PTM Framework, Johnstone et al, 2018) and National Institute for Health and Care Excellence (NICE, 2018) PTSD guidance, discussion surrounding findings in relation to the current study and future recommendations.

2.1 SEARCH STRATEGY

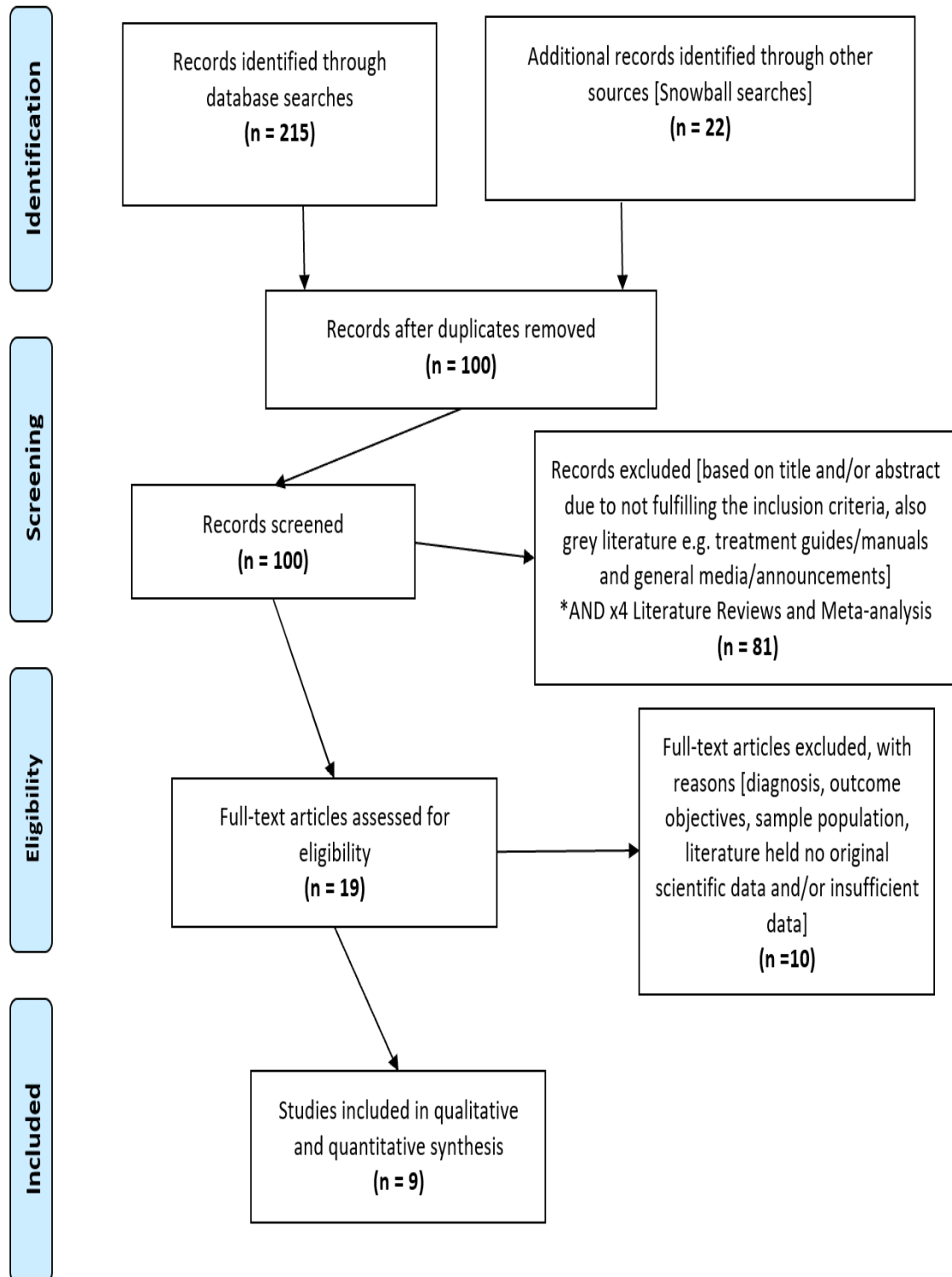
The main literature review was completed between 04/10/18-14/10/18 (please see Figure 1 below); however six-monthly search alerts within selected databases were also created (namely CINAHL, MEDLINE Ovid, SCOPUS and Web of Science) from then until the length of the project to capture any outstanding or newly published literature. Additional ongoing literature included that from EMDR UK and Ireland and EMDR-Centered library, EMDRIA, Research Gate, Mendeley software updates, University of Salford Institutional Repository (USIR) searches and local GMMH NHS Trust research projects. Moreover, obscure literature was checked via attended Continued Professional Development (CPD) events e.g. conferences/meetings and government guidance (namely NICE) via the ETHOS database. Emailed literature/research projects from the following organisations continued to be reviewed and included if relevant; the Global Initiative for Stress, Trauma Treatment (GIST-T), EMDR North East and York's Regional Groups. Although EMDR research is not readily available via the British Association for Behavioural and Cognitive Psychotherapies (BABCP), few articles had included RCTs comparing the two therapies hence communication was regularly checked for relevance. Importantly,

although this study contemplated a timeframe of ten years in order to gather the most recent studies, due to the vast body of literature before this period, since the Evidence-Based Practice (EBP) movement in the 1980's (Hall, 2008), earlier literature (namely, Llewelyn, 1988; Elliott and James, 1989) has also been added to cover client perspectives of therapy.

FIGURE 1: PRISMA 2009 FLOW DIAGRAM (2008-2018)



PRISMA 2009 Flow Diagram



Twenty seven databases were included; Box of Broadcasts, CINAHL (nursing and allied health, with corresponding search headings), Communication and Mass Media Complete, COPAC, DawsonEra, EMBASE, EBSCO Central, EBSCO eBook Collection, Hathi Trust Digital Library, Health and Wellness Centre (Gale), Highwire Press, JSTOR, MEDLINE (Ovid, biomedical information, with use of MeSH terms), Ovid Online, Oxford Reference Online, PILOTS Published International Literature On Traumatic Stress, ProQuest Central, PsycARTICLES, PsycINFO (psychological literature), SCOPUS, SciELO Citation Index, ScienceDirect, TRIP Database, UK National Statistics, USIR, Web of Science: Core Collection and Wiley Online Library, were searched following PRISMA guidelines (Liberati et al, 2009; Moher et al, 2009).

The researcher utilised free text and controlled vocabulary searching, the Boolean operator “AND” and “OR” as well as use of truncation and the search terms were selected from the thesaurus of the National Library of Medicine (Medical Subject Heading Terms, MeSH) with both UK English and American spellings to amalgamate the varying concepts (EMDR, Trauma, Childhood Sexual Abuse) in order to refine results, highlight relevant literature and reduce reviewer critique.

The search terms were searched according to title, as follows: EMDR or “Eye Movement Desensitization and Reprocessing” or “Eye Movement Desensitisation and Reprocessing” AND “posttraumatic stress disorder*” or “post-traumatic stress disorder*” or PTSD or “post-traumatic stress” or “posttraumatic stress” or “posttraumatic distress” or “post-traumatic distress” or “complex PTSD” or cPTSD or “complex posttraumatic*” or psychotrauma or trauma AND “sexual assault” or “sexual trauma” or “sexual violence” or “sexual attack” or “sexual molestation” or “sexual violation” or “sex abuse*” or “sexual abuse” or “child abuse” or “childhood abuse” or “childhood sexual abuse” or “sexual harassment” or rape or “sexual traumatic*”.

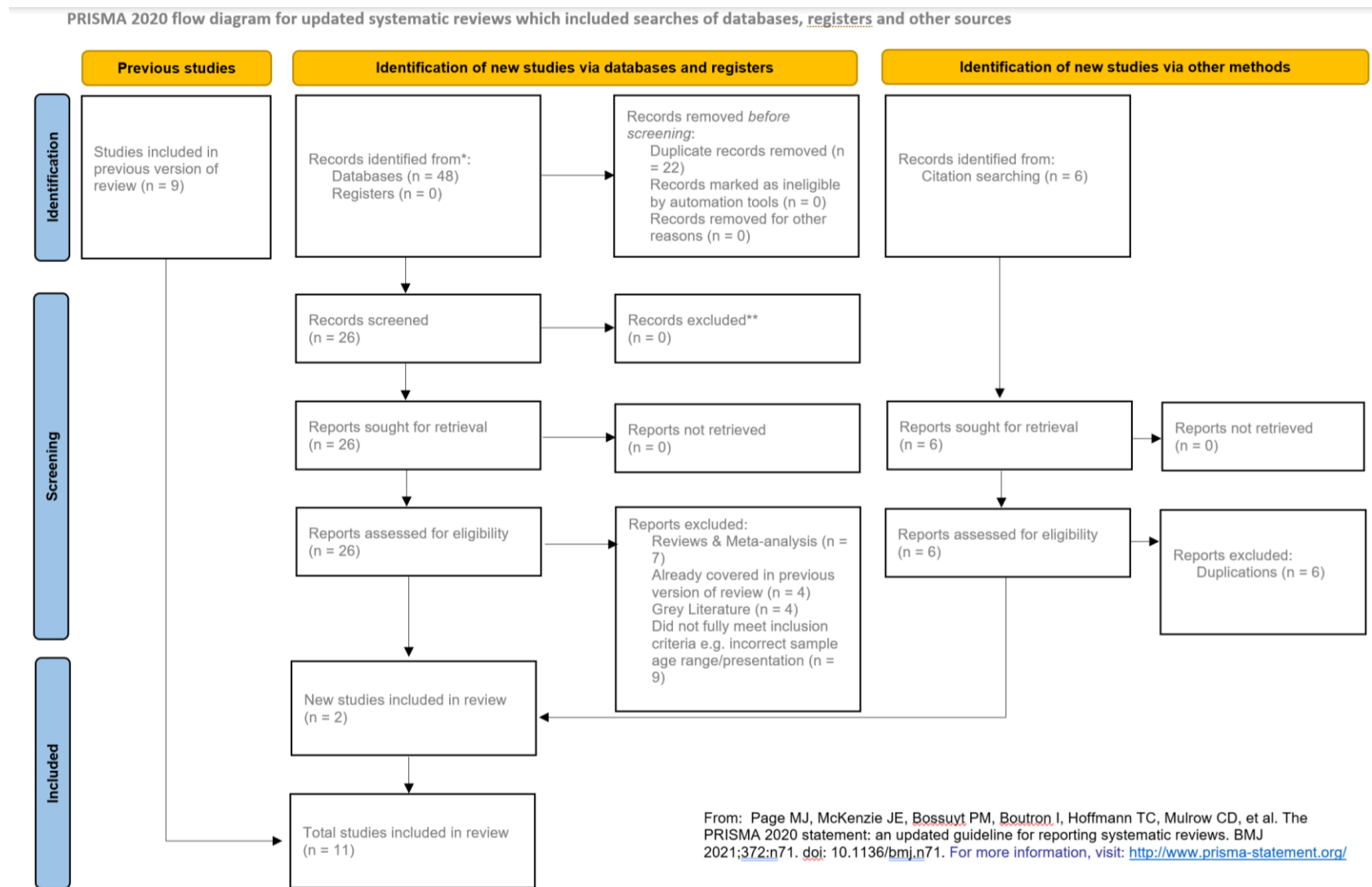
Furthermore, reference lists from included or selected literature were checked for relevance, 22 papers in total were identified via the snowball search (through extraction of papers from places such as SCOPUS, Web of Science and Google Scholar), as outlined in the PRISMA flow diagram (Moher et al, 2009; Figure 1).

The inclusion criteria included the following: sample which comprised of adult survivors of childhood sexual abuse; studies which empirically investigated the efficacy of EMDR when treating PTSD symptomology apparent in survivors of CSA; studies published since 2008. The exclusion criteria included the following: samples who had psychiatric comorbidities (e.g. personality disorders, schizophrenia; psychosis; eating disorders; drug and/or alcohol addiction); samples consisting of individuals under the age of 18 years; studies published before 2008; studies not in the English language. Moreover, chapters, posters; conferences abstract; dissertations, commentaries, unpublished work and books were excluded.

As seen in Figure 1 (the process of identifying the nine articles included in this review, search as conducted on 14/10/18), in total, 237 studies (over a period of ten years, 2008-2018) were identified within these database and snowball searches (Appendix 1, Database and Snowball Literature Search Results), of which 137 duplicates were identified. Following screening, nine papers met the present reviews inclusion criteria (Appendix 2). Details of the eighty-seven fully excluded papers are outlined in 'Appendix 3' alongside four papers which were identified as relevant though did not meet the inclusion criteria as they were reviews/meta-analysis. They were not included in the results section of this review though included in the introduction. The reference section of each review was screened for potentially relevant articles not identified in the database searches.

A further updated PRISMA (Page et al, 2020, 2021; Rethlefsen et al, 2021) database search was conducted on 18/03/21 (with use of the same search terms, criteria, restrictions and accessible databases as previously carried out) between 14/10/18-16/03/21 to highlight any differences in research since the last executed search, as seen in Figure 2.

FIGURE 2: PRISMA 2020 FLOW DIAGRAM (2018-2021)



As seen in Figure 2, above, 48 records in databases searching were identified. After duplicates removal, 26 records were screened, from which, two papers (Jamshidi, Rajabi and Dehghani, 2020; Wright and Warner, 2020) were included. Later, documents that cited any of the initially included studies were searched alongside the references of the previously included papers. However, all six additional papers were deemed duplicates, therefore, no extra articles that fulfilled inclusion criteria were found in these searches. All related PRISMA (2020) tables and figures can be found in Appendix 8.

2.2 RESULTS

A total of eleven studies were identified in the present review (details as seen in Appendix 4, 5 and 6) of which specifically, three were single case studies (Aranda, Ronquillo, and Calvillo, 2015; Ringel, 2014; Wright and Warner, 2020); two case series (Hutchins and Mason 2017; Shields, 2015), four RCT's (Edmond et al, 2004; Gerardi et al, 2010; Rothbaum, Astin, and Marsteller, 2005; Jamshidi, Rajabi and Dehghani, 2020), two quantitative comparative studies (Wagenmans et al, 2018; Woudenberg et al, 2017) and were reviewed with respect to quality assessment using the Critical Appraisal Skills Programme (CASP, 2018) in order to manage and synthesis key areas of research in accordance with the research aims and objectives.

2.2.1 Single Case Studies and Case Series Studies

The focus of the following three single case studies (Aranda, Ronquillo and Calvillo, 2015; Ringel, 2014; Wright and Warner, 2020); and two case series (Hutchins and Mason 2017; Shields, 2015) was dissimilar (e.g. from diminishing PTSD symptomology in most studies (i.e. Hutchins and Mason, 2017; Wright and Warner, 2020) to change in neuropsychological and physiological responses (Aranda, Ronquillo, and Calvillo, 2015). Generalisability of results was further limited due to mainly the length of treatment ranging from several sessions to anything over two (Ringel, 2014) or three (Wright and Warner, 2020) years, follow-up was also varied in timeframe as is sample, from case studies working with an adolescent (Aranda, Ronquillo, and Calvillo, 2015) to case series working with both a female and male sample, up to age 60 (Hutchins and Mason, 2017).

Positively though, a key theme in all studies appeared to be efficacy in results in every domain, from neuropsychological evaluations of attention, memory, and brain executive functions (Aranda, Ronquillo, and Calvillo, 2015) to reduction in clinical PTSD symptomology with use of EMDR in relation to Imagery Rescripting (ImRs) (e.g. Shields, 2015). However interestingly as case studies generally utilise an idiographic approach in that they are confined to the evaluation of an individual's presentation it must be mentioned that the depth of detail into mediating and moderating factors provided understanding of how not only the therapy process however also additional, partially external values can cause variance in outcomes as not all cases yielded conclusively positive effects due to complexity in client-therapist relationship, dimensions of finance, and reliance resultant in rupture (e.g. Ringel, 2014) all factors of which can be related to larger scale routine settings (e.g. lack of funding for Mental Health services causing restrictions in time and unnecessary pressures on both client and clinician).

As only a limited number of case studies and series were selected, only descriptive analysis could be performed hence clear estimates of the effect size of EMDR treatment could not be determined. Limitation is found in the impossibility to control other variables for the samples included in the case reports in terms of age, prescribed medication, and comorbid difficulties, while blinding was also variable; in Shields (2015) study the assessor was separate from the therapist creating some level of blinding whereas in Ringel (2014) and Wright and Warner (2020) the therapist was also the assessor, which could have created bias in the outcome analysis (CASP, 2018).

Unfortunately, the case study design indicated that findings may be due to placebo or alternative factors, often subject to reporting and publication bias (as with the meta-analysis, Ehring et al, 2014, indicating misjudged effect sizes, outlining the need for more systematic and methodologically rigorous research in this area). Moreover identified weaknesses in the current review were the lack of information sought from third parties (i.e. families, support workers) in establishing individual change (Aranda, Ronquillo, and Calvillo, 2015) and measures in identifying daily

function, mood and comorbid mental health difficulties in some case-studies (Hutchins and Mason, 2017) hence limiting findings.

2.2.2 Quantitative Comparison Studies

Two quantitative comparison studies were identified in the review (Wagenmans et al, 2018 and Woudenberg et al., 2017), the focus for both was on intensive trauma-focused therapy; overall, results suggested a decline in PTSD symptomology and as outlined the authors (Wagenmans et al, 2018; Woudenberg et al, 2017) claimed that CSA did not have a negative impact upon treatment outcomes. Intriguingly, in comparison to other papers (i.e. Gerardi et al, 2010; Rothbaum, Astin, and Marsteller, 2005) whereby the inclusion criteria allowed the index event to befall from the age of 12+ perhaps skewing findings in terms of length of time participants had to naturally process events prior to treatment and also in relation to stages in brain development at various ages, in these studies participants were divided into child, adolescent and adult groups for analysis to verify distinct differences in outcome.

According to the Hertlein and Ricci (2004) PS criteria, lack of controlled design (making it difficult to rule out the possibility that the observed improvements during treatment were a product of time) and inadequacy in information was apparent in both Wagenmans et al. (2018) study since insufficient follow-up data were available for analysis at that time due to the moderately short existence of the treatment centre and also in the Woudenberg et al. (2017) study due to adapting the process of data gathering during the course of the study i.e. staged introduction of measures (e.g. CAPS and IES) “resulting in differences in the number of patients per specific measure” (Woudenberg et al, 2017, p.8) and no measures introduced to address the high level of comorbidity. This indicated that consideration of possible mediators and moderators of the treatment effects are essential in future longer-term research in this area.

2.2.3 RCT Studies

Four RCT studies were identified in the present review (Edmond et al, 2004; Gerardi et al, 2010; Rothbaum, Astin, and Marsteller, 2005; Jamshidi, Rajabi and Dehghani, 2020). Exact comparison between studies was challenging as control-groups and measured outcomes fluctuated significantly however overall, findings investigated the effectiveness of EMDR in comparison to alternative trauma-focused therapies. For instance, Gerardi et al. (2010) and Rothbaum, Astin, and Marsteller, (2005) compared Prolonged exposure (PE) to EMDR; similar to the two comparative studies mentioned above (although these focused more so on intensity of treatment), as per CASP (RCT Checklist, 2018) guidance numerous relevant outcomes were measured (i.e. anxiety, depression) with the primary outcomes clearly defined (namely reduction in PTSD symptomology), effects for both were comparable from baseline to post-treatment. As with prior research (e.g. Rothbaum, 1997), key themes in all (Edmond et al, 2004; Gerardi et al, 2010; Rothbaum, Astin, and Marsteller, 2005; Jamshidi, Rajabi and Dehghani, 2020) currently reviewed papers appeared to be that EMDR and PE outcomes were significant to wait group / routine individual therapy. Possible difference in treatment protocols have been highlighted in answer to these results e.g. Rothbaum, Astin, and Marsteller (2005) suggests the 'blank it out' aspect is key as in EMDR the individual has time to pause between sets however "PE allows the dose of exposure to be titrated up by allowing the patient to gloss over more traumatic details in the first few sessions, gradually requesting more and more until focusing just on the hot spots repeatedly... In PE, the patient usually engages in more repetitions of the same traumatic scene than in EMDR" (p.614). Furthermore, interestingly regardless of being assigned homework as in PE, outcomes in EMDR patients were on a par with PE. On the contrary, Jamshidi, Rajabi and Dehghani (2020) focused on specifically EMDR with no comparison to alternative therapy, nonetheless results indicated a reduction in PTSD symptomology. However due to the unclear mechanism of EMDR it is yet unknown why EMDR works so well hence further research is required to investigate this notion.

Through use of the Hertlein and Ricci (2004) PS criteria, a good level of treatment integrity was indicated (appendix 7) in RCT's (Gerardi et al, 2010) due to double-blinding (Jamshidi, Rajabi and Dehghani, 2020), the use of an independent rating system especially as seen in Rothbaum, Astin, and Marsteller (2005) research when

evaluating adherence and competence of session tapes, in accordance with Dr. Francine Shapiro for EMDR and Dr. Edna Foa for (Prolonged Exposure) PE (Nishith and Resick, 1994, with recommendations made by Waltz, Addis, Koerner, and Jacobson, 1993). Also, it appeared that adequate assessments of each outcome and adequate selective outcome reporting were performed in RCTs and that data completeness was addressed in most of the studies. However important details regarding treatment given were missing, including therapist qualifications, EMDR targets, with some patients receiving alternative therapy prior to EMDR (this consisted of individual, couples, and group therapy, Edmond and Rubin, 2004) and that the EMDR method varied across the studies.

Limitations in this review included generalisability of results as the samples were predominantly female. A key difference in studies was the follow-up time, from no follow-up (Jamshidi, Rajabi and Dehghani, 2020), to six months (Gerardi et al, 2010; Rothbaum, Astin, and Marsteller, 2005) and eighteen months (Edmond and Rubin, 2004). Regardless of differences in follow-up time, EMDR yielded positive outcomes, namely a reduction in trauma symptomology.

2.2.4 Risk of Bias

Table 1 (as below) indicates bias in general terms considering the CASP tool though focused guidance from the 'Cochrane; Assessing risk of bias in included studies' (Higgins and Green, 2011) was utilised as consolidation of conclusions and as means of 'domain-based evaluation' whereby critical assessments are formed on an individual study basis for dissimilar domains to highlight level of bias.

TABLE 1: RISK OF BIAS TABLE

References	Blinding	Incomplete Participant Data	Alternative Therapy reported prior to EMDR	Treatment Length	Variance in therapist experience	Female only Samples	Index event during child or adulthood	Follow-up details provided
Aranda et al, 2015 (Case Study)	No	No	No	Eleven 90-minute weekly sessions	Thirteen-years post research experience	Yes	No	Yes (one year)
Edmond and Rubin, 2004 (RCT)	No	No	Yes	The EMDR group had a mean of six sessions of therapy between post-testing and the 18-month follow-up, with a range of 0 to 24 sessions. The routine treatment group had a mean of 20, with a range of 0 to 64 sessions between post-testing and the eighteen-month	Unreported	Yes	No	Yes (eighteen months follow-up study)

				follow-up. Those in the control group attended an average of 13 sessions between post-testing and the 18-month follow-up, with a range of 0 to 72.				
Gerardi et al, 2010 (RCT)	Yes (single)	Yes	Unreported	90-minute, twice-weekly EMDR and PE sessions	Highly qualified	Yes	Yes	Yes (follow-up of six and twelve months posttreatment)
Hutchins and Mason, 2017 (Case Series)	No	No	Yes	Three-eight sessions	Three-years post research experience	No	Yes	Yes (three months)
Jamshidi, Rajabi and Dehghani, 2020 (RCT)	Yes (double)	No	Unreported	The experimental group received EMDR at a Welfare Organization Centre of Shiraz, Iran, for three months, twice a week,	Psychologists	Yes	No	No

Ringel, 2014 (Case Study)	N/A	No	Unreported	during eight 90-min sessions 2+ years, at one stage it is recorded that “The EMDR process occurred twice weekly for approximately 2 months, when we resumed our unstructured, dynamic format”	Unreported	Yes	No	No
Rothbaum, Astin, and Marsteller, 2005 (RCT)	Yes (single)	No	Unreported	90-minute, twice-weekly EMDR and PE sessions	Integrity measures indicate “Using a scale from 1 to 7, mean EMDR therapist skill was rated 6.04 (<i>SD</i> = 0.58) or very good for essential and unique items”	Yes	Yes	Yes (six months)
Shields, 2015 (Case Series)	Yes (single)	Yes – incomplete sessional measures	Unreported	Maximum of 12 90-minutes	Unreported	Yes	Yes	Yes (eight week follow-up)

				sessions twice a week				
Wagenmans, Van Minnen, Sleijpen, and De Jongh, 2018 (Quantitative Comparative Study)	No	Insufficient follow-up data	Unreported	PE session of 90 minutes in the morning and an EMDR therapy session of 90 minutes in the afternoon; in total, the programme consisted of 16 sessions (24 hours) of trauma-focused therapy	Highly qualified	No	No	No
Woudenberg et al, 2017 (Quantitative Comparative Study)	No	Differences in quantitative data due to staged introduction of measures	Unreported	PE in the morning and EMDR therapy (both 90 minute individual sessions) in the afternoon	All therapists had a master's degree in clinical psychology and were trained in PE therapy and EMDR therapy	No	No	Yes (six months)

Wright and Warner, 2020 (Case Study)	No	No	Yes	32 sessions over 11 months	The therapist was the first author, a doctoral level clinical psychologist who had completed EMDR training and had 6 years experience in providing EMDR therapy in forensic services. She was also trained and experienced in the psychological treatment of adults who have sexually offended.	No	No	Yes (three year follow-up)
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There has been debate surrounding risk of bias scales whereby certain variables may be miscalculated in terms of their weight and may not entirely be supported by empirical evidence (Emerson et al, 1990, Schulz et al, 1995) deeming them somewhat unreliable assessments of validity (Jüni et al, 1999). Therefore, to further consolidate results, the Platinum Standard Scale (Hertlein and Ricci, 2004) was also used (Appendix 7) as this is specifically tailored to meet the needs of EMDR studies, built upon the work of Foa and Meadows (1997), Lohr, Tolin, and Lilienfeld (1998), and Maxfield and Hyer (2002). However, it must be mentioned that though every effort was made to assess bias, the true depth of such a matter is impossible to predict hence evaluations are somewhat limited.

Although high standards were achieved by some (Rothbaum, Astin, and Marsteller, 2005) via limited exclusion criteria to replicate a real-life sample, reliable and valid measures, independent raters, specified symptoms, trained assessors, unbiased assignment to treatment and a manualised treatment format (Foa and Meadows, 1997); various factors pertain to the limited reliability of some studies ranging from (i) small sample size, to (ii) the use of research methods without controls, or (iii) the use of methodologically deficient case studies as a means of assessing the effectiveness of EMDR. Although individual papers outlined their limitations, a majority indicated the efficacy of EMDR as a successful treatment modality for symptoms resultant from CSA.

Though the quality of studies according to the Hertlein and Ricci (2004) PS criteria for EMDR studies varies (the overall mean score was 8, from which six studies scored greater than the mean), as seen in Appendix 7; therapist training varied across studies, with some describing highly-qualified clinicians (Gerardi et al, 2010 and Wagenmans et al, 2018; Wright and Warner, 2020) ranging from three (Hutchins and Mason, 2017) to 13 years of clinical practice, following the standardised protocol of EMDR and complying with the EMDR research fidelity protocol as provided by EMDR International Association (EMDRIA) to assure treatment integrity (Aranda, Ronquillo, and Calvillo, 2015; Jamshidi, Rajabi and Dehghani, 2020) and with utilisation of approved supervision. However consistency was somewhat skewed in some cases, ranging from one case study reporting rupture in the client-therapist

relationship due to financial constraints since the author was also the principal researcher and private therapist of the participant, causing bias and restriction in outcomes (Ringel, 2014) as well as doubt in the study methodology and consistency in addressing the research aim (CASP, 2018); to the application of ‘therapist rotation’ whereby participants were treated by multiple psychologists with inclusion of four exercise activities daily, and psycho-education sessions each evening alongside EMDR in another (Wagenmans et al, 2018).

Further, inconsistency in methodology was highlighted in that literature reviews discussed articles in favour of their agenda such as formation of a phase-orientated EMDR treatment plan for sufferers of PTSD perhaps causing bias in results (Korn, 2009) and other researchers failed to provide inclusion and exclusion criteria in terms of the selection process (Paylor and Royal, 2016). Conversely, a good level of treatment integrity was indicated in selected reviews (Chen et al, 2018) and meta-analysis (Ehring et al, 2014) as two independent raters’ extracted and coded each study however, although an inter-reliability (kappa score of 0.86) was taken for agreement between the reviewers in selection of the eligible studies within Chen et al. (2018) study, no formal evaluation of inter-rater agreement was conducted in the meta-analysis.

2.2.5 Homogeneity, Participant Demographics and Comorbidities

A total sample of 749 participants were included in this review, of which, 134 were treated with EMDR, 97 participating in the control or comparator groups, and 518 treated with both PE and EMDR (Wagenmans et al, 2018; Woudenberg et al, 2017). Treatments aimed at symptoms of PTSD in survivors of CSA were assessed. The index event participants had experienced ranged from child to adulthood (aged 12+), with several studies including a female only sample (Aranda, Ronquillo, and Calvillo, 2015; Edmond and Rubin, 2004; Gerardi et al, 2010; Jamshidi, Rajabi, and Dehghani, 2020; Paylor and Royal, 2016; Ringel, 2014; Rothbaum, Astin, and Marsteller, 2005; Shields, 2015) making it difficult to differentiate results. Although, as seen in studies with a mixed gender sample (i.e. Wagenmans et al, 2018 and Woudenberg et al, 2017), over 70% of participants entering treatment were female,

suggesting participant preference. However, equally skewing results, as gender differences have been reported in the severity of PTSD symptoms and coping strategies (Ullman et al, 2005).

Although some studies (Rothbaum, Astin, and Marsteller, 2005 and Gerardi et al, 2010) were focused, including a diverse, yet homogenous sample of clients e.g. derived from various socio-economic backgrounds and varied in age, taking account of ethnic-religious backgrounds, having experienced abuse-specific variables, such as the age of initial onset of abuse, the duration of victimisation, the frequency of sexual abuse, and the type of the abuser (e.g. interfamilial); strength of validity is weakened due to the researchers allowing participants to take part in the study whether they had experienced the index event during childhood or adulthood. This was also displayed in case studies (Hutchins and Mason, 2017) further restricting generalisability of results since children may process memories differently to adults, depending on time since and age of trauma-onset.

Interestingly, the focus of the current project was primarily CSA however a theme in the literature appeared to be that some studies did not have exclusion criteria that restricted clients with other types of trauma (e.g. physical abuse or single-incident rape) nor comorbidities (e.g. some studies including literature on suicidal ideation, substance abuse and psychiatric disorders such as borderline personality disorder as outlined in Shields, 2015 case series). However, a breadth of experiences widens the scope of the participants' trauma histories and subsequently places limitations on the generalisability of research findings causing barriers in statistical confidence to claim treatment efficacy within the CSA population and warrant further investigation of the treatments and population. Treatment recruitment was also considered in that not all participants were derived from a voluntary sample (Edmond and Rubin, 2004) whereby, again generalisability of results suffered since certain groups (those of ethnic minority) were significantly underrepresented as the sample included only those CSA survivors who volunteered to participate in the Edmond, Rubin, and Wambach (1999) original study; hence participants for this follow-up study may have been dissimilar to those who did not volunteer.

Limitations included a lack of homogeneity across study design, intervention, control, comparison groups, outcome measures, and follow-up procedures, making it difficult to synthesize findings across papers (CASP, 2018), consequently reducing the impact of conclusions derived from the evidence. Hence, interpreting the literature and drawing conclusions was a significant challenge in some studies (Chen et al, 2018).

2.2.6 Treatment Approach

The eleven included studies can be categorised into three different therapeutic frameworks or approaches, of which, four were aimed at understanding the effects of EMDR in comparison to PE (Gerardi et al, 2010; Rothbaum, Astin, and Marsteller, 2005; Wagenmans et al, 2018; Woudenberg et al, 2017); one included Imagery Rescripting and EMDR (Shields, 2015); Ringel (2014) focused on the development of an integrative model in EMDR; and the remaining five studies (Aranda, Ronquillo, and Calvillo, 2015; Edmond and Rubin, 2004; Hutchins and Mason, 2017; Jamshidi, Rajabi and Dehghani, 2020; Wright and Warner, 2020) concentrated solely on EMDR.

As discussed in section 2.2.4, critical assessments were formed on an individual study basis for dissimilar domains to highlight level of bias; some studies provided longer follow-up time e.g. twelve months (Aranda, Ronquillo, and Calvillo, 2015 and Rothbaum, Astin, and Marsteller, 2005) to eighteen months (Edmond and Rubin, 2004, whereby the principal investigator, who had conducted the pre- and post-testing in Edmond, Rubin, and Wambach (1999) original study, was the only one that conducted the testing at follow-up also). The longest of which was a three-year case-study follow-up (Wright and Warner, 2020). However other studies did not provide follow-up details (Jamshidi, Rajabi and Dehghani, 2020; Wagenmans et al, 2018) restricting the evidence of impact over time or alternatively, included much lesser time before conducting follow-up e.g. eight week (Shields, 2015), three (Hutchins and Mason, 2017) to six months (Woudenberg et al, 2017). However findings were somewhat further limited due to application of alternative trauma-treatments in the interim (Woudenberg et al, 2017) and although in such cases one study (Edmond

and Rubin, 2004) excluded these participants it causes more difficulty in distinguishing the outcome effects due to the then even smaller follow-up sample (CASP, 2018), equally it was debatable whether this was an insufficient amount of time to support the effectiveness with this population. Further, in terms of target memories, additional traumatic experiences adequately addressed in subsequent therapy may have positively or negatively (given the variety of accessed treatments that lack empirical evidence) influenced measurable effects.

Clients seeking additional treatment may perhaps have done so due to the varied treatment time (as seen in Table 1 and Appendix 7), from three-eight sessions in Hutchins and Mason (2017) case series and six sessions in Edmond and Rubin, (2004) RCT due to restricted funding; to 90-minute, twice-weekly EMDR and PE sessions delivered during both RCTs (Gerardi et al, 2010; Rothbaum, Astin, and Marsteller, 2005) and similar timeframes in Jamshidi, Rajabi and Dehghani (2020) RCT and Shields (2015) case series. Generally, drop-out varied with lower rates in case series and larger in the RCTs, possibly deriving from lack of participant commitment to intensive treatment time since many participants alternatively opted for weekly therapy sessions.

EMDR phase 2 ('preparation') was also massively varied, this may be due to the time-limited framework of research since case studies (e.g. Ringel, 2014, utilised a two-year period before introduction of EMDR therapy) as opposed to comparative quantitative studies (e.g. Wagenmans et al, 2018, offering little prior resourcing) generally allow longer timeframes, which are clearly not sustainable in most services. The short time frame may have been limiting to the therapeutic process, and for the study itself as it did not appear to be sufficient for some participants, particularly those who were survivors of childhood sexual trauma. Further, the methodology of treatment adds to the lack of generalisability to other populations and treatment programmes, including the more naturalistic clinical settings, as not all studies applied a standardised EMDR protocol (Shapiro, 2001) such as Wagenmans et al. (2018), as patients participated in sport activities and psycho-education sessions between more-intensive than usual therapy sessions.

2.3 DISCUSSION

The purpose of this review was to evaluate the evidence regarding the use of EMDR as a treatment for CSA, from the eleven included papers, most participants were successfully treated for their trauma-related symptoms, irrespective of their comorbidities. Furthermore, ten additional systematic/literature reviews and meta-analysis were identified during the present review, of which, four (Barron, 2019; Chen et al, 2018; Paylor and Royal, 2016; Rowe, 2019) indicated the efficacy of EMDR in comparison to CBT and psychotropic medications. Others (Lewis et al, 2020; Melton et al, 2020; Rothbaum, Astin, and Marsteller, 2005) indicated EMDR equal in improvements to alternative treatments such as PE and TF-CBT whereas, Lewey et al. (2018) indicated that CBT was marginally better than EMDR, and “multicomponent interventions that included cognitive restructuring and imaginal exposure were the most effective for reducing PTSD symptoms” (Coventry et al, 2020, p.2). Moreover, Tichelaar, Deković, and Endendijk, (2020) found that certain therapy approaches might be specifically effective for specific groups of clients.

Chen et al. (2018) in particular, conducted research in exploration of similar aims to those of the current literature review. Though, there are numerous differences between that and the current review including the type of studies chosen for review, namely RCT's, whereas the present review included variance in the methodology of the studies. Secondly, they reviewed studies investigating the efficacy of EMDR on PTSD symptoms in both adults and children exposed to complex trauma (CT) whereas the current review focused on an adult only population due to IAPT service inclusion criteria and importantly, changes in brain development from infancy/early childhood to adulthood (Paquola, Bennett, and Lagopoulos, 2016, Paquola et al, 2017), which would be too extensive for the scope of the current project. Further, the author of the current review refined the target presentation to solely CSA whereas 'CT' covered a multitude of areas.

Study quality evaluation indicated somewhat reliability in results as 54.5% ($n = 6$) of the included studies were controlled, however some may question whether symptom improvement in the remaining 45.4% ($n = 5$) included studies was due to the

delivered therapy or supplementary factors (e.g. natural recovery, time). Furthermore, follow-up assessments were employed in 63.6% of included studies ($n = 7$) and were administered from immediately after to three-years posttreatment, treatment benefits were reported as being maintained during these timeframes. It is recommended that future research employs the use of follow-up assessments to evaluate the continuity of symptoms change.

The current review exhibited a low pooled dropout rate across studies in comparison to the standard 20% in PTSD studies (Imel et al, 2013), with RCT's showing larger rates (e.g. 16.7% in Rothbaum et al, 2005) than alternative studies, even comparable to quantitative comparative studies (4% in Wagenmans et al, 2018 and 2.3% in Woudenberg et al, 2017) however, this may be connected with numerous factors; therapy commitment/engagement (e.g. Shields, 2015), psychological-mindedness, external stressors, break in therapeutic alliance (e.g. Ringel, 2014). Future research could explore accommodation of client preferences to address this issue although, there is no assurance that the implemented measures may improve participation rates (Tompkins, Swift and Callahan, 2013).

Assigning adaptations to the protocol could not be reported at present as uncontrolled factors may have been accountable for symptom change. Also, heterogeneity is equally imperative in understanding results amid drop-out and trauma-related symptom change. Despite limitations of the current review, the successes outweigh the failures, and therefore point to the potential promise of EMDR treatment in promoting to short- and longer-term symptom change. Especially as the lack of newer EMDR research with a 18-25 aged CSA survivor population is surprising given the advancements in the literature and research however this may have been due to the sensitive nature of this subject and participant reluctance to divulge information/partake in research.

2.3.1 Comparison and Outcome Data

This section will aim to illustrate necessary areas of interest in the present study in accordance with an amalgamation of learning from current review findings and attended CPD events, during the course of this project.

2.3.1.1 Application of Treatment

The two included quantitative comparative studies (Wagenmans et al, 2018; Woudenberg et al, 2017) indicated that the nature of intensive EMDR and PE delivery may result in rapid symptom alleviation compared to standard treatment. However, further RCTs are required to ascertain the efficacy of intensive treatments in the decrease of symptoms and increase in functioning, especially as a majority of studies included within this review utilised the standard protocol. It is equally essential that future research is also offered in a timely manner with consideration of real-world clinical settings (i.e. IAPT), ideally following a manualised protocol.

Additionally, although routine activation of the information processing system via “bilateral stimulation” was performed in various manners (e.g. light bar, arm movements) or was not recorded across all studies included in this review, recently attended EMDR CPD (Paterson, 22/09/18 and 01/12/18) collectively indicated that methods such as bodily contact (i.e. tapping), may cause discomfort in sexually abused clients due to the nature of the somatic symptoms, feelings of shame (Gilbert and Kerr Workshop 06/10/18) and sensation of touch. Hence eye movements, butterfly hugs and bilateral sounds may be most beneficial, however more research is needed in attaining a solid understanding of effects.

2.3.1.2 Neuropsychological

From the present review, it is apparent that research with traumatised child and adult populations differs (Camacho-Conde, 2020; Goodnight et al, 2019) as child studies use variable data from salivary assays of cortisol and behavioural, social, cognitive, and emotional psychological assessments to account for individual functional information and allow contained investigation of neuro-biochemical dysregulation. Generally lowered cortisol levels in adults is associated with worsened PTSD

symptoms (e.g. Altemus, Dhabhar, and Yang, 2006). Interestingly, one included study (Aranda, Ronquillo, and Calvillo, 2015) considered neuropsychological evaluations of attention, memory, and brain executive functioning in an 18-year old adolescent CSA survivor, which displayed pre-treatment impairments in attentional processes, information processing speed, and working memory and post-treatment improvement of these cognitive functions, with significant differences on the Paced Auditory Serial Addition Test (Gronwall, 1977). Substantial post-treatment decrease in mean scores on the Beck Depression Inventory-II (Beck et al, 1961; Beck, Steer, and Brown, 1996) and the Dissociative Experiences Scale (Bernstein and Putnam, 1986) were also found. Furthermore, the participant exhibited no signs of PTSD after the intervention, based on the Posttraumatic Stress Global Scale (McCarthy, 2008). Another included study (Gerardi et al, 2010) examined changes in salivary cortisol levels pre- to post- EMDR or Prolonged Exposure (PE) treatment in female rape victims; overall results of the study indicated that improvement in PTSD symptoms was significantly greater in both the PE and EMDR groups as compared with the WAIT group, and that PE and EMDR groups did not differ significantly from each other on measures of outcome at post-treatment and at six-month follow-up. Baseline resting cortisol levels measured prior to initiation of treatment indicated no group differences.

However, as above mentioned it seems much sensitivity is lost when classifying populations against the DSM PTSD criteria when accounting for developmental aspects of the traumatic stress response as while adults are vulnerable to effects of neuroendocrine dysregulation of the Limbic system, HPA-Axis, and Prefrontal Cortex, children are similarly vulnerable to effects on corpus callosum and brain volume, alongside cortisol dysregulation (Camacho-Conde, 2020; Goodnight et al, 2019; Schwartz and Perry, 1994). A review of such literature was beyond the scope of this paper however highlighted the need for future studies to monitor adaptations in participants' neuropsychological functioning (namely attention, memory and executive functioning).

2.3.1.3 Emotional and Behavioural Functioning: Quality of Life

As exhibited during this review, problems with self-perception, attachment failure, self-destructive behaviour, dissociation, interpersonal difficulties were associated with CSA (HAVOCA, 2021; Kliethermes, Schacht, and Drewry, 2014) hence, achieving a functional end-state. Improvements in attention and consciousness (Chen et al, 2018) and adaptive emotional (major comorbidities as identified in this review i.e. anxiety, depression, self-esteem) and psychosocial (quality of life) adjustment (Smith et al, 2016) is often an underlying target in treating CSA survivors (Schwarz et al, 2020; Jiménez et al, 2020; Griffioen et al, 2017).

2.3.1.4 Client Perspectives

Client choice is paramount in tailored treatment and as outlined in Lori et al. (2018) study comparing medication and mental health counselling in the treatment of PTSD, findings suggest that participants who were presented with a choice of treatment (e.g. drugs or therapy) displayed greater reduction in symptoms, were more likely to continue with their treatment schedule and further eventually lost their PTSD diagnosis more so than those without choice (Bath, 2008). Furthermore, a recent systematic review (Whitehouse, 2019) exploring client views about their EMDR experiences concluded similar results to the current study (e.g. 'EMDR changes a person, necessary conditions for EMDR to effect change, EMDR method as agent of change and EMDR therapist as agent of change'). Such research clearly displays consideration for future research in understanding the importance of service-user involvement, also reflective of this, participants were made aware of treatment choice before enrollment onto this study and results were cascaded with the service provider.

As outlined in the British Psychological Society (BPS), Power Threat Meaning (PTM) framework section, clinicians face a variety of difficulties in balancing client demand for trauma-treatments and implementation of therapies, including financial and time constraints, lack of communication and representativeness. However despite the growing NHS ideology of need for service user involvement (Telford et al, 2002) as evidence for policy and clinical development (Consumers in NHS Research, 2000; Involve, 2014), alongside ethical benefits regardless of barriers to professional territory (Davies and Maguire, 2014), there remains to be reluctance in presenting

clients as experts within research, somewhat limiting practice (Tait and Lester, 2005).

Further research is required to highlight client choice and perspectives, Hodgetts and Wright (2007, p.159) discuss both sides of this debate implying restricted client perspectives may potentially preclude from “researchers’ methodological or theoretical shortcomings” (e.g. undebated doctrines surrounding non-contamination of clinical settings and ideology around “pure” quantitative research). Conversely similar to McLeod (2001), they also indicate reduced value in client perspectives due to bias in judgements as they are only partially involved with the significance of therapeutic processes. Further, there are also evidenced differences between the client and therapist views even when considering the same session (Llewelyn, 1988; Paulson, Overall, and Stuart, 2001; Manthei, 2007; Bachelor, 2011) hence limiting the accuracy of findings as in the included Edmond and Rubin (2004) eighteen-month follow up study, which included client perspectives, whereby findings suggested therapeutic benefits of EMDR for adult female survivors of CSA can be maintained. Although since the Elliott and James (1989) meta-synthesis it has been evident that the main source of support is the clients confidence in establishing a healthy working relationship with their mental health professional (Riede, 2018; Bedi and Duff, 2014) causing variance in results due to uncertain rupture in relationships as seen in the Ringel (2014) case study.

Client characteristics also play a crucial role, in some cases, CSA may impair the outcome of the therapy due to the severity of symptoms, length of impairment and client’s reluctance to engage (Bukh et al, 2013; similar to other trauma cases, McAndrew et al. (2014) hence, the need to idiosyncratically acknowledge both helpful and unhelpful aspects of therapy, for different clients. Llewelyn (1988), in a study that explored 40 therapist-client pairs asked participants to record their views concerning the helpful or hindering elements of psychological therapy, with use of the Helpful Aspects of Therapy (HAT) form as will be utilized in the current study. Similar research (Goldman, Brettle and McAndrew, 2016) with the use of HAT form interviews has been conducted in exploring client perspectives of Counselling approaches. Four superordinate themes were presented, including it being a helpful process, the client’s view of a counsellor, gains; and negative aspects.

Overall, included studies suggested a key impact of and connection between survivors of CSA in general, amid individuals of all ages, appeared to be isolation due to fears of stigmatisation (Beer 2018; Browne and Finkelhor, 1986), leading to issues of self-worth and acceptance (Thoits, 1995). Hence, resilience in CSA survivors is their personal attributes and views in relation to the availability and quality of emotional support (Domhard et al, 2015; Collishaw et al, 2007; Valentine and Feinauer, 1993), which mainstream services such as IAPT are thought to provide.

2.4 LIMITATIONS

A limitation of the current review largely related to heterogeneous differences in sample populations. The variety in inclusion criteria (e.g. the index event occurred at various ages in studies) also proved difficult when selecting relevant research. Subsequently, causing difficulties in assessing developmental factors in the traumatic stress response. For instance, effects of stressor timing in relation to brain development were not entirely understood as in early childhood, experiences such as neglect have illustrated hypo-responsiveness, attention and behaviour difficulty effects. Whereas, in adolescents and early adulthood, the effects are predominately seen in evolving cognitive and emotional processing difficulties (Goodnight et al, 2019; Andersen and Teicher, 2008; Lupien et al, 2009). Furthermore, due to the small number of studies found, results were restricted in terms of generalisability across populations and comparison groups.

Interestingly case studies found EMDR to be the most effective, closely followed by both RCTs and comparative studies. There are many reasons for this including the nature of alternative therapies investigated (e.g. PE was used in both the comparative studies and also two of the RCTs) which is a well-known treatment for PTSD. However due to the unknown mechanism of EMDR these studies were at a loss in fully identifying why results for both these treatments were comparable (Rothbaum, Astin, and Marsteller, 2005). Additional discrepancies may have rooted from individual study limitations such as predominant factors of changes in levels of salivary cortisol pre- to post-treatment (Gerardi et al, 2010) in that such changes

'might be related to diurnal variation or other extraneous factors such as pattern of sleep' (p.355) causing restriction in findings. Bias in research must also be addressed due to lack of blinding and researcher allegiance e.g. the researcher acting as therapist (Ringel, 2014; Wright and Warner, 2020). As per CASP (2018) guidance, alternative issues also included data quality i.e. a limited number of controlled studies, small sample sizes, dissimilar employed methodologies and scarcity in findings within the specified subject field.

2.5 CLINICAL IMPLICATIONS AND RECOMMENDATIONS

The above-mentioned literature learning, spanning over 10 years, integrates with current recommendations from both the British Psychological Society (BPS, 'Power, Threat, Meaning,' PTM Framework) and the NICE, EMDR Guidance, as per the below sections.

2.5.1 NICE Guidelines: 2018 EMDR Guidance for PTSD

This section will primarily provide a general perspective on the use of EMDR with PTSD, in accordance with the June 2018 NICE proposed guidance on the treatment of PTSD referred to as 'GID-NG10013' (NICE, PTSD Guidance, 2018), indicating stakeholder (e.g. EMDR UK and Ireland Association) and wider EMDR Therapy International Community (e.g. EMDR Europe) feedback. Although EMDR therapy has been recommended for efficacy when working with children (Barron et al, 2019), adolescents and adults via the World Health Organization (WHO, 2013; 2017), the Department of Veterans Affairs and the Department of Defence (2017) reinforcing strength in its empirical efficacy (Health Quality, 2018; Foa et al, 2017), barriers in its application had been highlighted within GID-NG10013.

According to the body of EMDR publications (EMDRIA and EMDR Europe) by the end of 2017, 38 controlled studies were undertaken illuminating EMDR treatment of severe trauma and PTSD, with research indicative of its safety and effectiveness as a psychological treatment intervention (Bongaerts, Van Minnen, and de Jongh, 2017). However regardless of this strong evidence base there was debate about the GID-NG10013 guidance within certain populations; specifically, 'Adolescents and

Adults' will be addressed in this section in accordance with the current research sample.

Little is presented solely with an adolescent populace; however, research is generally merged with a child populace hence a recent literature review (Verardo and Cioccolanti, 2017) whereby comparison with alternative trauma-treatments suggested that fewer sessions are required for better outcomes. This was consistent with previous meta-analysis, Moreno-Alcázar (2017) suggested the efficacy of EMDR in treating PTSD and comorbidities (e.g. depression, anxiety, low self-concept, disruptive behaviours, and/or substance use disorders) in such groups. Results displayed comparable effects between CBT and EMDR whereas it was superior to waitlist/placebo conditions in reducing post-traumatic and anxiety symptoms. However, a similar but non-statistically significant trend was apparent for depressive symptoms. Such research contradicted guidance from GID-NG10013 suggesting, the conduction of EMDR secondary to TFCBT.

In terms of the adult population, the current project was conducted in agreement with the recommendation as per Section 1.6.16 (GID-NG10013) that treatment should "Typically be provided over 8 to 12 sessions but more if clinically indicated, for example, where people have experienced multiple traumas" (up to 16 sessions within GMMH IAPT services are generally offered at step-3 and approx. 20 at step 3+) and reflective of real-world clinical settings; regardless of some studies within this review and that conducted by Nijdam et al. (2012) indicating a shorter-more intensive programme, with outcomes suggesting that 92% of participants lost their (single event) PTSD diagnosis after just five EMDR sessions. Committee recommendations in sections 1.6.12 and 1.6.18 (GID-NG10013) were debatable since research on CSA (Chen et al, 2018; Paylor and Royal, 2016; Rothbaum, Astin, and Marsteller, 2005) clearly illustrated the efficacy of EMDR therapy with adults between 1-3 months and that EMDR therapy should be contemplated by way of 'choice', and equilibrium between alternative trauma-treatments (e.g. TF-CBT), as opposed to the suggestion that there is 'limited evidence' between the two.

Tension, due to issues of clinical relevance in 'real' clinical environments and settings (Barkham, 2003) was also considered, between the 1980's introduction of

Evidence-Based Practice (EBP), which is a major component in UK Health policy (i.e. NICE) and 'Practice Based Evidence' (PBE) whereby the application of empirically supported treatment interventions are safe, effective and efficient is becoming increasingly difficult due to NICE demands, primarily that TF-CBT is chosen over EMDR in treating trauma. Also, a recent poll of therapist opinions (Farrell, 2018) regarding this matter highlighted the following narratives; greater need for trained EMDR therapists due to the lack of access to treatment in relation to high demand in treating such presentations, also the need to increase client choice and preference. Lack of practitioner accessibility due to possible issues of financial costs, time and trainer availability in the UK may equally restrict continued professional development of therapists.

Equally, as exhibited in the selected studies, regardless of rigorous methodologies including blinded assessment, loss at follow-up is inevitable, which may reach 50% at six-month follow-up. The average dropout rate across treatments in PTSD clinical trials is approximately 20% (Imel et al, 2013), with no significant difference between EMDR therapy and alternative empirically supported treatment interventions for PTSD however interestingly, 8.8% in PTSD integrative treatments (Swift et al, 2013). Though two studies in this review indicate decline in symptom severity and lower drop-out than usual for integrative (Ringel, 2014) and intensive (Woudenberg et al, 2018) trauma-focused treatment schedules.

Hence, this section illustrates the need for up-dated NICE Guidance for PTSD, more closely associated with the WHO (2013; 2017) recommendation for treating children, adolescents and adults diagnosed with PTSD (DSM-V, 2013). However, possibly more closely linked with C-PTSD, as defined by ICD-11 (2018) and above mentioned in section 1.5. Especially as CSA is generally prolonged, rather than 'single incident' PTSD and therefore, more likely to fall within the diagnostic criteria of C-PTSD.

2.5.2 BPS – 'Power, Threat, Meaning (PTM) Framework'

As mentioned above, this review demonstrated some promising evidence for the use of EMDR in the treatment of CSA with comorbid PTSD; this is not surprising given the proven effectiveness of EMDR to treat PTSD (Bisson et al, 2013; NICE, 2005). It

suggested that EMDR decreases comorbidities such as anxiety and depression, so often associated with the condition. Although, importantly the evidence from this review indicated that EMDR could potentially be a beneficial treatment for those that do not specifically meet the criteria for PTSD (DSM-V, 2013) and/or C-PTSD (ICD-11, 2018) however, that have presented with symptomology due to complex histories of childhood sexual and physical abuse. Additionally, EMDR is intended to treat traumatic memories (not solely PTSD), hence clients referring to current identifiable distressing trauma memories (regardless “small t” or “big T” trauma) (Cvetek, 2008; Shapiro, 2014) may be appropriate for EMDR therapy (with or without comorbid PTSD).

Although controversial at present, discussion surrounding the recent BPS ‘Power Threat Meaning (PTM)’ Framework (Johnstone et al, 2018) during a recent Greater Manchester Mental Health (GMMH) Trauma Research Conference (Allsopp et al, 30/07/18) suggested an alternative to the more traditional models based on psychiatric diagnosis. Interestingly the framework was formed alongside psychologists and service users (survivors/campaigners), taking account of their perspectives around “...typical patterns in the ways people respond to the negative impacts of power...patterns of meaning-based responses to threat.” (PTM Summary, 05/11/18). Constructively, the framework is not an official BPS position nor policy document/service plan however rather an academic/conceptual source for clinicians wanting to apply such ideas and principles into their practice, providing flexibility in application, perhaps adopting an idiosyncratic approach.

Evidently, literature evaluated during this review highlighted social, cultural, discriminatory issues at the forefront of clinical presentation, since not all participants had received a diagnosis of PTSD yet experienced such issues alongside comorbidities often resultant in emotional distress, troubled behaviour and distorted self-perception causing deficiency in their mental ability to process events (Korn, 2009), hence need for the below mentioned IESR baseline measure, concentrating on trauma symptomology as oppose to the definitive “*DSM/ICD mindset*” of diagnosis at screening. Unfortunately, the need for ‘diagnosis’ seems deeply rooted within MH services, perhaps skewing the client’s journey, turning peoples ‘problems into illnesses’ (Widiger and Crego, 2015; Nemeroff et al, 2013; Bolton, 2013). It is

important to mirror a real-world population (Majid, 2018) and in cosmopolitan cities such as Manchester this would include participants from an array of cultural, ethical, socio-economical backgrounds in which an idiosyncratic approach would work well in establishing common forms of behavioural responses to certain kinds of threat CSA poses (e.g. dismissal/rejection, entrapment, coercion, shame) whilst employing innovative ways of coping (i.e. peer/wider support, arts, physical activity, nutrition). This moves away from the personal experience and further exhibits the individuals role in a broader struggle and desire to belong in a just society, restoring links between personal distress and social injustice (Johnstone et al, 2018).

2.6 FUTURE RESEARCH DIRECTIONS

There is a need for future research to concentrate on obtaining larger sample sizes (e.g. observational studies), given the small number of participants evaluated in the case studies presented within this review, so that evidence can be generalised and replicated across populations, and comparison groups. Furthermore, the field requires more thorough large-scale RCTs, with consistency in outcome measures, inclusive of long-term follow-up and standardised methodologies; specifically the format and length of EMDR treatment (as seen in this study, often clinicians provide a lengthy period of safety and stabilisation before survivors can actively engage in processing their trauma) (McLean et al, 2017), in exploring the efficacy of particular treatment impact and components (e.g. PTSD, depressive, anxiety symptoms and neuropsychological functioning) associated with complex childhood trauma/CSA when working with adult and adolescent populations (Chen et al, 2018). It may be useful to consider a follow-up study to investigate perceptions of individuals who choose CBT over EMDR and whether EMDR protocols can be changed to allow it to be more acceptable to such people; with scope to repeat this study in various settings to build a comprehensive knowledge of un/helpful factors in establishing a modified EMDR protocol.

2.7 CONCLUSION

Following recommendation since the Layard report (2006) gaining evidence of best practice techniques has been crucial to therapists hence mirrored in growing research. However, differences in research between qualitative and RCT studies pose fraction in profession, albeit each illustrating both strengths and weaknesses as seen in this review. Regardless of limitations in the present literature, it offers scope into the possibilities that EMDR therapy could hold for individuals having survived CSA, with and without comorbid PTSD. Additionally, the review has identified how this study will identify changes in clients' functioning and view of the EMDR therapy process, however crucially this study hopes to add vital knowledge about the treatment in young adult (aged 18-25) survivors of CSA that is timely and relevant in a field that has only partially been covered before.

Eleven relevant papers were identified (the reference section of relevant systematic reviews, literature reviews and meta-analyses identified in the database searches were screened for any potentially relevant articles which were not identified in the database) of which the evidence gathered suggested scarcity in information within this subject field due to variance in the selected research methodologies, particularly within the searched domains (neuropsychological, emotional, behavioural functioning and quality of life issues). However, the available evidence indicated that EMDR therapy improved trauma-associated symptoms in adult survivors of CSA.

More research is required to exemplify the complexity of working with the mentioned group in conjunction with EMDR therapy. However, the studies identified in the present review indicated that EMDR is an effective psychotherapy to treat trauma-associated symptoms in survivors of CSA. Initial evidence also indicated that EMDR treatment is beneficial for those experiencing anxiety and depressive symptoms and could potentially be useful in the treatment of low self-esteem.

2.6.1 Literature Informed Decisions

Literature has clearly indicated a need for triangulation of the qualitative approach and use of descriptive statistics via outcome measures in order to capture any missing data used in just one of the two methods (verbatim and statistical outcomes) and also in answering the research questions as neither one could fully depict rich

results alone (Tashakkori and Creswell, 2007). Hence, the rationale in undertaking qualitative interviews was that it allowed participants to play a potent part in raising concerns, suggestions and their personal experiences across the research/therapeutic process. The 'Helpful Aspects of Therapy (HAT)' interview forms (Llewelyn, 1988), alongside three specifically designed additional questions to assess neurological functions were used in order to provide space for participants to explore a broad variety of factors when answering to enrich research findings; the open-ended aspect of questions enabled them to be answered more profoundly, consequently better informing links and contradictions between descriptive statistics and qualitative data, in an attempt to highlight the issues being studied (Wilson and Creswell, 2013).

The aims and backdrop of this study (as described in the introduction chapter) illuminate not only the population (survivors of CSA, aged between 18 to 25) however also the service in which treatment takes place (IAPT) hence generally providing short-term treatment whereby descriptive statistics were utilised via outcome measures, two of which were used in this study (GAD7 and PHQ9) would commonly take place in IAPT each session from assessment through to end of treatment. Additional IAPT measures were not utilised due to unspecific relevance to the subject under study and avoidance of additional client time in completion. However, being mindful of the qualitative research questions and statistical points of interest in this study, both these measures alone would not have been sufficient enough in capturing various other factors highlighted in literature as important to explore, these include self-esteem, quality of life stressors and value of living. Hence, additional outcome measures were introduced to investigate these particular elements of change (as described in the methodology chapter).

Further, there was an apparent need to undertake neuropsychological means of assessing change due to the current gap in research around this topic, especially within the young population this relating to this study and during the international COVID-19 pandemic; which essentially sets this research apart from others.

In terms of sample, as seen in the literature there appeared to be lack of studies surrounding young people, this may be due to ethical considerations such as

questions around how to balance the interests of the participant with research aims and the interest of the wider community/society or family (ESRC Research Ethics Framework, 2005) and equally, in determining connections between research, risks, and health/social impacts. Furthermore, issues of obtaining informed consent from primary caregivers, and assessing capacity of children to consent at the outset of outcome measures or interviews may pose difficulty as proved to be the issue with this study; due to the nature of IAPT services the employed sample could only be aged 18 and over as otherwise there would need to be an element of dual-working across departments (i.e. IAPT and Child and Adolescent Mental Health Services, CAMHS) in order to secure a younger sample however as seen in this literature review, due to the ethics i.e. subject sensitivity, participation and consent, this would have been too large for the scope of this project and hence it was decided to work within IAPT alone, resultant in a sample aged between 18 to 25.

CHAPTER 3: Methodology

The aim of this chapter is to provide an overview of both qualitative methodology and descriptive statistics via outcome measures as used in this study, followed by an overview of ethical considerations and finally, the research design and function of individual measures will be presented (ending with the write-up procedure used in compiling credible systematic case-studies).

Three main changes in methodology occurred during the course of this project; (a) the comparative outcome study design was amended to that of a case series analysis in consideration of the small sample; (b) changes in sample age range from 16-19 to 18-25 reflective of IAPT services and in accordance with ethics were agreed and (c) changes in treatment from 'in person' to 'online' EMDR sessions were offered due to COVID-19. Consequently, a rationale for revisions in individual research measures and processes to account for these factors will be discussed in this chapter.

3.1 QUALITATIVE METHODS WITH DESCRIPTIVE STATISTICS

Two conventional methodology camps have formed over time with differing theoretical principles, epistemological roots and functions (Morse, 1994); evidence-based quantitative and the more holistic qualitative research. Both ideologies pose difference in objectivist/positivist (quantitative) research and constructionist/subjectivist (qualitative) research, as below.

3.1.1 Quantitative Research (Positivism and Post-Positivism)

As described in Francis Bacon (1561-1626, referenced in Crotty, 1998) however later distinguished by Comte (1788-1857) as the originator of Positivism (Butts and Rich, 2011); this concept is perceived to provide notions of precise and distinct understanding of the world through a 'scientific' view stipulating that results should be based upon valid, reliable and generalisable measures, not conjecture, rather posited data (Crotty, 1998).

However there is debate in the field of Positivism (the recognition of reality with inevitability through facts based upon appraisal, test and comparison, proposing that worldly articles had prior meaning and are autonomous of any consciousness) in that the Post-Positivism movement believes in *likelihood/chance* as opposed to *inevitability* (Crotty, 1998). The main dissimilarities between the two include that the Positivism ideology bases findings upon theory authentication e.g. solely empirically verified means (Ponterotto, 2005) whereas the Post-positivism movement recognises flexibility in reality, indicating that this can merely be estimated (Denzin and Lincoln, 2000).

In terms of the current study, the principal researcher attempted to bracket herself from the descriptive statistics under study (through inclusion of independent research raters, employment of an external EFRS rater and participant member checking) to ensure an impartial viewpoint was taken (Ponterotto, 2005), in measuring individual difference in participant EMDR outcome measures. Although, inevitably such methods (Campbell and Stanley, 1963) may statistically explore the efficacy of EMDR, specifically in relation to therapeutic change participants may have experienced throughout treatment within a specified or measured dimension (e.g. comorbidities, symptomology). Such methods are restricted in exploratory research evaluating client perspectives, without pre-determined hypotheses, as the hermeneutic (or interpretive) constructivism stance does not begin with theory, however, rather allows hypotheses to evolve from the data (Fishman, 1999). The present study was undertaken in the context of qualitative research to better understand participant experiences and change processes (Harper & Thompson, 2012), with support of descriptive analysis.

3.1.2 Qualitative Research (Constructivism and Post-Modernism)

Although the Post-positivism pluralist approach is derived from non-empirical modes of inquiry, the Post-modernism stance describes this as a kind of science that provokes silence, anger and distrust (Denzin and Lincoln, 2000). Post-modernism holds the perspective that there are numerous valid realities or forms of peripheral reality (Bryman, 2008). As per the foundations of this approach, Constructivism/ Interpretivism (Ponterotto, 2005), within the present study, the principles of 'reflexive

thematic analysis' (RTA) (Braun and Clarke, 2006; 2019; 2020) were utilised, situated within a “*Big Q*” qualitative orientation – that is, “one in which qualitative techniques are underpinned by a distinctly qualitative research philosophy that emphasises, for example, researcher subjectivity as a resource (rather than a problem to be managed), the importance of reflexivity and the situated and contextual nature of meaning.” (Clarke and Braun, 2018. pp.1). Furthermore, RTA’s “independence from a specific theoretical framework permits broad, and flexible application of the analytic approach across a range of epistemologies - including essentialist and constructionist paradigms... the researcher is responsible for selecting theory and epistemology, and ensuring that reflexive thematic analysis fits within that selected philosophical approach” (Campbell et al, 2021, pp.5). The principles of ‘reflexive thematic analysis’ (RTA) (Braun and Clarke, 2006; 2020) were applied for the client interviewing stage of this project to identify authentic perspectives and evolving themes, positioned within a Big Q (Kidder and Fine, 1987) qualitative orientation, conducted within an interpretivist paradigm (Braun and Clarke, 2019; Clarke and Braun, 2018).

Although, this approach allowed the researcher a choice in understanding themes, these essentially correlated with key elements of existence e.g. personal values and principles, disparities in power, eco-social and cultural norms through a framework which provides parity in all areas, essentially the clients lived experience (Onwuegbuzie and Johnson, 2006); in consideration of eventual and evolving (in relation to context) change in their reality (Ross, 2004).

3.1.3 Issues of Validity: A Qualitative Approach Utilising Descriptive Statistics

Therapy outcome and perspectives cannot be isolated into neat measures of intervention alone due to complexity in determining the human state (Dattilio, Edwards, and Fishman, 2010). Thus the present study chose to utilise a qualitative approach with use of descriptive statistics (in the form of a case series analysis) in order to cover lost ground in limitations posed by either domain and in answering manifold elements of the research questions, as often such aspects cannot be addressed through solely one research method (Brannen, 2005). The qualitative

research questions and statistical points of interest allowed investigation of both outcome measures to identify changes in individual clinical presentations and qualitative interviewing to seek client perspectives of their therapy experiences, without the need for hypotheses (Fisherman, 1999). Any hypotheses generated from current amalgamated data or qualitative research can then be utilised in additional studies (McLeod, 2013).

Similarly, Elliott, Fischer, and Rennie (1999), Lincoln and Guba (2000) suggested a structure for evaluating the validity of qualitative research; *credibility* (similar to internal validity, relating to continued employment with the data in order to provide an in-depth description of the data source, Morrow, 2005); *transferability* (similar to external validity or the level in which a reader can generalise findings in their own context alongside depth of researcher reflexivity); *dependability* (similar to reliability, transparency of data analysis) and *confirmability* (similar to passable representation of the phenomena). As described by Guba and Lincoln, (1994) there are several areas of methodological concern, in the current study these aimed to be addressed via qualitative methodology, in aid of descriptive statistics to disclose confictions, consequently informing supplementary research (Greene, Caracelli, and Graham, 1989).

Foremost, there appears to be dissimilarity in views, for instance, qualitative methods generally consider core or internal views whereas descriptive statistics accord with the etic theory of an external or detached view from the studied subject. Within the current study, intrinsic perspectives and changes were observed through namely an emic perspective. However, the researcher was aware of the emic limitations, such as possible bias, and hence, descriptive statistics allowed her to equally understand results from an outsider perspective.

Secondly, qualitative data is generally sought in linguistic or written form directly from the subject, in their own descriptive words as opposed to descriptive statistics which are generally sought in numeric form, again directly from the subject however as an indirect form of their experience about the topic being researched (Taylor et al., 1995). A variety of data were collected and analysed, both in verbatim and statistical form in the present study to account for parity in data.

Further, this project concentrated on qualitative research to consider particular relative background/circumstantial knowledge of the participant's world (Denzin and Lincoln, 2000) so that the phenomenological meaning and purpose of human behaviour could be understood. Descriptive statistics focused more so on a set of variables in evaluating treatment outcomes, alongside the client's intrinsic distinctions.

The current study attempts to emphasise originality in how an individual thinks about his/her social world, which consequently affects their knowledge about the world in which they live; taking an emic perspective fashions how this is perceived (Mason, 2002). Hence, there are numerous models we can use for such an approach in recognising differences in life sciences (Cresswell, 1998).

3.1.4 Case Series Analysis Design: Rationale

Of the eleven studies included in the Literature Review, three were single case studies (Aranda, Ronquillo, and Calvillo, 2015; Ringel, 2014; Wright and Warner, 2020) and two case series (Hutchins and Mason 2017; Shields, 2015) suggesting significance in such research design, especially within this field as it provided a dynamic perspective of the link between the treatment process, client and outcome. Additionally, in analysing prior research, utilisation of both qualitative methods (via conduction of one-month follow-up interviews – providing participants with the opportunity to report on experiential elements of their changes, the process of change) and descriptive statistics (via self-report outcome measures) appeared to be most appropriate, as covered in the previous section. Rather than clarity in causality, the researcher set out to generate rich descriptive data, to examine multiple questions in understanding client perspectives, mechanisms of therapeutic change and related outcomes. Qualitative data analysed through TA (Braun and Clarke, 2006) allowed the researcher to understand possibly otherwise unobserved connections (i.e. unseen in solely a quantitative study) in explaining the findings. Whereas, descriptive statistics via outcome measures enabled a level of assurance regarding symptomatic changes; albeit complementing one another in data coverage. Therefore, the current case series analysis utilised qualitative

methodology, with aid of descriptive statistics, as the most appropriate manner in view of limitations of size, interest in getting a deeper understanding of the clients' experiences and in the exploration of the research questions.

Many definitions (Dekkers et al, 2019) of case series have been suggested, including “a collection of patients with common characteristics used to describe some clinical, pathophysiological or operational aspects of a disease, treatment or diagnostic procedures” (Porta, 2008, p.33) and more recently, “case series is a variation of a single case report in which the author describes several cases and their relation to one another and to the existing body of literature” (El-Gilany, 2018, p.10). However, numerous methods of case-study design attain differing areas of attention (Fishman, 2012), in addressing such variance, the researcher has outlined a brief description of three key case series analysis:

Clinical, namely founded upon the therapist's account of the therapy hence arguably untrustworthy for research purposes due to matters of bias and subjectivity, Iwakabe and Gazzola (2009); though Flyvbjerg (2006) claims that case study research generally challenges the researcher's 'preconceived views' due to the rich generated data.

Experimental, often utilised to test particular interventions, a critique is often that 'soft' data is not considered due to the prominence of behavioural change and outcome (Iwakabe and Gazzola, 2009; McLeod, 2010) hence unsuitable for the current project due to potential dismissal of the impact of external factors/stressors and influence of the therapeutic relationship on the change process.

Systematic, appeared most appropriate as this resolved some of the methodological issues as above-mentioned e.g. interviews, questionnaires, client-practitioner perspectives and subsequent triangulation to investigate whether different sources of data converge (Iwakabe and Gazzola, 2009) often address methodological inadequacy frequently found in both clinical case-studies (lacking in reliability due to

their underpinning in the therapist's subjective or bias account of the therapy) and that of the experimental design (due to the absence in the therapeutic alliance in relation to the change process, or the impact of external factors) (Iwakabe and Gazzola, 2009).

Moreover, Kazdin (1981) established proposals of quality control in order to add scientific validation to systematic case-study design as seen in this study, namely in the implementation of multiple repeated reliable and valid outcome measures during therapy to ascertain the level of change in client presentations. Secondly, he identified the need for replication (across client cases, as per the current study) in research to eliminate the possibility that change has taken place by chance so that findings can then be generalised. If change is demonstrated within a few cases with similar presentation/symptomology, some validity for the treatment of that particular issue or client population can in turn be argued.

Further, in consideration of current subject sensitivity, it was apparent that the use of 'small n or single-case studies' in structured case study analysis can produce reliable evidence for evaluating therapy change processes (Kiesler, 1983; Flyvbjerg, 2006; Hackshaw, 2008). Hennekens, Buring, and Mayrent (1987) findings also indicated that 'case series' design was most suitable for the current study as there was no definitive limit, with authors considering three plus cases to be a case series analysis. Similarly, data from the current small case series was presented in a rich case format in order to highlight any unknown clinical incidents/discrepancies (Hefny, Eid, Al-Bashir, and Abu-Zidan, 2010; Webster et al, 2011; Keeble et al, 2015) which was helpful in establishing hypotheses and/or changes in future research (Fogarty and Wardle, 2015; Kooistra et al, 2009; Johnson and Onwuegbuzie, 2007). For instance, a follow-up study to investigate perceptions of individuals who choose CBT over EMDR and whether EMDR protocols can be changed to allow it to be more acceptable to such people; with scope to repeat this study in various settings to build a comprehensive knowledge of un/helpful factors in establishing a modified EMDR protocol.

However, though some of the disadvantages of case series analysis may include somewhat lack of generalisation and causal inference to explore cause-effect relationships (Hulley et al, 2007) more importantly, advantages include the ability to report correlations (e.g. uncontrolled observations around symptoms, significance and evolution of case formulation, dual-diagnosis, elements of client complexity in influencing the outcome; Jenicek, 1999), alongside educational merit (Grønli, 2013), and in resolving ethical constraints that may be seen in large RCT's (Bjånes et al, 2011). For instance, RCTs though robust, have been questioned for their loss of rich descriptive data in acknowledging why or how the phenomena has produced the said change (Elliott, 2001) as opposed to comprehensive case studies which incorporate variance in data. Case studies are not limited to one person's experience, and more so in instances whereby phenomenological methodology has been utilised, also the view of individual client experiences.

3.1.4.1 Case series vs. RCT Design

Throughout the history of Psychotherapy, in theory building (Flyvbjerg, 2006; McLeod, 2010; Stiles, 2007) and testing efficacy (Berne, 1961), case studies have served as the fundamental pillar of understanding in the human condition (Iwakabe and Gazzola, 2009), within the emergence of Freud's (1901, 1909) psychoanalysis and behavioural therapy (Wolpe, 1958). However in more recent times, the evidence-based movement has directed researchers towards the path of RCTs with some researchers debating this and calling for integrative methodologies with use of practice-based, qualitative and systematic approaches in an attempt to produce reliable and valid data (Barkham, Hardy, and Mellor-Clark, 2010; Dattilio, Edwards, and Fishman, 2010; McLeod and Elliott, 2011; Westen, Novotny, and Thompson-Brenner, 2004).

Although RCT's are thought to hold high internal validity in consideration of their controlled conditions, there have been issues raised with dismissal of 'soft' data e.g. the therapeutic alliance, responsiveness, therapist credibility, client hope (Dattilio *et al*, (2010) which often disregards routine practice (Westen, Novotny, and Thompson-

Brenner, 2004). In comparison, case-studies address complexity in therapy change-orientated factors, provide a variety of data sources and offer accurate accounts of the client's view (McLeod and Elliott, 2011) justifying the methodology of the current research. Though case study research has been disregarded as unscientific, biased and as simply 'anecdotal evidence' (McLeod, 2010) in comparison to RCTs (as seen in the systematic review), developments in design have started to tackle such critique via the use of vigorous methods (e.g. Elliott's Hermeneutic Single-Case Efficacy Design 'HSCED') (Elliott, 2001; 2002) for conducting case study research (Bohart, Berry, and Wicks, 2011; Fishman, 1999; Iwakabe and Gazzola, 2009; McLeod, 2010; Miller, 2004).

As employed in this project, Chambless and Hollon's (1998) suggest three key areas in judging criteria for empirically supported therapies; standard treatment with aid of a manual (or its logical alternative) must be adhered to in conjunction with clarity in a problem-specific population (in the current project, clients with a history of CSA, suffering with trauma symptomology). Consideration must also be given to reliable and valid outcome measures inclusive of a baseline measurement of the target-problems (outlined in the research design section). Additionally, a minimum sample size of three participants and replication of positive results via a second independent research group with a minimum sample size of three or with a further six systematic case studies must be observed to cover issues of objectivity and researcher allegiance which may be present in other case study designs (Elliott, 2001; Fishman, 2012; McLeod, 2010). In order to achieve this, within the current study two independent researchers (IRR's) rated measures via following a similar structure to that of the Hermeneutic Single-Case Efficacy Design 'HSCED' (Elliott, 2001, 2002); a systematic case study method based within a quasi-legal context whereby data were cross-examined via use of an adjudication panel.

3.1.5 Qualitative Approaches: Interpretative Phenomenological Analysis (IPA) vs. Thematic Analysis (TA)

Two main methods of interview data analysis were highlighted and explored during this study; IPA (Husserl, 1927; Smith, Flowers, and Larkin, 2009) and TA (see Boyatzis, 1998; Braun and Clarke, 2006; Holton, 1973).

Though both utilise coding and theme development, TA concentrates predominantly on patterning of meaning amongst subjects (Braun and Clarke, 2006) whereas IPA, more so on individual characteristics of the subject; nevertheless, both promote the capture of contrast and similarities in data analysis (Auckland Research Department, 2020). In achieving this, the analytic processes for both are somewhat dissimilar; IPA uses initial coding comprising of categorization of 'initial noting' (brief commentaries about linguistics, non-verbal communication etc, labelled 'descriptive' and 'conceptual' comments) to capture the initial analytic observations about the data on each specific item (e.g. interview transcripts); this is similar to the notion of 'semantic' and 'latent' codes in TA. Once data items are coded in IPA, the researcher then develops themes for that data item before moving to the next item and so on, until eventually themes are analysed across the absolute dataset. In contrast, TA recommends the practice of data familiarization whereby the researcher notes analytic observations about individual and further, the full dataset, followed by coding collectively across all data items.

This reflects theme development whereby TA focuses on one stage (themes formed by codes and across the dataset) whereas IPA on two stages; 'emergent' themes are usually highlighted on the data item itself and 'superordinate' themes are then developed across the dataset through collective analysis of emergent themes from each data item (Callary, Rathwell, and Young, 2015). TA has historical underpinnings as a phenomenological method that predates the development of IPA (Langdrige, 2007), for the current study, taking into consideration the small however rich sample which required intricate robust analysis, it was initially thought that IPA (Smith, Flowers, and Larkin, 2009; Larkin, Eatough, and Osborn, 2011) would be most appropriate and hence data were analysed with initial noting consistent with IPA guidance with view to elicit super- and sub-ordinate themes however it was later realised that to remain consistent with the research aims and interview questions, enabling participants to reason and reflect on their experiences in a broader context (Folkestad, 2008), investigation of patterned meaning across the dataset as seen in TA was key in understanding efficacy of EMDR, especially in maintaining an idiographic direction which offered insight into how the participant, in their given context, made sense of EMDR by highlighting both helpful and unhelpful aspects of

their experience. The TA (Braun and Clarke, 2006) approach was consistent with the research questions and provided richness in outcomes from two key perspectives; (a) that based on coding in an inductive manner (Thomas, 2003) and (b) from a data-driven viewpoint.

3.1.6 Thematic Analysis (TA)

Change process research is essential in experimental or interpretive single-case causal designs in identifying “the existence of a causal relationship between therapy and client change...a plausible explanation or narrative linking cause to effect” (Elliott, 2010). Similar to Elliott’s (2010) method of change process research in the form of ‘Qualitative Helpful Factors’ design in determining what clients found helpful (or hindering) in their therapy, TA was undertaken to identify key qualities of the client’s therapeutic experience (Braun and Clarke, 2006). Unfortunately, the use of post-session questionnaires as suggested in the ‘Qualitative Helpful Factors’ design could not be fully utilised due to time restrictions within the service in addition to administration of other sessional measures. However, a semi-structured post-treatment interview on the basis of the ‘Helpful Aspects of Therapy’ (HAT) form (Llewelyn, 1988) enabled the researcher to interpret the participants reflection on the whole therapy process via TA. This provided rich qualitative data, distinctly valuable in systematic discovery-based case study research.

Two key approaches were researched (Moran, 2002): an interpretive approach (based on Heidegger’s writings) and a descriptive tradition of phenomenology, based on Husserl, who suggested the possibility of ‘universal essences;’ recognising commonalities in articles of lived experiences between individuals having experienced a similar event via consideration of the root of essential aspects of consciousness, viewing everything in its entirety (Moran, 2002). Husserl believed these to be the genuine nature of the phenomena being studied, an impartial reflection of reality, detached from context (Lopez and Willis, 2004), taking a step back from our regular attitude and rather, to inherit an inward ‘phenomenological attitude’ concerning the subject being studied (Shinebourne, 2011). Though, Husserl

did emphasise the link between insight and its objects is not inert hence, not to suppose the experience of this world (Gubrium and Holstein, 2000).

Conversely, there is debate of Husserl's driver mentality of eradicating the 'consciousness of all intrusion from objective actualities' (Moran, 2002, pp.11) such as biases and expectations as some believe this state is near difficult (Moustakas, 1994) or unattainable as suggested by a pupil of Husserl's, Heidegger (Reiners, 2012). There is variance in their interpretations of the distinctive way of existence (Wheeler, 2013). Heidegger rejected Husserl's theory that this is an automatic consciousness of the self that also distinguishes the presence of others and accepts there can be no detachment from a pre-existing domain of society, objects, language and culture (Smith, Flowers, and Larkin, 2009). Instead he argued the word 'Dasein' signifying, living life in a manner in which the understanding of being is acknowledged (Crotty, 1998).

Although TA primarily concentrates on patterns of meaning across data sets, as opposed to the participants' individual lived life experience, the Heideggarian approach as adopted, was taken as the research questions aimed to produce knowledge about the subjective experience of the participants e.g. their emotions, cognitions and perceptions which informed their experience. Furthermore, Braun and Clarke (2006) suggest that TA can be conducted from diverse epistemological standpoints (e.g. social constructionist, phenomenological, realist) and that TA is an advantageous methodological framework due to its flexible nature when utilising differing theories (Clarke & Braun, 2013; Willig, 2013). The researcher was therefore able to interpret individuals' accounts of their experiences – importantly, in the manner of Reflexive Thematic Analysis (Braun and Clarke, 2006) - to immerse herself in the context of their social world. This allowed the researcher to acknowledge their individual perspectives, emphasising comparisons and disparities, and attaining unexpected insights (King, 2004). The researcher was mindful of her epistemological position (Patton, 2015) in relation to her pre-existing knowledge (e.g. referral pathways, limitations in time etc) and experience of therapeutic and socio-political viewpoints in terms of IAPT, which initially innovated this project, and therefore was hypervigilant of producing a reflexive account of such incongruities.

Hence, the employment of independent research raters, EFRS rater, member-checking and continual discussion with academic and fieldwork supervisors and moreover, consultation with recent research and training events. Furthermore, as this study was based in clinical settings, a certain level of clinical competency and prior involvement was required to make practice-based informed decisions (Lee, 2009) about the research design based on idealistic and realistic service and academic demands, whilst collaboratively analysing participant data. Although, the meta-theoretical position of critical realist epistemology, which is ontologically realist (indicating that there is an assumption of an external reality that is independent of human minds) and epistemologically relativist (variance in methodology generate differing perspectives on reality), lends itself well to such an investigation due to its reflexive philosophical stance (Archer et al, 2016). The researchers focus was to understand, as opposed to solely describe social reality; the research design was chosen to foster unity amid client perspectives, clinical practice, and research, to address real-world clinical problems. The selected approach was more valuable in investigating contextual elements of experience (Lopez and Willis, 2004) as it presented an organic philosophically informed understanding of human behaviour, closely connected with the participants individual world view. Therefore, critical realism uses a variety of deduction, induction, retroduction and abduction to estimate the fundamental processes which create human change and differentiates these changes and processes from individual viewpoints.

3.1.7 Limitations of Methodology

When compared with alternative qualitative methodologies (grounded theory, phenomenology, and ethnography), as with all, some disadvantages were highlighted when researching TA including that it may fail to capture more nuanced data (Nowell et al, 2017) and due to its flexibility in approach, issues of discrepancy when forming themes originating from the research data may become apparent (Holloway and Todres, 2003). Hence, in the current study the researcher was mindful of rationally underpinning the study's empirical assertions (as seen in section 3.1.4), alongside ensuring trustworthiness (Green, 2000; Tracy, 2010), credibility (Tobin and Begley, 2004) and dependability (Koch, 1994) - as seen in Table 4. A key aim of this project was to allow the participant to voice his/her experience of EMDR,

how they grasped this in the context of reality and for the researcher via the RTA model, to be an interpretive mediator for the participants own account in this subject area.

Importance was given to consider and envisage the participant's experiences however this is also largely dependent upon their memory recall of events (Brocki and Wearden, 2006). Language formed a key part of this as an unacknowledged presupposition of pre-existing reality (i.e. the positivist/realist stance) whereas, "interpretive researchers assume that access to reality (given or socially constructed) is only through social constructions such as language, consciousness, shared meanings, and instruments" (Myers, 2008, p.38). Heidegger's interpretation of being, depicted as *Dasein's* "understanding of its being" (Heidegger, 1927-2011) has directed the progression of hermeneutical phenomenology through his ideals of phenomenological description, discourse, language, interpretation, and understanding (Ezzy, 2002; Gadamer, 1975; Ricoeur, 1976). Hence, in unfolding such layers, reading 'between the lines' was essential in enhancing meaning of participants' lived experience, through use of their own words (Willig, 2001, 2008). Hence, in an attempt to responsively and realistically interact and fully absorb the analysis it was important for participants to be allowed adequate time for their responses to semi-structured HAT interview questions in order to avoid pressure or anxiety in memory recall of their experiences. Similarly, a process of reflection took place as the researcher revisited numerous questions during the interview if participant responses to additional questions triggered this; in taking an analytical approach when following the TA framework, the researcher felt firmly grounded and competent in participant reflections of their experiences.

Respectively, no controls were put in place however the applied outcome measures provided generalisability and reliability in results, something which if taking solely a qualitative approach may have been limited.

However, time constraints in administration of outcome measures were restrictive due to fluctuation between individual participant cognitive ability in completing lengthy questionnaires, with addition of the Psychology Experiment Building

Language 'PEBL' battery test (which took over one hour to administer). In consideration of this, participants were not required to complete 'Helpful Aspects of Therapy (HAT) forms as originally intended by their creator (Llewelyn, 1988), following each session. Rather, the follow-up interview was based upon the HAT ideology of helpful and unhelpful aspects of therapy as a guide in conducting the semi-structured interviews. This helped save time yet still preserve Heideggers philosophical stance (Smith, Flowers, and Larkin, 2009) of the researcher being inextricably subjectively part of the way that emergent themes in client perspectives were interpreted.

When considering subject sensitivity in terms of CSA disclosure and drop-out rates, too small a sample would have caused difficulty in analyzing descriptive statistics to then later generalise. It was envisaged that a small sample would be sought also due to limitations in participant age range (18-25) as often this is seen to be a 'grey area' in services due to over-lap between Children and Adolescent Mental Health Services (CAMHS, whereby clients are seen throughout childhood up to age 18) and IAPT (whereby clients are seen from age 16+). Hence there would have been insufficient descriptive statistics to conduct a large-scale comparative study, therefore a case series analysis design was implemented for this project to act as a milestone for future larger-scale research.

3.1.8 Limitations of Case Study Design

Limitations in case-study design include research settings as it has been highlighted that a majority of case-studies are conducted away from real-world settings (i.e. educational institutions) hence the need for such research conduction to take place in routine clinical settings (McLeod and Elliott, 2011) to create high field validity (in order to generalise results to routine clinical practice and provide generous amounts of understanding with both the therapist and client populations) through adopting a 'naturalistic case study design' to strengthen the research-practice gap.

Therefore, in an attempt to address internal and external validity within the current study, a naturalistic case-study design was employed, held in routine clinical settings and reflective of the complex client presentations often seen in IAPT practice. The

study was utilised with two research therapists of similar background/knowledge to avoid fluctuations in length of experience, bias in background core qualifications and differences in adherence to EMDR therapy protocol (as they also undertook routine monthly supervision sessions with a designated EMDR Consultant to ensure compliance of technique via use of the EMDR Fidelity Rating Scale 'EFRS,' van der Kolk, 2007). The intention was not to produce large quantities of empty data, rather examination of all of variables and their connections (Dooley, 2002).

3.1.9 Data Collection

In keeping with IAPT protocol and the 'naturalistic' study design, data collection of outcome measures was conducted via the allocated therapist and both baseline and post-treatment measures via the principal researcher. All participants received the same treatment conditions. The main source of data collection was through questionnaires, PEBL battery-test and one-month follow up interviews which were also conducted by the principal researcher and recorded (with consent) in order to analyse individual differences and collective themes in participant perspectives. Common EMDR themes in session material, derived from therapists' clinical notes were, in relation to ethical compliance – anonymously utilised as a data source, and outlined in each participant's individual rich case record (see Results). Such details supported readability of the rich case record's and helped address the research questions in understanding the therapeutic alliance and employed interventions, when exploring the efficacy of EMDR. These data were triangulated with the other data sources through predominantly exploration of session content, which participants voluntarily discussed at interview. All data analysis was cross-examined by two IRR's and academic supervisors had access to increase credibility and reduce bias. There was no probability placed on participants responding to questions in a similar manner as this research hoped to identify individual difference in participant opinions (to convey the phenomenon under study) rather than to generalise or reproduce viewpoints (Castonguay et al., 2010).

3.1.10 Data Analysis

Evaluation of data were undertaken in accordance with Kazdin's (2003, p290-299) criteria (to ensure structure/meaning were maintained) for visual inspection of single-subject research design; mean levels were taken at various intervals (pre- and post-treatment); alongside qualitative interviewing at follow-up via the TA model.

In order to address the secondary research questions, the researcher utilised categorical ordinal (categories that are ordered variables e.g. participant selects from 'not worried', 'very worried', 'don't know') to analyse data as she would be working with mean measures of central tendency albeit being mindful that this may be misrepresentative of extreme values (e.g. if a participant had scored high in one therapy session and low in another on the same measure, the mean average was presented in the data outcome which did not portray the fluctuation in scores).

Additionally (albeit very little) not all participants answered all questions within each measure during each session hence such missing data within the broader data potentially affected the outcome; hence, the use of IBM SPSS software (Field, 2013) would initially have been utilised however since the change in methodology from quantitative comparative study to case series analysis, the SPSS trainer during a research-specific workshop (01/05/19) held at the University of Salford, outlined that the methodological changes would not qualify for use of such software due to the small 'n' sample. Likewise, a similar Nvivo software workshop (Wiredu, 17/06/19) highly recommended manual analysis of descriptive statistics due to small 'n' sample, this was then cross-referenced with Nvivo qualitative data.

However, in the mainstream both sets of data were utilised to analyse difference in results (i.e. qualitative data investigated client experiences and descriptive statistics aimed to explore therapy outcomes). 'Hard data' for instance, classification differences e.g. gender (male/female), ethnicity (white British/ethnic minority), number of incidents of abuse (single/multiple) was explored and to then compared against 'soft data' e.g. neuro, behavioural, emotional functioning and quality of life

issue outcomes. However again, due to limited sample size this was not possible. Hence, the principle researcher, where possible, included all sessional values in findings to address the above issues.

Also the researcher questioned initially whether some measures could be taken out or replaced with more relevant measures as there were too many for participants to feel comfortable in undertaking and as outlined by Polit and Hungler (1995, 2000) this may have consequently reflected structure and meaning in later analysis. Thus, only necessary IAPT measures (GAD7 and PHQ9) were utilised (to analyse emotion and behaviour within comorbidities such as anxiety and depression), alongside additional/more specific measures (as seen in the 'Research Design and Function of Individual Measures' section, below).

Furthermore, in such an un-represented sample area whereby client perspectives were largely unknown, the researcher attempted to offer in-depth thematic description of the complete data set. Hence interviews were conducted by the GMMH Trust employed principal researcher in an attempt to maintain confidentiality and relate to the interview content for purpose of later data analysis. All stages of the Braun and Clarke (2006) TA model were followed in exploring emergent themes, detection of convergence and divergence and also, commonality and nuance.

The process of data analysis incorporated aspects of the original HSCED practitioner-researcher model (McLeod, 1999) for use with single researchers, therapists and trainees wishing to systematically examine research cases (Elliott, 2002; Stephen and Elliott, 2011) however applied in conjunction with the more recently developed HSCED model whereby cross-analysis of data is now commonly conducted by more than one researcher; within the present study the principal researcher initially analysed data before reflections were sent to two IRR's and academic supervisors to then independently adjudicate the evidence in relation to *'the central research questions of client change and the causal role of the therapy in that change'* (Stephen and Elliott, 2011). The designated IRR's autonomously rated

both descriptive statistics and qualitative interview transcripts to both ensure consistency in analysis and eliminate researcher/therapist allegiance.

As per the TA approach (Braun and Clarke, 2006), data were differentiated into data sets, with accurate data extracts derived from certain areas of text, through somewhat time-consuming however precise repeated reading of transcripts and listening of video-recordings (initial noting of interview content and the use of participants language), to assist in determining emerging themes, from which main themes and sub-themes highlighted client perspectives. This was achieved in-cooperation of Nvivo software (Wiedu, QSR, 2019) via the following steps:

(1) Familiarisation of Data

Each interview transcript was read and re-read to ensure accurate translation of meaning in accordance with the video recordings (this included analysis of non-verbal communication and ensuring all words were accurately typed and understood in context for purposes of internalisation) before being copied and pasted onto Nvivo. Initial ideas and meanings were described in a few words in the margins before connection (similarities, differences, contradictions and paradoxes) between them, from the participant's own lived experience as opposed to the researcher's perspective, were identified.

(2) Generating Initial Coding

Participant experiences were analysed and re-analysed in order for data to be understood in the search for new and original aspects rather than existing knowledge through utilisation of Nvivo to produce codes. Initial interesting features were then coded "in a systematic fashion across the entire data set, collating data relevant to each code" (Braun and Clarke, 2006, p.87) to further deeply understand the participants perspective. The key aspect of this data-driven coding stage was to focus on determining patterns of meaning (the participants words with the researchers understanding), identifying the psychological principle of the work with equilibrium between being grounded and conceptual. Hence it was imperative that the researcher's interpretation was in accordance with the Heidegger philosophical

stance in terms of researcher subjectivity (Crotty, 1998) and respectful of the participant's view, which equally placed huge sense of accountability on the researchers work. Therefore, re-reading and listening was crucial in understanding depicted themes from the broader transcript; accuracy in this step helped IRR's later re-analyse data.

For this stage, a central 'Thematic Coding Framework' folder held 'nodes,' main themes were identified as 'Helpful' and 'Unhelpful' factors of EMDR as well as EMDR 'Outcomes' and changes in treatment due to 'COVID-19.' Working through data, nodes (categories) and sub-nodes (subcategories) emerged labelled with appropriate headings, careful of the 'interpretive' labelling attached to each entity.

(3) Searching for Themes

Coded nodes on Nvivo were re-read numerous times to recognise significant patterns of meaning (potential themes). During this phase it was important not to deviate from the initial research goals hence any data unrelated to the research was excluded e.g. client experiences of previous therapy unconnected with their current EMDR treatment. From this, main-themes and sub-themes were created.

Stages may read as consecutive however they were repetitive, fostering progression and analysis from prior stages. Due to the nature of the TA, it enables themes and their pervasiveness to be established in various manners; in the current study, Nvivo automatically highlighted the number of source references in each category and subcategory in helping determine patterned themes.

(4) Reviewing Themes

Categories were amalgamated into core categories (those referenced most, in accordance with patterned meaning). Themes were checked in conjunction with "the coded extracts (Level 1) and the entire data set (Level 2)" (Braun and Clarke, 2006, p.79), appendix 15 displays a screenshot of Nvivo categories and sub-categories. In accordance with Thomas (2003, p.237) indicating that most "inductive studies report

a model that has between three and eight main categories in the findings,” the current study displayed three (possibly also limited by the small sample); Appendix 16 shows the theme on Unhelpful Factors of EMDR as an illustration.

(5) Defining and Naming Themes

Due to the small sample size and variance in sample, collective themes or Nvivo ‘classifications’ (e.g. participant demographics) could not be added in order to compare, cross-reference and determine correlations between ‘hard’ and ‘soft’ data (e.g. gender). Time was allowed for the researcher to re-visit more general naturally occurring classifications (e.g. individual impact of moderating life stressors) in accordance with to the research question before themes were adequately defined and named.

TA was solely dependent upon the interview recordings and transcript and was substantiated by what was presented in the individual data and wider body of evolving analysis. As opposed to views pertaining that there cannot be an absolute interpretation of a personal account (Schwandt, 2000), the duty of the researcher in this study, in alignment with RTA (Braun and Clarke, 2019) was to ensure minimal bias; pre-beliefs were eliminated (as much as possible) in an attempt to provide reliable results however, subjectively generated within a particular context, as per the Heidegger epistemological stance taken within this research. Hence it was the researcher’s interpretation of the participant’s experience from the participant’s interpretation of their own experience that was presented in this thesis.

Further, though Nvivo was beneficial, any form of software data analysis has drawbacks (Ishak and Bakar, 2012) hence, data were doubly re-analysed by two IRR’s to provide an impartial perspective and to ensure no detrimental impact on the phenomena being studied.

As seen in Appendix 17, the above steps were formatted within the following columns, similar to free “textual analysis” (Smith, Daunic, and Taylor, 2007, p.121); *right column* for initial idea’s noting whereby patterned emergent themes were initially indicated and further progressed with the aid of Nvivo.

Although the researcher attempted to eradicate her own constructions and perspectives to ensure as little bias as possible, it must be mentioned that these cannot be utterly eliminated (Hollway and Jefferson, 2000). Although there is disagreement surrounding the criteria for evaluating the quality of qualitative research there appears to be two main strands of advice; obedience to sampling strategies, self-reports, prescriptive-checklists (Power, 2001) and sensitivity to context, commitment and rigour, transparency and coherence and lastly, impact and importance (Yardley, 2000). Therefore, in order to provide subjectivity to the interpretation and as a checking process, the anonymised transcripts were reviewed by two IRR's. These were then explored to highlight any differences in interpretation to ensure credibility of the analysis (Osborn and Smith, 1998) and inform authentic findings. Likewise, Yardley (2000) principles were adhered to, as follows:

Sensitivity to context: though the broader research was presented partially in accordance with a socio-political context, the principal researcher was mindful of adhering to organisation and local workplace policies/procedures in maintaining subject sensitivity. This was also achieved through a counterbalance between academic demands and realistic clinical goals. Therefore, the desire to choose a triangulated research design to capture awareness of individual perspectives of their therapy experience, ending, time restraints in accordance with service demands, through qualitative means and individual clinical progression in symptomology through analysis of descriptive statistics. An array of data based upon valid clinical measures and various verbatim extracts provides richness in analysis and outcome, both supporting the points of this study alongside promotion of the participants unique opinion for the reader to self-interpret.

Commitment and rigour: participants were consistently taken from the IAPT waiting list, they were offered a choice in treatment to ensure appropriateness of the research objectives was thoroughly addressed. Employment of two IRR's (external to the local IAPT work environment, with good understanding of ethics and previous research analysis experience) to cross-check all data analysis reduced bias and increased validity. Workshops were attended (both online and in-person) for use of Nvivo software and equally, many discussions continued to take place with peers and academic supervisors, who had previously utilised the TA and IPA models in

ensuring accuracy in analysis. Willig (2013) indicates that the researcher's role in connection with the research and generated hypothesis informed by the research questions must be recognised before the allocation of methods of data analysis. In the current study, the IPA approach was initially considered for data analysis however the research questions' rational (as outlined in the Introduction chapter), and the above-mentioned academic discussions and theoretical guidance led the researcher to take a TA approach for this study.

Transparency and coherence: as displayed all flaws and uncertainties have been projected in this thesis, with incorporation of faculty, independent supervisor and CPD training advice. The phenomenological and hermeneutic elements of this study have been presented, consistent with the values of RTA (Braun and Clarke, 2019; Clarke and Braun, 2018). Likewise, all findings from descriptive statistics are evident through use of tables and annotated examples.

Impact and importance: the aim of this project was to utilise the findings to provide ideology of even subtle positive changes in the EMDR profession, whether service changes (i.e. reduced wait times) or general (i.e. trans-diagnostic, moving away from working with a diagnosis of PTSD alone, rather working with individual symptomology and issues as described in the BPS PTM Framework). Hence, in terms of dissemination, as defined by the National Collaborating Centre for Methods and Tools 'NCCMT' (2018) all stakeholders are key for various functions including gaining additional research funding, understanding societal and political actions, the local context/community issues thus implementation of changes within IAPT services and consistency of high standards of client care.

3.2 ETHICS

McLeod (2010) highlighted three key ethical problems in conducting case study research: informed consent, management of confidentiality, and avoidance of exploitation or harm, as described in this section.

As per EMDR Europe (Code-of-Ethics, 2018), therapeutic practice and study objectives were established upon evidence-base from ongoing (research projects, CPD events) learning and prior literature in order to protect participants alongside formation of ethically attentive clinical practice. Accordingly, ethical approval for the instigation of the research project were sought via the NHS National Research Ethics Service (NRES) for which, consequently the local NHS Trust provided approval (Appendix 9) and the University of Salford School of Health and Society Ethics Panel (Appendix 10) whereby the researcher was required to provide a thorough risk assessment and detailed research summary sheet for participants. Conversely, NRES approval (Appendix 11) was slightly more tedious, spanning approximately six months, with sequential fieldwork supervisor meetings attended to update/sync with ongoing changes in service processes.

Due to the researchers 13+ years NHS service, issues of risk, confidentiality and data protection were familiar territory hence consideration was given to ensuring all processes were adhered too to provide a good standard of care and high levels of study fidelity.

Logistically speaking a Research Assistant (RA) could not be hired due to lack of time in (a) setting up honorary IAPT contracts (b) waiting times for classroom based training in relevant policies such as 'Information Governance' (c) management time in the training of local procedures such as 'Health and Fire Safety' (d) I.T. time in setting-up and familiarising the volunteer RA with appropriate IAPT software packages such as 'PCMIS' and 'Amigos' and lastly, improvement time restrictions in inputting IAPT data following appointments (uniformly completed within a 24hr slot in order for this to remain of statistic value for funding purposes), in consideration of their additional commitments e.g. university/work timetables.

Thus, in accordance with the 'naturalistic' study design, the designated therapist input sessional outcome measures as per standard IAPT procedure and the principal researcher input pre- and post-treatment measures as well as handling transcriptions of follow-up interviews in the quest to precisely analyse collated data. Moreover, two

independent researchers (IRR's) rated outcome measures and equally cross-examined qualitative interview transcripts in order to minimize bias and increase validity. This also served well in identifying risk (McLeod, 2010) throughout the project, via the initial screening appointment (conducted at pre-assessment), again at assessment (conducted at pre-treatment stage), throughout treatment via active listening and evaluation of participant responses and post-treatment, during the one-month follow-up interviews. This allowed the therapists and researcher to pinpoint any harm towards individual participants and others, so that this could appropriately be reported and managed, in accordance with NHS policies and procedures.

3.2.1 Informed Consent

University and NRES ethics (ref: 19/YH/0241) were obtained before commencement of the study. The researcher aimed to utilise a risk-analysis approach (Long and Johnson, 2007); all participants underwent standard IAPT assessment/screening in identifying risk and exclusion criteria via the Greater Manchester Mental Health Central Referral HUB. Ethical and consent issues were addressed according to organisational, NICE and EMDR Europe (Code-of-Ethics, 2018) policy and procedures during further assessment. Research and treatment procedures were also described and consequently participants had an opportunity to raise concerns/queries and withdraw from research if desired, within one month of being interviewed. Thus, consent was seen as an ongoing process throughout the case study design (Barnett et al, 2007; Grafanaki, 1996; McLeod, 2010).

The study was explained to the participants via the 'Participant Invitation Letter' (Appendix 12) alongside a written statement of the research aims, procedures and information about any potential risks, all contained in the 'Participant Information Sheet' (Appendix 13). Participants were encouraged to contact the researcher directly in order to be made aware of the research procedure and address any queries, after which informed written consent (Appendix 14) was requested from each participant, if they chose to participate. As per EMDR-Europe Ethics (2010), safeguards were put in place e.g. participants were made aware of the potential of

emergent hurtful case material and in turn, support resources via an information sheet (with relevant crisis service details) provided to them; 'Additional Support Service' details were also included in the 'Participant Information Sheet' for both written and verbal reiteration. Further, for ease of accessibility and to ensure equality, participants were presented with choice of the researcher verbally reading consent forms to them in cases of literacy issues. An original copy of the participant information sheet and completed informed consent forms were given to the participant, in addition to the original copy that was stored in the researchers file.

Equally, care was taken to ensure participants understood that this was a research project, not an extension of therapy hence the referral HUB/administrative staff would have no research-related therapeutic intent during their participation in this project. All participants maintained a copy of the researcher's details who they could consult/complain too regarding any issues derived from their involvement in the research project. Further, academic supervisor details were also outlined within the Information sheet as a means of additional contact.

3.2.2 Data Protection

Data protection was in alignment with IAPT organisational policy and procedure, at management discretion, to ensure accuracy of data collection and identify any potential risk and safety issues (e.g. forensic history, sensitivity of information, conflict of interest).

Confidentiality was paramount, including estates (e.g. therapy generally took place at the locality base or within designated NHS Health Centres/GP surgeries) whereby recorded measures (throughout the study) for each participant were kept on GMMH encrypted equipment within a lockable room or alternatively, an encrypted agile GMMH laptop. As outlined by McLeod, (2010) the sheer amount of personal data sought in case-study design as opposed to '*large n*' methodology raises issues of the

participants personal identifiable information becoming common-knowledge in the public domain hence permission was requested from participants for the follow-up interviews to be video-recorded and transcribed verbatim to which participants were allocated an alias to uphold their anonymity.

Equally therapist identity remained concealed to protect them from possibly challenging exposure of their work (i.e. in poor outcome cases) and also in an attempt to protect client confidentiality as acquaintances of a participant may have been informed of the identity of the client's therapist if he/she discussed this and thus assume the identity of the participant through deductive disclosure (Bond, 2004).

Likewise security of personal data, retention and disposal of the data were adhered too accordingly (in alignment with the GMMH Information Governance Policy, NHS, 2018 and General Data Protection Regulation 'GPDR,' 2018; an updated version of the Data Protection Act, 1998). To ensure paramount confidentiality, only the principal researcher and designated therapist were aware of the link between each individual participant (i.e. client identifiable information) and alias due to their permanent GMMH contract status in protecting the client's identity, whereas the two IRR's solely had access to participant aliases due to their external position.

Participants were made aware that the collection, storage and usage of data gathered was solely utilised for the purpose for which the participant's consent had been obtained. There was no unauthorised access, use or disclosure. Participants were made aware that the only exception to breaching confidentiality was if the participant disclosed risk to self, others or any criminal activity (e.g. money laundering, terrorism). Although, where possible the researcher would attempt to gain the participant's permission in appropriately divulging such information.

As per the Code of Human Research Ethics (BPS, 2014) participants were also made aware of their right to withdraw from the project at any time up to 1 month of being interviewed, during their participation without fear of reprisal. In consideration

of McLeod (2010), potential ethical issues in case study research, '*avoidance of exploitation or harm*,' heightened sense of suicidal ideation when exploring trauma were considered (a discussion was held with any participant deemed particularly unsuitable for EMDR phases 3-8). Safe practise was essential including a gauge of the participants general functioning and future behaviour (BPS, Risk Assessment and Management Paper, 2006); current incident, offence or risk behaviour, antecedents to risk behaviour, attitude towards risk behaviour, emotions and impulsivity, physical, medical and psychiatric factors, victim factors, self-neglect and negative coping mechanisms. Such a collaborative approach to service delivery was both cost and outcome efficient (Ridgely et al, 1998).

NHS National Research Ethics Service (NRES) approval was sought and gained alongside implementation of the above-mentioned bodies' codes of ethics. The importance of confidentiality was highlighted in both the information sheet and consent form hence participants were made aware that all information was subject to the GPDR (2018). The following points were highlighted in the invitation letter/sheet which was issued to the participants before commencement of assessment and treatment: assurances of anonymity and confidentiality, aims of the research project, how information was used and significance of gaining informed consent.

3.2.3 Sample

Variance in participant recruitment was questioned in terms of adding richness to design (e.g. one group seen in NHS IAPT settings and another in an alternative NHS IAPT service with utilisation of the same therapists) however this was too broad in terms of set-up timeframes in relation to ethics committee and resources (e.g. relevant therapists, HR checks, building/property allocation and availability, confidentiality and local assessment processes; not all Trusts followed the same assessment criteria/format which added inconsistency to results; INVOLVE, 2012) hence this study aimed to conduct research solely within GMMH Trust.

The sampling strategy was purposive, it related to the phenomenon of interest and in accordance with the research questions being addressed by the study (Kemper et al, 2003). The researcher aimed to create rich data so clarity in inferences and credible explanations could be concluded (Wisdom et al, 2011), generalisable to dissimilar settings or populations (please see Table 4). The principal researcher aimed for a heterogeneous sample in accordance with the TA (Braun and Clarke, 2006) approach. No exclusion was placed on gender or ethnicity although recruitment was exclusive to English speaking adult (aged 18-25) participants taken from NHS IAPT services, as child perspectives differ from those of adults, adding a new dimension to the research hence inclusion of younger participants would have been too great for the scope of this project. Also specifically those awaiting trauma-focused EMDR (up to 16-week) were invited as the researcher was mindful that the sample should be typical of the total set of units under investigation (Greenfield, 2002) and equally due to timeframes already set within IAPT in accordance with NICE Guidance, cost of travel, feasibility (clinic appointments catered as closely as possible to the participants home location to avoid drop-out), and diversity of those entering into such services. Correspondingly this approach allowed the researcher to consider specifically participants who had experienced the phenomenon under investigation (Parahoo, 1997).

Strengths included the varied demographics within IAPT which partially represented the whole populace (“Compared to London, Manchester has greater ethnic diversity in the sense that no one ethnic group exceeds 10 per cent of the overall population.” Census 2011), in terms of generalisability for future research. However, weaknesses included confidentiality of such sensitive information, it was envisaged clients would scarcely be willing to share such information for research purposes.

IAPT inclusion criteria was a further limitation; a sample of participants, both male and female, aged between 16 (generally when clients would enter IAPT) and 19 were initially proposed however upon consideration of client demographics within Manchester Central IAPT Services, this was later changed to participants aged

between 18-25 to ensure consistency in original research aim (working with adolescents/young adults) and ease of ethical approval.

Respectively, literature reviews, service demands/adherence, treatment fidelity, clinician feedback and training/CPD events led to the development of inclusion criteria for this study; participants must have a) experienced sexual trauma (as defined by the WHO, Consultation on Child Abuse Prevention, 1999) before the age of 16 b) exhibited trauma symptomology as identified by the baseline Impact of Events Scale 'IESR' measure (described in-depth below - used as an assessment tool and to measure change in trauma symptomology) c) reported that trauma symptomology was present for over three-months and primarily derived from pre-16 aged trauma d) been available for treatment-sessions on a weekly basis for up to 16-sessions e) have had good understanding of the English language to avoid language barriers/additional time spent with interpreters f) if taking medication, this would have been stable for a period of at least 2-months g) had EMDR as their sole treatment for trauma from baseline until follow-up to avoid conflict of interest (e.g. difference in underpinning theoretical models of therapy, such as the Humanistic school of Psychology promoting Person-Centred Therapy; Rogers, 1942) .

Certain additional criteria also applied in that "1.9.2.3 The duration of trauma-focused psychological treatment should normally be 8–12 sessions when the PTSD results from a single event" (NICE Guidance, 2018) however the researcher was mindful that many IAPT clients present as complex having suffered multiple instances of abuse over a prolonged period of time which may have required extended sessions (as was the case) "1.9.2.4 Healthcare professionals should consider extending the duration of treatment beyond 12 sessions if several problems need to be addressed in the treatment of PTSD sufferers, particularly after multiple traumatic events..." Hence, the need for up to 16 sessions, taking consideration of both NICE stating EMDR should "typically be provided over 8 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas" (NICE, 2018) and GMMH IAPT service guidance. Additionally, participants exhibiting significant psychiatric comorbidity, comorbid psychotic disorder, bipolar disorder type 1, alcohol

or drug dependence, acute suicide risk, pregnancy, acute PTSD from trauma within the past 6 months, trauma focused treatment within the past 3 months or scheduled to begin another form of trauma treatment, and those who were involved in current research or had recently been involved in any research prior to recruitment were excluded. However inevitable flaws in terms of reliability included day-to-day changes in human behaviour, changes in procedures in accordance with client presentations and cultural differences in participants (DePoy, 2005).

3.2.4 Sample Size

Further to carrying out the systematic review, a clear and realistic understanding of the amount of time and the complexity involved in carrying out such research was acquired, including the observation of service trends; a recent caseload survey (Verbist, 2019) indicated that a majority (66%) of clients were female with an overall mean age of 39.8; presenting issues had been reported as spanning between 2-5 years, with the modal frequency of problems ranging between 4-5 and only 16% having reported trauma symptomology hence a smaller than imagined sample was sourced. Also, since two therapists were proposed to work on this project, the understanding of service demands was crucial in consideration of their caseloads (e.g. part- or full-time). Hence the greatest approximate number of participants entering into this study would mount to one full-time equivalent caseload capacity (e.g. $n = 20$) to account one half of each of the two therapists caseloads so that provision was maintained for them to utilise the other half of their caseloads in adhering to IAPT demands in treating a varied populace, this sufficed to make data analysis manageable with the understanding that this research could then serve as a starting-point for a further, more in-depth study in the future.

Comprehensibly, although the systematic case-study methodology recommends a minimum of 3 participants (Chambless and Hollon, 1998; further collaborated by Boston University Medical Campus, 2021) in order for it to be deemed empirically supported, the recommended sampling size when exploring the phenomena

surrounding experience is six participants (Morse, 2000); though Guest (2006) indicates that thematic saturation is greater in a sample of twelve. The current study employed six, determined by participant availability and consent in consideration of subject sensitivity which falls within this range.

The TA model emphasises that interviews should aid the conclusions resulting from the data as opposed to hypothesising what cannot be reinforced by the data hence quality of data to obtain accurate insights was promoted rather than quantity of participants which was thought to generate data too artificial for practice (Becker, 2012). The aim of this research was to gain an accurate understanding of as many participants' therapeutic experiences as possible (Cresswell, 1998), within the allocated timeframe and mindful of accessible costs.

In sum, from literature learning (e.g. drop-out, exclusion criteria) and understanding of both systematic case-study design and the TA approach a minimum of six participants would have been a conventional estimate for interviewing to facilitate investigation of the mutual and exclusive manifestations of the intended phenomenon; and a maximum of twenty participants in consideration of financial and statistical service demands posed upon the designated therapists. However, ideally the study included as many participants as possibly able (Adler and Adler, 2012); six were employed with no drop-out.

3.2.5 Therapists (referred to as 'Therapist-1' and 'Therapist-2' in remainder of thesis)

Initially two therapists were planned to conduct treatment, the principal researcher and her colleague, both accredited EMDR therapists working within IAPT services and have a number of years Mental Health NHS experience (with Counselling and Psychology backgrounds); alongside aid of a Research Assistant (RA) to undertake data collection and analysis. However two therapists, from a differing team to the

principal researcher, unrelated to the research design were selected to provide an outsider perspective (Leedy and Ormrod, 2001), to conduct treatment to reduce therapist bias and add variance in approach (Falkenström, Solomonov, and Rubel, 2020; Thomas, 1973). Thus, freeing up the principal researcher to undertake the initial assessment appointments (at pre-treatment) and one-month follow-up interviews. Additionally, two IRR's were utilised in place of the RA who could not be employed for the above-mentioned reasons (namely, IAPT time constraints and contracting) to reduce therapist and researcher allegiance.

Moreover, to encourage consistency, difference in therapist technique was considered; this study employed two therapists with 5+ years of EMDR experience (and a core qualification of Clinical Psychology spanning over 10 years) to conduct treatment. Bias in approach was considered and therefore the standard 8-stage EMDR protocol (Shapiro and Forrest, 2004) was aimed to be conducted, with adherence to the 'EFRS' (van der Kolk, 2007). As per EMDR UK Accreditation-FAQ Guidance (2018, Online), both therapists received adequate clinical supervision on a monthly basis; group supervision of less than five supervisee's, from an external accredited EMDR Consultant working for GMMH.

As aforementioned although no treatment session recordings were taken due to subject sensitivity and in keeping with a 'naturalistic' study design, the researcher was aware that prior learnt therapy interventions (e.g. DBT, especially in cases whereby extensive preparation was required as seen in this project) may have usually been a regular feature in individual therapist style when conducting EMDR thus treatment adherence was addressed during monthly supervision sessions and via the use of the 'EFRS' (van der Kolk, 2007) in rating compliance with the EMDR treatment manual and in assessing level of therapist competence. Further, consistent supervision sessions were a chance to explore core therapy themes and issues covered in the session, the applied interventions/treatment approach and additionally any significant interim extra-therapy events which may have occurred between sessions in eliciting change. Thus, the position of the clinical supervisor

within this study was limited to evaluating treatment integrity, adherence and competence, consequently providing reliability and validity in results.

Accordingly, the designated therapists were briefed before commencement of research to understand guidance around the conduction of therapy as 'naturalistic' for the purposes of this project. This was used in understanding outcome data (e.g. what worked well/not so well each session in determining increase/decrease in scores and how this linked with the participants interview data).

Lastly, the issue of therapist bias in writing case reports has been an agenda item for case-study research for some time (Sieck, 2012) due to this being cautiously in favour of therapy however all case reports were written by the principal researcher as opposed to the allocated therapist, in compilation of both qualitative and descriptive statistics, and with addition of two IRR's. Also, minor demographic details (e.g. *geographical location and unique physical characteristics*) were amended in accordance with Sieck's (2012) recommendations, however the validity of the case description remained by ensuring the necessary cultural or 'internal' variables (e.g. *gender, ethnicity, and sexual orientation in establishing a client's internal experience*) were not compromised or inaccurate. An interpretivist position was taken to consider matters such as power dynamics, role, ethnicity between participant and the principal researcher, as well as socio-cultural and contextual considerations. Furthermore, member-checking (Cresswell, 1994; Yanow and Peregrine, 2006) was conducted to verify rich case records and interview data. Participants were invited to stipulate any amendments they would like the researcher to make to the rich case record before data to be utilised for research purposes and to be made publicly available.

3.2.6 Researcher Allegiance: Hermeneutic Single-Case Efficacy Adjudicated Design (HSCED) and Use of Independent Research Raters (IRR)'

In order to alleviate researcher allegiance, similar to Elliott's Hermeneutic Single-Case Efficacy Adjudicated Design (HSCED) (Elliott, 2001; 2002) two IRR's critically

reflected and re-analysed both qualitative and descriptive statistics (Iwakabe and Gazzola, 2009; McLeod, 2010) to form a thorough and plausible argument that the participant had/not changed as a result of therapy (Elliott, 2002; Stephen and Elliott, 2011). However, this may equally have been based on the subjective quantitative measures provided by the participant and their end of therapy interview, so may have been present in the data prior to its independent analysis by the IRRs.

The investigated HSCED research questions are generally conducted by a team of researchers however for this study they were deciphered with the two IRR's to alleviate research bias, as follows:

“Did the client change substantially over the course of therapy? Is this change substantially due to the effect of the therapy? What factors (including moderator (therapy) and mediator (client) variables) may be responsible for the change?” (Stephen and Elliott, 2011 p.231) – With the addition of one question for this study “Based upon cross-analysis of data what category would this case fall under; Positive Improvement, Moderate Improvement, No Improvement?”

In order to provide an affirmative verdict for each case based on the above questions, firstly each IRR was assigned the task of either identifying a case as ‘Affirmative’ or ‘Sceptic,’ after which rebuttals took place, as follows;

Affirmative Case

It was recommended that at least two of the following points were fulfilled in forming an affirmative case (evidencing constructive and substantial participant change resultant from therapy):

- 1. Changes in stable problems: client experiences changes in long-standing problems*
- 2. Retrospective attribution: client attributes therapy as being the primary cause of their changes*

3. *Outcome to process mapping: 'Content of the post-therapy qualitative or quantitative changes plausibly matches specific events, aspects, or processes within therapy' (Elliott et. Al, 2009; 548)*

4. *Event-shift sequences: links between 'client reliable gains' in the PQ scores and 'significant within therapy' events*

Sceptic Case

Formation of the sceptic case was founded upon a 'good-faith' claim querying the affirmative case, e.g. were positive changes characteristic of treatment via examining shortcomings in the rich case-record whereby counter-arguments exploring mediator/moderator effects could be conveyed to account for reported changes, with use of the following indicators:

1. *Apparent changes are negative or irrelevant*
2. *Apparent changes are due to measurement or other statistical error*
3. *Apparent changes are due to relational factors (the client feeling appreciative of, or expressing their liking of the therapist or an attempt to please the therapist or researcher)*
4. *Apparent changes are due to the client conforming to cultural or personal expectancies of change in therapy*
5. *Improvement is due to resolution of a temporary state of distress or natural recovery*
6. *Improvement is due to extra-therapy factors (such as change in job or personal relationships etc.)*
7. *Improvement is due to biological factors (such as medication or herbal remedies)*
8. *Improvement is due to effects of being in the research*

Rebuttals

After each IRR had identified the case as either 'affirmative' or 'sceptic' via the above quasi-legal method of cross-analysis, they switched roles in an attempt to provide counter-arguments hence both providing rationale, critique and defence for both the

'affirmative' and 'sceptic' assertions, resultant in a comprehensive and impartial verdict.

Consensus

The IRR's then issued their observations in relation to each case on the following pro-forma;

1. To what extent did the client change over the course of therapy? (rated on a scale of 0-100% at 20-point intervals)

1a. How certain are you? (rated on a scale of 0-100% at 20-point intervals)

1b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

2. To what extent is this change due to the therapy? (rated on a scale of 0-100% at 20-point intervals)

2a. How certain are you? (rated on a scale of 0-100% at 20-point intervals)

2b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

3. Which therapy processes do you feel were helpful to the client?

4. Which characteristics and/or personal resources of the client do you feel enabled her to make best use of her therapy?

(Stephen, Elliott and Macleod, 2011)

IRR consensus of case mediators/moderators and outcome verdicts were then returned to the principal researcher in the form of a written 'commentary,' which has been directly added to the results chapter.

3.2.7 Recruitment and Setting

This study was conducted within IAPT services to investigate results in terms of current knowledge and previous theory. Participants could self-refer or alternatively

clinician referrals were accepted, they were screened via the GMMH Central Mental Health Referral HUB whereby a standard therapist assessment protocol was undertaken via telephone to identify any risks, concerns and safeguarding issues, these were adequately ruled out before triage into IAPT services (a script was devised to discuss routine research practice however not used as participants opting into the study had already completed this stage and were on the IAPT waiting list).

At this stage, a research invitation letter, information sheet and consent form were posted to the potential participants (these included the researchers' details in case of further queries). As customary practice within IAPT settings consents were taken over the phone, this included consent to pass potential participant details onto the principal researcher by administrative staff.

A more in-depth assessment via the principal researcher was conducted with those who showed an interest in the project and research conducted once enough participants had opted in/consented and in keeping with allotted timeframes. Treatment and research procedures (those enlisted in the 'Participant Information Sheet' and the processes for entry and recruitment onto the project) were further discussed during assessment. Pre-treatment consent was double-checked, and confidentiality was also explained to ensure anonymity and consistency in answering any questions/queries potential participants may have had. Note that the in-depth assessment and entry onto the project was subject to adherence of the *Impact of Events Scale-Revised 'IESR' and Dissociative Experiences Scale 'DES'* (as described in the 'Research Design' section), alongside relevant inclusion and exclusion criteria (as outlined in the 'Sample' section of this chapter). Any participants unfit for research were directed to appropriate alternative IAPT or non-IAPT services; advocacy, education and medical services, as required. Equally, concerns regarding subject sensitivity, and any perspective distress caused by the treatment process were discussed during this stage; participants were made aware that there would be no pressure in participation and that their treatment would not be affected, should they have chosen to opt out of the study. Such issues were periodically checked by therapists throughout the project and all participants had

contact details for the principal researcher, academic supervisors and administrative staff, in case they felt more comfortable speaking to someone external to the project.

Once participants had successfully entered into the study, they were allocated a therapist (one of two working on this project) dependent upon their residence and locality of treatment venues. All treatment and follow-up interviews were conducted at a mutually convenient time and location, often centrally based health centres or GP surgeries to reflect real-world IAPT clinical settings. Treatment rooms were adequately safe and secure in that panic alarms fitted and security on site to provide assistance if required, as well as health-related equipment (e.g. defibrillators, first aid kits etc). Therefore, the University and GMMH 'lone worker' policies were unnecessary as participants did not undertake any aspect of treatment or follow-up away from a fully resourced environment (i.e. in participants own home). Further, administrative staff had full access to the research therapists' appointment list and designated reception staff were also aware of the whereabouts and time of each appointment. Contact details for the therapists' clinical supervisor, line manager and fieldwork supervisor (also allocated Service Clinical Lead) were equally at hand should issues of risk and such-like have arisen.

Regarding conduction of treatment, adherence to the model was covered by following the standard 8-stage EMDR protocol via use of the EMDR Fidelity Rating Scale 'EFRS' (van der Kolk et al., 2007). Being mindful of disruption to the therapeutic alliance, participants undertook/experienced routine EMDR, reflective of 'naturalistic' IAPT settings. No video or audio recording of sessions was permitted as this would have added variance in the participants experience (e.g. perhaps apprehension) and consequently to results.

In conjunction with the present 'naturalistic' routine-practice based study, it was essential for therapists to conduct themselves in a 'therapy as usual' format however due to the pressure of treatment critique and allegiance to their therapy technique, changes in their behaviour from that of 'standard practice' were inevitable in an

attempt to 'produce positive results' hence this point was addressed in the therapist and supervisor debriefing (verbal and email communication) in order to ensure that the therapy was delivered as 'naturally' as possible.

3.3 RESEARCH DESIGN AND CHOICE OF MEASURES

The focal point of this project was to examine aspects related to beneficial and unbeneficial outcomes of therapy; and, to investigate the efficacy of EMDR via clinical case study research. The current systematic case study project methodology was based on the use of (a) two IRR's for validity and reliability of utilized of descriptive statistics via outcome measures following the structure of the Hermeneutic Single-Case Efficacy 'Adjudicated' Design (Elliott, 2001; 2002) and (b) richness of qualitative data in identifying key positive and negative aspects of the therapy process, evaluated and associated to one another, using the TA approach (with elements of Elliott's, 2010 'Qualitative Helpful Factors' design), in developing conclusions in terms of the outcome and meaningful factors of the therapy.

This systematic case series analysis was undertaken using repeated outcome measures with a non-experimental design, non-manipulation, randomisation or control group as influenced by Chambless and Hollon's (1998) seminal paper defining criteria for empirically supported therapies. Individual change was addressed through a single-subject design (Baseline; Treatment; Follow-up) with a "*small n*" sample derived from NHS GMMH IAPT services as to ensure consistency and remain within ethics, timeframes (e.g. compliant with NICE guidelines and GMMH policy). Due to the diversity of participants within IAPT services, variance in results was envisaged (Rose, 2013). Data from qualitative interviewing, with aid of descriptive statistics via outcome measures, were utilised to identify outcomes to therapy and the process of change.

3.3.1 Therapist Adherence Measure

The EMDR Fidelity Rating Scale 'EFRS' (initially developed by van der Kolk et al, 2007) was employed to assess quality adherence to the EMDR standard eight-phase treatment approach (Shapiro, 2001; 2017) in addressing distressing memories of adverse life experiences or current triggers. The EFRS was the measure of choice for research purposes due to its efficacy when working with trauma symptomology (Watts et al, 2013; WHO, 2013). This was assessed by an 'EMDR Consultant Rater' (ECR - an EMDR Consultant, different to the therapist's allocated EMDR Consultant clinical supervisor), to address issues of bias in research and in specifically evaluating the clinician's fidelity of the standard protocol.

As recommended (EMDRIA, 2019) the most updated version of the EFRS (2: Korn et al., 10/01/2018) which incorporates continued feedback from clinicians, raters, and researchers was used in this study, inclusive of the EFRS Scoring Workbook, *'which contains an embedded calculator that automatically calculates (1) scores for each session, (2) a therapist's overall fidelity, and (3) the overall fidelity for a research study.'* This delivered analysis of treatment mechanisms, and gauged "acceptable" adherence via a rating system, ranging from 0 (No Adherence) to 3 (Very Good Adherence), with a cut-off score of 2.0 for acceptable fidelity. From this a 'Study Fidelity Score' was produced to evaluate both *'Single Session and Three-pronged Protocol Fidelity Scores'* for each case study.

The EFRS was originally developed for utilisation in a study by van der Kolk et al. (2007), however was updated to "Version 2" in 2018 (Korn et al.) following feedback from researchers and raters regarding the assessment of EMDR sessions, regardless of clinical presentation, whereby the standard protocol and the three-pronged protocol are delivered to work on imagery or present triggers. As recommended via the EFRS manual (Korn et al, 2018), unfortunately, a practice run of client work in conjunction with the EFRS was unable to take place due to the limited research timeframe, however prior discussions/email communication was conducted and additional time (15mins) following individual sessions allocated for unexpected participant crises (e.g., suicidal behaviour/plan, psychosis, dangerous social situations) and EFRS write-up. Equally, all unscheduled contact (e.g.

insignificant telephone calls between treatment sessions) did not form part of the fidelity rating.

Clinicians were also briefed on the completion of the *Single Session Summary* 'SSS' (each session to indicate what treatment was provided) and *Treatment Plan Tracking* 'TPT' (initially completed during History-taking and Treatment Planning, updated at the end of each session to document the individual client's presenting issues and associated past, present, and future targets and when these were addressed throughout their treatment) forms to "enhance the accuracy and consistency of an intervention [and] to ensure it is implemented as planned and that each component is delivered in a comparable manner to all study participants over time" (Smith et al, 2007, p.122). Both forms worked in conjunction with one another to inform the independent 'EMDR Consultant Rater' (ECR - an accredited EMDR Consultant, external to the study) about missing data e.g. if the clinician had not noted a clinical decision within the TPT form (e.g. lack of Body Scan), this resulted in a "No Adherence" score within the relevant section however the ECR had access to the SSS form, therefore this information could be checked and appropriately questioned (e.g. insufficient time to carry out this activity) and thus scored correctly.

Although observational procedural fidelity is highly recommended (Ledford and Gast, 2014; Johnston and Pennypacker, 1993), in the absence of sessional audio-video recording in keeping with the 'naturalistic' study design and apprehension of drop-out in consideration of the already limited sample, the ECR (Consultant EMDR Rater; employed from a differing Mental Health team across the district) formed judgment on individual session and three-pronged treatment fidelity via both the SSS and TPT forms (completed as research therapists self-evaluation whilst utilising the EMDR manual) and rated in conjunction with client self-report outcome measures for quality assurance purposes (Miller and Rollnick, 2014). It must be mentioned that clinicians selected for this study continued ongoing supervision with their allocated EMDR Consultant so that they had the opportunity to address any arising issues (i.e. risk, safeguarding), appropriately. The ECR completed one EFRS Scoring Form for each SSS or TPT form that she evaluated, before entering these ratings into one or more (when x10 or more treatment sessions were completed with that said participant)

EFRS Scoring Workbook/s. *The Study Fidelity Score is the mean of all the Single Session and Three-pronged Protocol Fidelity Scores in all study workbooks. If the Study Fidelity Score is 2.0 or greater, the study is deemed to have “Acceptable Fidelity.”* (Korn et al, EFRS Manual, 2018)

In keeping with the van der Kolk et al. study (2007), inclusion of at least 10% of sessions per clinician and session type (e.g., INTRO, ALE, RDI, FT) were selected for review in the fidelity assessment. For instance, in the current study 16 EMDR treatment sessions could be provided to 6 participants, for a total of 96 sessions. Two clinicians each treat 3 participants and thus were able to provide 48 therapy sessions each. Thus, the researcher would randomly select 10% (n=9.6; rounded up to the nearest whole number, 10) of the overall session recordings for subsequent rating, with 5 from each clinician. Importantly however due to the limited sample size, lack of session recordings and possible missing data (e.g. issues with memory retention in recording absolute session content), as suggested for case-study design (EFRS, 2018, p.48) a more thorough analysis was required. Hence, the ECR examined the information provided on all the SSS forms (to account for “...different phases of treatment” (Borrelli, 2011), for instance, the INTRO, RDI, ALE, and FT subscales), for a given participant along with the information documented on the TPT form, to optimise generalisability of results throughout treatment and amid clients (Gresham, Gansle, and Noell, 1993).

Clinicians and participants used anonymous identification numbers; all completed SSS and TPT forms were then securely emailed to the ECR for evaluation before workbooks in which fidelity ratings were recorded, were arranged.

3.3.2 Participant Measures

Participants were required to enter IAPT assessment and treatment (approximately up to x16 EMDR therapy sessions at 60-90mins each); alongside this the below outlined supplementary qualitative interview at one-month follow-up and descriptive statistics via outcome measures at specified times throughout treatment were

administered. However, although standard IAPT tools (IAPT Toolkit, 2008), both the IAPT Phobia Scale 'IPS' to measure levels of phobia and the Work and Social Adjustment Scale 'WSAS' to measure levels of anxiety in work and social settings were both deemed unwarranted for use during this study as they did not yield specific trauma stress response data in identifying the efficacy of EMDR and also in consideration of possible participant burnout in completing redundant measures. Hence, these were excluded and replaced with specific measures (please note, both the IAPT 'PHQ9' to measure depressive symptoms and 'GAD7' to measure anxiety were included as these were highlighted as common symptoms of trauma as part of the literature review and hence, most appropriate of all IAPT measures in determining the emotional and behavioural effects on survivors of CSA), selected and implemented during certain stages to evaluate change (Galovski et al, 2005) in the following areas as not to overload the participants any more than the routine IAPT procedure:

Baseline measures: DEScale (Appendix 18, dissociation screening tool, conducted before treatment), IES-R Scale (Appendix 19, gauge level of PTSD symptomology and assesses the *DSM-5* symptoms of PTSD, conducted pre- and post-treatment)

Neuropsychological functioning: The Psychology Experiment Building Language (PEBL) Battery Test (conducted at only baseline and planned to be conducted post-treatment session as not to inundate participants, in the absence of conduction during numerous timepoints throughout treatment due to time constraints. However, this was not completed at post-treatment also due to COVID-19 restrictions. Though, the WPS-CR (Appendix 20) was conducted every session and one-month follow up interview questions were adapted to monitor relevant changes in memory, attention and executive functioning, as described below, as a means of validating this aspect of the project)

Emotional and Behavioural functioning: the IAPT GAD-7 and PHQ-9 (Appendix 21), WPS-CR (all of which were conducted on a sessional basis) and Rosenberg

Self-Esteem Scale 'RSES' (Appendix 22, conducted at baseline and post-treatment session)

Quality of Life: Valued Living Questionnaire 'VLQ' (Appendix 23, conducted before each session)

Outcome/evaluation: Qualitative Interviewing with use of adapted HAT form regarding client perspectives of therapy (Appendix 24, conducted at one-month follow-up)

Please find in-depth details of measures below.

3.3.2.1 Baseline Measures

All baseline measures were conducted during a standard IAPT assessment session; a semi-structured interview to establish presenting problems (e.g. underlying anxiety, depression, psychotic disorders etc) and significant information regarding participant history of abuse. This was undertaken before initial referencing of participant medical records via use of GP and Secondary Care I.T. systems to highlight any prior or current instances of risk (i.e. suicidal ideation, harm to self or others), service involvement (e.g. CAMHS or Community Mental Health Team 'CMHT') and forensic history. This information was double-checked against the current IAPT I.T. system to ensure no previous instances of therapy had taken place and if so, what these consisted of and why (e.g. were they related to the current therapeutic work and what was the outcome of screening, would this affect current treatment). Individual participant data acted as a general understanding of the participants circumstances, level of disclosure and most importantly, their needs in order to cater treatment. Research specific measures were undertaken at baseline, as follows:

Dissociative Experiences Scale 'DES' (Bernstein and Putnam, 1986 and Sidran, for Children/Adolescent use)
(Conducted as an assessment tool, at baseline, to gauge levels of PTSD symptomology, according to DSM-V (2013) criteria)

The DES scale screens for particularly Dissociative Identity Disorder (Multiple Personality Disorder) and Other Specified Dissociative Disorder (Bernstein and Putnam, 1986). Only 1% of people with Dissociative Identity Disorder have scored below 30 and a majority of those scoring above 30 have exhibited trauma symptomology alongside specific symptoms of dissociation (e.g. amnesic barriers, depersonalisation, derealisation) (ISSTD, 2011), with the average DES score in research being 36 (Carlson and Putman, 1993).

As determined through IAPT service themes a majority of clients score approximately or above 30% suggesting clinical dissociation however high scores do not necessarily indicate greater severity in dissociative disorder as the DES measures both normal and pathological dissociation (Carlson and Putman, 1993: 18). Hence in such cases, within the present study the named clinician was able to undertake a clinical interview, requesting examples of specific participant experiences that they may have questions answered 20% or more of the time, before making a decision (in consideration of the participants additional outcome measures and overall clinical presentation) regarding onward referral to whichever NHS or third sector clinical pathway may have been most suitable, whereby symptoms could further be explored via the DES-Taxon (Waller, Putnam, and Carlson, 1996, Waller and Ross, 1997), if required.

Impact of Events Scale-Revised 'IESR' (Weiss and Marmar, 1997)
(Conducted at baseline and pre-treatment)

22-item self-report measure to evaluate impact of sexual abuse in terms of traumatic stress, abuse attributions and social reactions. For the present study, a sensitive

measure of the impact of sexual abuse from the participants perspective was needed such that it could detect change within an individual throughout treatment.

The IESR is a revised version of the older 15-item IES (Horowitz et al, 1979) hence includes seven additional items in relation to the hyper-arousal symptoms of PTSD, which interlink with 14 of the 17 DSM-IV symptoms of PTSD. Participants were asked to rate their level of distress in relation to their traumatic history (as many of the survivors had experienced multiple trauma) on a 5-point scale ranging from 0 (“not at all”) to 4 (“extremely”), ultimately providing the researcher with a total score (ranging from 0 to 88). From this, subscale scores were calculated for ‘Intrusion, Avoidance, and Hyper-arousal.’ Weiss and Marmar (1997) recommend utilisation of mean scores rather than raw sums for each subscale in order to compare with scores from the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994).

For this study, the IES-R was not used to diagnose PTSD, rather capped scores were used for an initial understanding of trauma symptomology and gauge of participant eligibility onto the study, and any changes in trauma symptoms at post-treatment. Any score equal to or greater than 33 on the IES-R was considered as IAPT caseness (NHS England IAPT Manual, Appendix D, 2018) and was evaluated and taken under the therapists clinical discretion alongside adequate supervision guidance in terms of suitability within IAPT or alternatively, appropriate onward referral.

3.3.2.2 Neuropsychological Functioning

The Psychology Experiment Building Language ‘PEBL’ (Mueller, 2010; Mueller, 2012; Mueller and Piper, 2014) battery test software (Conducted at baseline and planned to be undertaken at post-treatment however unable due to COVID-19, originally would have been conducted at numerous time-points throughout treatment however this was also not possible with IAPT time constraints. Baseline results were included in data as they interconnected with specific questions on the WPS-CR measure and hence progression in these domains could be analysed in accordance with such data.)

More intrusive methods of neuro-analysis were initially planned (e.g. brain imaging) however due to invasiveness and time restrictions, delivery was not possible within IAPT. For instance, originally the alternative 'Automated Neuropsychological Assessment Metrics 'ANAM' (Cernich et al, 2007) would have been implemented however adaptation due to time-restrictions in application within IAPT and also based on adherence of conduction qualifications (e.g. administrator or supervisor must be educated to post-doctoral level) caused barriers in use.

Alternatively, both the E-prime and Gorilla (2018) software packages were explored however although the Gorilla sample tasks could have been used in terms of their programming, they would likely need updating in terms of trial numbers, stimuli etc causing barriers in research due to limited Dprof timescales. Likewise, E-prime presented as a software solution for creating experiments however a pre-built database of tasks was not provided hence these would need to have been created or searched for online thus presenting complexity in installation and loan of an NHS USB licence key. Hence, it was apparent that PEBL would provide the widest variety of pre-built tasks for this project.

The PEBL is an electronic neuropsychological battery utilised to monitor adaptations in participants' neuropsychological functioning. There are a number of peer-reviewed publications and conference papers (Publications Citing PEBL, 2018) citing PEBL as a reliable and valid means of measurement. Subtests were carefully selected in consideration of prospective clients' cognitive ability, prior research-use of subtests and IAPT time constraints in administration of each test, these will be described in terms of research aims as follows:

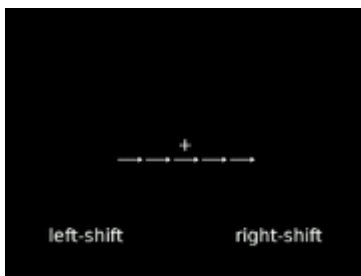
PEBL Attentional Network Test (PANT) – Based upon Fan et al. (2002) Attention Network Test (ANT), it is designed to assess alerting, orienting, and executive attention. This took approximately 40-60 minutes to administer in order to evaluate all three categories of attentional processes.

Alerting is formed by a signal that contains no information regarding where the target will occur, below or above the fixation point in order for attention to remain dispersed

across the two possible target sites. Orienting is produced by a spatial cue that suggests where the target will be designated. Conflict is induced by flankers surrounding the target that are incongruent with the target.

The task was to press the right-shift key <rs> if the central arrow pointed rightward and vice versa (<ls>). The target arrow was surrounded by flanker arrows that either pointed in the same direction (congruent) or the opposite direction; hence involve conflict resolution processes (incongruent).

FIGURE 3: A SCREEN SHOT OF THE PEBL ANT TASK



One of four cue conditions was presented before the target:

- a) Uncued (no cue)
- b) Centre cued (a single central cue)
- c) Top-bottom cued (double cue)
- d) Direction Cued (spatial / a single cue at the location of the upcoming target)

Each trial began with one of the above cue conditions; the cue was then followed by a congruent, incongruent, or neutral (the middle arrow is flanked by two lines on either side) stimuli. Subtractions to measure each attentional network were automatically calculated via the PEBL software:

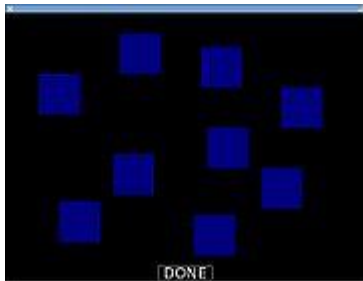
Alerting = uncued rt – top-bottom cued rt

Orientating = centre cued – direction cued

Conflict = incongruent target – congruent target

PEBL Corsi Blocks Test (PCBT) – A traditional spatial working memory task. A set of blocks drawn as boxes on a computer screen were displayed before participants and they were asked to remember the order in which the blocks were “tapped” (shown as changing colour). Following a sequence of “taps,” participants repeated the order by clicking on the boxes with the mouse. One box at a time changed colour for a duration short enough to deter the use of idiosyncratic coding strategies (e.g. guessing patterns/themes, numerical coding of box locations). One practice trial followed by a series of forward span complete trials with progressively lengthier taps were completed by each participant, results hoped to indicate the average completed block span and overall short-term memory score for each participant.

FIGURE 4: A SCREEN SHOT OF THE PEBL CORSI BLOCK TEST



A common variant is backward span which is available by setting the direction parameter from 1 to -1 via the PEBL software launcher dialog however this was not set as default in the PEBL software and hence unutilised in this study to avoid complexity in data as this has been questioned in its use to examine working memory deficits (Kessel et al, 2008; Mammarella and Cornoldi, 2005; Cornoldi and Mammarella, 2008) and additional time spent on test conduction due to restricted IAPT appointment timeframes and as one is not thought to be more difficult than the other. Thus, the functioning of visuospatial short-term working memory via the Corsi forward span (Monaco et al, 2013) will be solely evaluated, with both the inter-stimulus and time between trials set at 1000ms. This test is built upon research from

both Corsi (1972) and Kessels et al (2000) and took approximately 10 minutes to administer.

PEBL Iowa Gambling Task (PIGT) – Both this test built for adult/advanced users and the ‘Hungry Donkey Task’ built for child/basic users were trialed to identify whether client cognitive ability would be most suitable to conduct; the ‘Hungry Donkey Task’ focused on decision making skills as described in Crone et al. (2004) research and is based upon the adult Bechara et al. (1994) “Iowa Gambling Task” however this seemed condescending hence, the original adult version “Bechara’s Iowa Gambling Task” was utilised in accordance with the sample age range and cognitive ability.

Although initially a manual version of this task was developed by Bechara, Damasio, Damasio, and Anderson (1994), for this study a computerised version of the Iowa Gambling Task was employed (Bechara et al, 1999; Bechara, Dolan, and Hindes, 2002; Crone, Vendel, and van der Molen, 2003; Suzuki et al, 2003) via the PEBL software. In this procedure, subjects were given \$2000 to begin, they then chose one of four decks of cards with use of a mouse-click, prolonged playing of some decks was resultant in general financial loss, whilst playing other decks was resultant in small but consistent gains; they read the outcome on the screen which varied depending on whether the trial was a ‘win’ or a ‘loss,’ and this was reflected via a bar chart on screen.

FIGURE 5: A SCREEN SHOT OF THE PEBL BECHARA’S GAMBLING TASK



The monetary gain/loss structure matched that of the original Iowa in Bechara et al. (1994). ‘When 100 cards have been selected, the task is complete. Unlike the real-world version, the deck is just rotated on each draw, so that the top card moves to the bottom of the 40-card deck, and so the sequence will repeat after 40 cards in the

original order, rather than becoming exhausted after 40 draws.’ (PEBL Sourceforge, 2018). This took approximately 10-15 minutes to administer.

As displayed in the results chapter, the 100 card selections from the original gambling task (Bechara et al, 1994), was split into five blocks: 1–20, 21–40, 41–60, 61–80, and 81–100 in order to determine the payoff (net outcome) and sensitivity to loss frequency via use of the Stocco, Fum, and Napoli, (2009) scoring technique; this was done by subtracting the number of draws from bad decks from the number of draws from good decks (e.g., (Deck C + Deck D) – (Deck A + Deck B). The aim of the task was to establish whether participants learnt to choose good over bad decks, through process of trial and error. In each stage, a net score below zero implied that subjects were choosing disadvantageously, and vice versa.

3.3.2.3 Emotional and Behavioural Functioning

Generalized Anxiety Disorder 7 ‘GAD-7’ (Spitzer, et al, 2006)
(Conducted each therapy session)

Standard IAPT tool to measure levels of anxiety. Initially the Multidimensional Anxiety Scale for Children ‘MASC’ (March et al, 1997) self-report measure would have been adapted for use with adolescent/adult participants however the GAD-7 worked well in widely assessing anxiety symptoms and as a means of comparison between anxiety functioning throughout treatment and individual emotional and behavioural functioning. This was also already in place within IAPT settings hence replication seemed irrelevant.

Participants were asked to rate their level of anxiety on a 7-point scale ranging from 0 (“not at all”) to 3 (“nearly every day”), in selecting a response from a multiple choice of four answers per each of the seven questions, the researcher was provided with a total score (ranging from 0 to 21). The higher the score, the greater the anxiety.

Patient Health Questionnaire 9 'PHQ-9' (Kroenke, Spitzer, and Williams, 2001)

(Conducted each therapy session)

Standard IAPT tool to measure levels of Depressive symptoms. Initially the Children's Depression Inventory 'CDI' (Kovacs, 1992) would have been adapted to meet adolescent/adult participant needs however the PHQ-9 worked well as a measure of depressive symptoms and in comparison, of individual emotional and behavioural functioning. Again, this was already in place within IAPT for ease of access.

Participants were asked to rate their level of depression on a 9-point scale ranging from 0 ("not at all") to 3 ("nearly every day"), in selecting a response from a multiple choice of four answers per each of the nine questions, the researcher was provided with a total score (ranging from 0 to 27). The higher the score, the greater the depression.

Weekly Problems Rating Scale (original WPS-C child version founded by Sawye and colleagues, 2004-2006 was exchanged for the revised version, WPS-CR child-revised version as per Project SAFE, Wilson, 2009, with the addition of three questions (in absence of the PEBL being conducted numerous times throughout and at post-treatment due to primarily COVID-19) to measure daily neuropsychological functioning, wording was slightly adapted for questions 1-11 and questions 12-14 were erased on this measure to reflect the young adult 18-25 year old sample as oppose to the 12-17 year old sample this tool was intended for use with)

(Conducted each therapy session)

The WPS-CR is a valid means of repeated assessment with good internal consistency and temporal stability (Sawyer et al, 2006), consisting of 11 statements that participants were requested to rate in order to describe their feelings and interactions during the past week to gauge general emotional and behavioural

functioning from the participant's perspective. As outlined above, this measure was revised, with the addition of three items specifically relating to the neuro-PEBL aspect of this research; assessing attention "I have trouble paying attention", memory "I am forgetful", and executive functioning "I have trouble planning ahead and following through on tasks" to verify biological cogency and enhance ecological validity in the assessment of neuropsychological functioning in the participants personal environment. Answers for all questions were from a choice of the following statements: "never" "almost never" "a little of the time" "some of the time" "most of the time" "all of the time." Generally, the more negative the selected statement, the greater the indication of issues in functioning within that given domain.

Rosenberg Self-Esteem Scale 'RSES' (Rosenberg, 1965)
(Conducted at baseline and post-treatment)

The 10-item RSES measured global self-worth by measuring both positive and negative feelings about the self. This scale has been utilised in many settings and variance in languages and although studies such as Beeber et al. (2007) and Farruggia et al. (2004) suggest a low item-total correlation of 0.23 for the negatively worded item "I wish I could have more respect for myself;" Marsh, Scalas, and Nagengast (2010) indicated that the RSES is a uni-dimensional model with transient method effects, whereby two strategy approaches are utilised in the method effects through association between the positively worded items and/or the negatively worded items (Marsh and Grayson, 1994), namely the latent method factor (LMF) strategy and related uniqueness (CU) strategy (Bagozzi, 1993).

A more recent Thai comparison study (Wongpakaran, 2012) of reliability and construct validity between the 'original' and 'revised' versions of the RSES, suggested of equilibrium between the two in their high levels of reliability however slightly greater construct validity in the revised version. For this study the original version was used due to the researchers' previous experience in its administration and reading of results as to maintain consistency.

Participants were asked to rate their level of self-worth by measuring both positive and negative feelings about the self. All 10 items are answered using a 4-point Likert

scale format, as follows: “Strongly Disagree” 1 point, “Disagree” 2 points, “Agree” 3 points, and “Strongly Agree” 4 points,’ ultimately providing the researcher with a total score (ranging from 10 to 40). Higher scores indicate higher self-esteem.

3.3.2.4 Quality of Life Issues

*The Valued Living Questionnaire ‘VLQ’ (Wilson and Groom, 2002)
(Conducted each session)*

The VLQ is an instrument that taps into 10 valued domains of living. A recent study (Cotter, 2011) outlined findings which supported the ‘general reliability and validity of the VLQ for use with normative and distressed collegian samples.’ Likewise numerous similar studies have been conducted, including (Wilson, Sandoz, and Kitchens, 2010) undertaken to deliver preliminary consideration of the reliability and validity of the assessment of valued living, or the level to how an individual’s behaviour connects them with their values, as defined in Acceptance Commitment Therapy (ACT), again results were indicative of its ‘internal consistency, stability over time, and its relationship with theoretically relevant outcomes.’

Scoring: respondents were asked to rate the 10 areas of life on a scale of 1 (not at all important) –10 (extremely important), indicating the level of importance and how consistently they had lived in accord with those values in the past week, ultimately providing the researcher with a total score (ranging from 10 to 100).

3.4 QUALITATIVE INTERVIEWING

*Helpful Aspects of Therapy ‘HAT form’ Interview (Llewelyn, 1988)
(Conducted at one-month follow-up, as initially a three-month follow-up time was planned following literature review findings, however this was queried at ethics board. It was thought that three months may have been disadvantageous for participants as they may have needed to engage in alternative treatments in the interim, between their final therapy session and*

the interview. As no alternative therapy engagement was an inclusion criterion of the current study, a more appropriate one-month period was agreed.)

Following consideration of the Client Satisfaction Questionnaire (Larsen et al, 1979), and the CORE (Cooper, 2018) an alternative qualitative measure was conducted to add variance in research via a semi-structured interview at one-month follow up. The first seven questions of which utilised an adapted version of the HAT form to identify helpful/unhelpful aspects of therapy, the eighth question specifically focused on changes in neuropsychological factors, consistent with the PEBL assessment and WPS-CR measure, especially useful in absence of PEBL-post-treatment scores due to COVID-19. The final three questions concentrated on ending and any recommendations for treatment.

Although the follow-up interview was based upon the HAT Form, this could not be utilized as an evaluation of each session as formerly intended by its originator (Elliot, 2010) due to service time constraints in accordance with the conduction of additional participant measures. Hence the researcher utilised this as a one-off semi-structured interview, the Likert Scale was removed as this did not fit with the TA approach as applied within this project. Instead, there were an addition of four questions to (a) evaluate the progression of therapy as a whole and (b) add richness in results. This was a means of obtaining an inclusive perspective, whilst aiding empathic consideration of the participants broader understanding of their therapy experience, as opposed to the researcher's opinion. Hence, such semi-structured interviewing is thought to be the most suitable manner in which to acquire valuable therapeutic accounts (Broadbent, 2013).

Equally the counterbalance between questions utilised in the HAT interview, outlining details of both 'helpful' and 'hindering' aspects of therapy were thought to foster reduction in bias which is something the researcher was appreciative of as it allowed participants to explore a broader perspective of their experiences. Likewise, this addressed her own optimistic beliefs about EMDR and her questioning of the positivist absolute of evidence-based practice, largely pertaining descriptive statistics via outcome measures are thought to produce inevitability without contemplation for validity (Proctor, 2015). Although bias cannot be completely eradicated, the contrast

in these views helped the researcher form a more balanced view of the research stance and therefore fortified leadership in conduction of the project, consequently assisting her in alleviating any possible bias. This approach supported her in identifying underlying assumptions which were investigated against emerging themes and individual judgements throughout the study.

3.5 IMPACT OF COVID-19 ON THE RESEARCH DESIGN

There were slight changes to the methodology of this project due to the coronavirus pandemic, which unfortunately occurred mid-way through this study. The British Prime Minister (Boris Johnson) during the Daily No.10 COVID-19 Briefing (22/03/20) introduced measures ('lockdown') in an attempt to reduce transmission whereby British citizens were advised to stay at home except for 'essential travel.' In terms of work, Matt Hancock (the Health Secretary, 24/03/20) further added that individuals could, travel to or from work, only if this could not be done from home. In light of these announcements, NHS IAPT services nationally began to roll out software to accommodate online therapy. GMMH Trust IAPT management, in which the current research took place, released guidance and cascaded email recommendations to carry out therapy via online means i.e. Microsoft Teams (MS-Teams) software (25/03/20, Outlook). Migration of MS-Teams took place on 26 March 2020 (McMonagle: email) and a series of webinars to instruct users for use of MS-Teams within IAPT were rolled-out on 1 April 2020 (McMonagle, 30/03/20, Outlook). However, understandably not all research participants opted for this approach, for various reasons highlighted in the rich case records, and some tried however retracted from this medium, finding it a strange and uncomfortable experience; hence, instead reverting back to telephone sessions which unfortunately did not allow for EMDR BLS to take place. Though management advice throughout COVID-19 (from March 2020 onwards) for any client opting for only 'in person' sessions had been to work towards discharge and re-referral after the pandemic, both research therapists within this study ended EMDR sessions for such participants and provided support phone calls in the interim (data is included in the current study), until ending.

However, Dominic Raab (the Foreign Secretary) during the Daily No.10 COVID-19 Briefing on 16 April 2020 informed the British public that lockdown measures in the UK would continue for “at least” another three weeks as to avoid harming public health and the economy. Following this announcement, the decision was made to carry out all post-treatment measures and interviews for those that had opted out of online EMDR therapy and were receiving only telephone support sessions, as it could not be determined when the normality of ‘in person’ sessions would resume, especially as the UK had entered a second lockdown on 5 November 2020. As per management advice, three clients opted for discharge and self-referral following the end of the first lockdown (which was anticipated to be outside of the timeframe for this project).

3.6 COMPOSING RATIONAL SYSTEMATIC CASE STUDIES

Upon retrieval of measures and interview data the researcher initially wrote up a comprehensive description of the participant, inclusive of appropriate demographic details, history, diagnostic symptomology and a presenting issues narrative established upon descriptive statistics via outcome measures and the therapists sessional therapy notes (e.g. main themes derived from sessions, employed interventions and theoretical analysis of the session and/or case). In the absence of sessional audio-video recordings, the therapist adherence measure (EFRS) was cross-checked with treatment notes to ensure a rational and precise illustration of the participant and therapeutic change process was preserved.

Secondly, interview audio-recordings and transcripts were analysed by the principal researcher (and both independent raters and the academic supervisors to reduce bias) in conjunction with the TA approach and grouped into relevant themes. Both descriptive statistics and qualitative interviews were independently rated by two researchers external to the study (complaint with HSCED) and EMDR approach.

Upon completion of write-up, case-studies were member-checked (Cresswell, 1994; Yanow and Peregrine, 2006) thus cross-referenced by the individual therapist and corresponding participants themselves to ensure accuracy and transparency, before

verbal consent was obtained to make these publically available for research purposes.

Chapter 4: Results

Individual rich case record analysis, inclusive of IRR comments for all six participants (K1, K2, K3, B1, B2, B3) and with use of outcome measures, in the form of descriptive statistics will be provided, alongside general EMDR themes (e.g. the participants level of safety, threat, responsibility etc) derived from clinical notes, to primarily address the research question regarding the efficacy of EMDR for young adult survivors of CSA. The thematic analysis across all cases, which primarily addresses the research question regarding the helpful and unhelpful aspects of therapy will then be presented. This will be followed by triangulation of descriptive statistics to address whether there have been changes in various domains (neuropsychological, emotional and behavioural functioning, self-worth and quality of life issues) following engagement in EMDR. A summary of results will then be presented.

4.1 INDIVIDUAL RICH CASE RECORD ANALYSIS

Any score equal to or greater than those as outlined below were considered as IAPT caseness, a term used to describe symptoms severe enough to be regarded as a clinical case (NHS England IAPT Manual, Appendix D, 2018):

33 on the IES-R (for trauma symptomology)

9 on the PHQ9 (for depressive symptoms)

7 for the GAD7 (for symptoms of anxiety)

4.1.1 K1 Case Presentation

Case identifier	K1
Brief demographic information	<p>Baseline DES score for dissociation: 13.39%</p> <p>Number of Sessions with Research Therapist: 8</p> <p>General Assessment and Treatment Overview</p> <p><i>Phase 1: History and Treatment Planning</i></p> <p><i>Previous Therapy; n/a</i></p> <p><i>Comorbidities; possible OCD, health anxiety (due to previous heart problems resultant in hospital admission), anxiety and depressive symptoms</i></p> <p><i>Moderating life stressors; work-related exams, recent physical ill health</i></p> <p><i>Age at onset and end of abuse; inappropriate touching by step-grandad at age 16/17 though main abuse used for this study is that which took place approx. 8-9 years of age</i></p> <p><i>Duration; approx. one year</i></p> <p><i>Frequency; occasional, only when staying at maternal auntie/uncle's house (uncle was perpetrator)</i></p> <p><i>Nature; sexual</i></p> <p><i>Intrusiveness (scale of 1-10, 10 being severe); 8</i></p> <p><i>Risk: K1 did report of previous self-harm, would scratch head and hands (during teenage years, when living with mums controlling ex-partner) however no current plan or intent to hurt herself was reported throughout or post-treatment. Recreational drugs and alcohol had also been previously utilised as a coping mechanism however not reported at the time of treatment. K1 reported current coping strategies as distraction and to confide in partner.</i></p>

	<p><i>Triggers:</i> work, as this involved dealing with sensitive legal cases whereby young children had been similarly affected and also, men being within close proximity and visiting relatives houses whereby she may see/meet perpetrator</p>
<p>Brief overview of presenting difficulties (taken from clinical notes)</p>	<p>K1 reported of experiencing bullying in the early years of her primary school life and domestic violence within the home environment, the earliest most prominent memory of this was approximately aged 7 whereby her mother suffered a broken nose following a domestic dispute with her father. After which, K1 fled with mum and was estranged from her father for 8 years. During this time, her mother had started a new relationship however K1 found him to be “controlling and manipulative.” K1 also reported of criticism received from both him and her mother. Consequently, in later life she had developed a fear of “bald headed men” and also reassurance and praise-seeking behaviours which she would often exercise in romantic relationships, as a means of building self-worth. Some of the phrases used by K1 during this stage were “failure,” “judged,” “not good enough,” “am I damaged (because of the abuse)”, “will I ever feel better.”</p> <p>Other common behaviours exhibited by K1 were high expectations of self, avoidance in relationships, “I push people away” although at the time of treatment, K1 was in a stable relationship of four years. K1 reported of flashbacks, mainly when alone, not only of the CSA however also other traumatic events such as her mother’s deteriorating mental health resultant in multiple threats to take her own life.</p>
<p>Outcome measure results – descriptive statistics</p>	<p>Overall PTSD Clinical Symptomology (relating to the IESR, WPS-CR question 8)</p> <p>Consistent with reductions in IESR scores, K1 also recognised a decrease in her levels of guilt around the trauma when asked WPS-CR question 8 (“I feel guilty about things that have happened”), reporting “most of the time” at pre’ and “never” at post-treatment.</p> <p>Non-caseness and reliable improvement for trauma symptomology was achieved as K1 commenced treatment with a score of 48 and ended with a score of 6, showing a 42-point decrease.</p> <p>Quality of Life Issues (relating to the VLQ, WPS-CR questions 4-6)</p> <p>K1 responded as follows to WPS-CR self-report questions:</p>

- 4) "I argue or fight with people" - pre "almost never" to post "never" treatment
- 5) "I get yelled at or get into trouble" - pre "almost never" to post "never" treatment
- 6) "I get along with my friends" - pre "most of the time" to post "all of the time" treatment

Though only two areas of life (spirituality and community) showed a lack of importance, K1's above self-assessment of quality of life issues suggests that she further noticed a general improvement in these areas also. This is consistent with K1's overall VLQ personal sense of importance which rose from 48/90 at pre-treatment to 86/90 at post-treatment, evidently showing an increase in her quality of life.

Emotional and Behavioural Functioning (Anxiety, Depression and Low Self-Esteem)

K1 observed a significant improvement in self-esteem via the RSES outcome measure however remained within IAPT caseness for the GAD7 measure and reliable improvement was not achieved for both anxiety and depressive symptoms however we must bear in mind that the trauma-work was interrupted by COVID-19 and hence treatment was not fully completed.

Anxiety (relating to the GAD7, WPS-CR question 2)

Consistent with the below graph displaying GAD7 outcome data, K1 recognised a decrease in her levels of anxiety when asked WPS-CR question 2 ("I feel nervous or worry about things"), reporting "all of the time" at pre' and "some of the time" post-treatment.

Depression (relating to the PHQ9, WPS-CR question 1)

Consistent with the below graph displaying PHQ9 outcome data, K1 recognised a decrease in her levels of depressive symptomology when asked WPS-CR question 1 ("I feel sad"), reporting "most of the time" at pre' and "almost never" post-treatment.

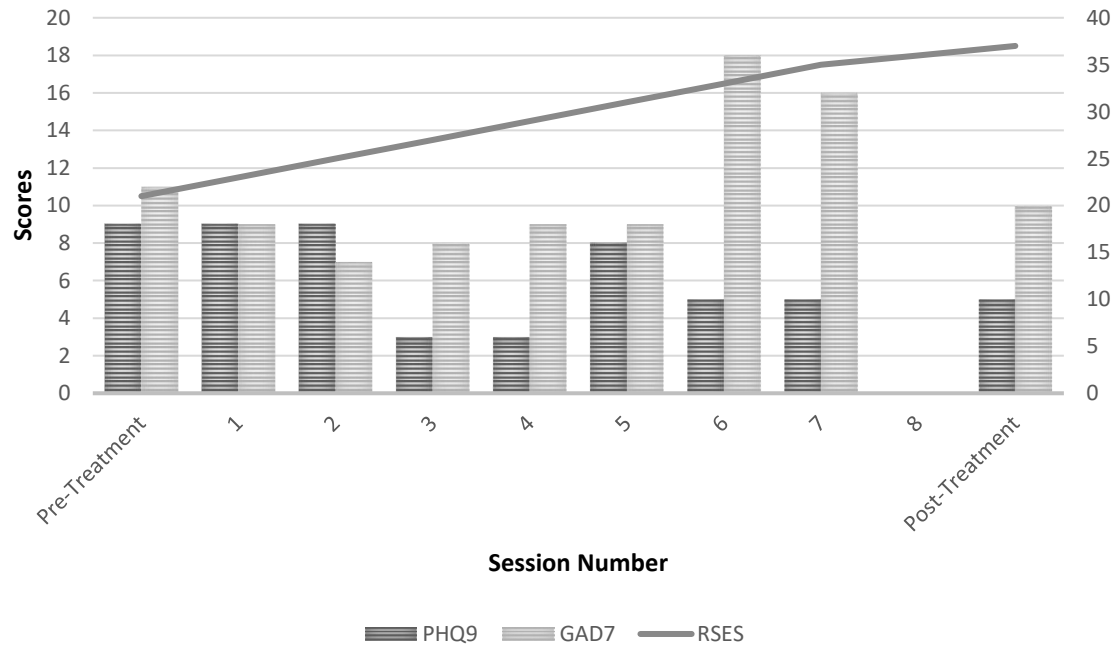
Low Self-Esteem (relating to the RSES, WPS-CR question 3, 7)

K1 responded as follows to WPS-CR self-report questions:

- 3) "I like myself" - pre "some of the time" to post "most of the time" treatment
- 7) "I feel like I am as good as other kids/people" - pre "most of the time" to post "some of the time" treatment

Consistent with the below graph displaying RSES outcome data, K1's self-assessment of levels in self-esteem via the above WPS-CR questions also suggest a significant increase in confidence from pre- to post- treatment.

TABLE OF PRE-POST RSES AND SESSIONAL PHQ-9 & GAD-7 SCORES



Memory (relating to WPS-CR question 9 - I am forgetful)
 Pre-treatment: Some of the time
 Post-treatment: Almost never

Memory (relating to the Pre-Treatment PEBL Corsi Blocks Test (PCBT) Results)

Block Span: 5

Total Score: 35

Total Correct Trials: 7

Memory Span: 4.5

Attention (relating to WPS-CR question 10 - I have trouble paying attention)

Pre-treatment: Some of the time

Post-treatment: A little of the time

Attention (relating to the Pre-Treatment PEBL Attentional Network Test (PANT) Results)

Total Errors: 144

Mean Accuracy: 0.5

Mean Response Time (milliseconds): 577.15

Alerting (all trials): 7.30

Orienting (all trials): 26.5

Conflict (all trials): 108.01

Alerting (correct trials): 1.13

Orienting (correct trials): 32.02

Conflict (correct trials): 120.91

Executive Functioning (relating to WPS-CR question 11 - I have trouble planning ahead and following through on tasks)

Pre-treatment: Some of the time

Post-treatment: Almost never

Executive Functioning (relating to the Pre-Treatment PEBL Iowa Gambling Task (PIGT) Results)

	<p style="text-align: center;">Mean Number of Good–Bad Card Selections per Deck</p> <table border="1"> <caption>Data for Mean Number of Good–Bad Card Selections per Deck</caption> <thead> <tr> <th>Age Group</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>0.1-20</td> <td>-11</td> </tr> <tr> <td>21-40</td> <td>2</td> </tr> <tr> <td>41-60</td> <td>-10</td> </tr> <tr> <td>61-80</td> <td>0</td> </tr> <tr> <td>81-100</td> <td>-4</td> </tr> </tbody> </table>	Age Group	Score	0.1-20	-11	21-40	2	41-60	-10	61-80	0	81-100	-4	
Age Group	Score													
0.1-20	-11													
21-40	2													
41-60	-10													
61-80	0													
81-100	-4													
<p>Number of completed EMDR phases out of 8</p>	<p>8</p>													
<p>Independent Research Rater information (actual notes from the IRR)</p>	<p>OVERALL CASE VERDICT</p> <p>Affirmative – Positive Improvement</p> <p><i>Independent Research Rater (IRR) Commentary</i></p>													

K1 appeared to give a general overall indication that she felt that the process of undergoing EMDR had a positive impact on her trauma symptoms (1. Changes in stable problems and 3. Outcome to process mapping). Rating scales indicated a general improvement in most areas. She understood that her bodily responses were normal given her past experience and had learned that the psychoeducation she received helped her not to add to her difficulties by thinking she was going mad (2. Retrospective attribution). It also helped her to process the emotions / experiences in a manner from being 'negative' to 'positive' in a meaningful way for her (3. Outcome to process mapping – enhanced scores on quantitative measures). (MODERATORS).

K1 (MEDIATORS) engaged with the therapy / did what was suggested and chose to use her bedroom as her 'safe space.' Engagement with the therapy was an important factor for K1 to the extent that she refused to use her 'safe space' (as this was her actual bedroom) for ongoing treatment during Covid. (4. Event-shift sequences). That she had found a sanctuary through engagement with the process of EMDR seemed precious to her and she wanted to protect it for ongoing use. K1 appears to have learned what a 'safe' person looks like through the therapeutic alliance. K1's work with trauma survivors (in her professional legal role) was a mediator as a trigger and also potentially as a motivator so she could help her own clients in future.

1. To what extent did the client change over the course of therapy? (rated on a scale of 0-100% at 20-point intervals) 80%

1a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 80%

1b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

Client is no longer in caseness of IESR.

EMDR was successful in that VOC had reached 7/7 and client had reported an improvement in self esteem.

In interview, client reports improvement in resilience in dealing with daily stressors and her confidence.

WPS-CR Q8 reduction in guilt from "most of the time" (pre) to "never" (post). VLQ, WPS-CR Q4-6 Quality of life question 4. "almost never" (pre) to "never" (post), 5. "almost never" to "never" (pre to post), 6. "most of the

time” to “all of the time” (pre to post). PHQ9 Depression pre 9 to 5 post. Self report questions RSES/WPS-CR 3. “some” to “most” (of the time – self-liking, pre to post). PEBL-Corsi, WPS-CR9 Memory function 9 “some” to “almost never” (pre to post). Attention “some” to “a little” (pre to post). PEBL-ANT, WPS-CR10 Executive planning “some” to “almost never” (pre to post).

2. To what extent is this change due to the therapy? (rated on a scale of 0-100% at 20-point intervals) 100%

2a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 100%

2b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

In interview, client reported how psychoeducation had enabled her to understand her problems better. She also reported that she felt that EMDR didn't try to change her even though it did, acknowledging the natural changes that occurred. She did not speak of any other variables that led to an improvement in symptoms of quality of life.

K1 Affirmative – psychoeducation seemed to matter to K1 as this was the first thing she mentioned in interview that she identified as something she took from the sessions to help her understand her bodily responses. The safe space seemed to help her and she appeared to engage well with the use of it. K1 was able to reinterpret her experiences (all mentioned in the interview) and less self-blaming perspective and more self-compassionate one

3. Which therapy processes do you feel were helpful to the client?

Psychoeducation, processing. The installation of the new ‘in control’ way of being in order to feel safe in the present moment and moving forwards seemed to help K1 as did psychoeducation that her responses were normal.

4. Which characteristics and/or personal resources of the client do you feel enabled her to make best use of her therapy?

	<p>Client reported she knew of a colleague that had benefitted from EMDR. She had good insight into her difficulties before therapy.</p> <p>K1 worked with clients who had trauma so this may have motivated her to engage fully to feel less triggered and also to encourage those she worked with that recovery was possible.</p>
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K1 entered therapy with mixed expectations, she was the only one, of all six participants, not to have previously experienced any therapy. K1 appeared to be very engaged and enthusiastic. Though K1 scored the lowest on the IESR measure, from all participants at pre-treatment, she displayed a significant improvement at post-treatment. In terms of self-esteem, K1's WPS-CR responses of liking herself and being as good as others reduced at post-treatment however, she did report of improvements via both the RSES measure and at interview, following EMDR. In accordance with research (as outlined in the discussion chapter), those exhibiting the poorest executive functioning via undertaking the PIGT at pre-treatment, generally display the most improvement, this was also consistent with K1's WPS-CR response for the relevant question.

4.1.2 K2 Case Presentation

Case identifier	K2
Brief demographic information	<p>Baseline DES score for dissociation: 10%</p> <p>Number of Sessions with Research Therapist: 9</p> <p>General Assessment and Treatment Overview</p> <p><i>Phase 1: History and Treatment Planning</i></p>

	<p><i>Previous Therapy</i>; had counselling in College and support through Victim Support Services however found unhelpful at the time</p> <p><i>Comorbidities</i>; GAD and Clinical Depression (diagnosis received 2019)</p> <p><i>Moderating life stressors</i>; Studies/College, resides with and supports both mum who suffers from depression, anxiety, OCD and suspected Asperger (undiagnosed) and also younger sister (aged 15) who is diagnosed with ADHD and is currently abusing alcohol and drugs</p> <p><i>Age at onset and end of abuse</i>; approx. aged 10-13 however K2 reported that this was more “rough and prominent” when aged 12/13</p> <p><i>Duration</i>; approx. 2.5 years</p> <p><i>Frequency</i>; mainly weekends when K2 was generally left without another care-giver or sometimes with younger sister/alone with perpetrator (step-dad)</p> <p><i>Nature</i>; sexual and emotional (grooming, perpetrator would buy garments of sexualised clothing for K2 and ask her to try these on for his pleasure)</p> <p><i>Intrusiveness (scale of 1-10, 10 being severe)</i>; 8, K2 reported of experiencing vivid intrusions at least a couple of times a week</p> <p><i>Risk</i>: bites nails/picks her skin when distressed,</p> <p><i>Triggers</i>: unfamiliar people of male gender</p>
<p>Brief overview of presenting difficulties (taken from clinical notes)</p>	<ul style="list-style-type: none"> - Childhood – unstable home life, single-parent family, mum is unemployed, reliant on benefits, estranged from biological father, feels rejected by him. Stepdad was physically and mentally abusive towards mum. - Aged 10-12 – Step dad sexually abused K2, Police involvement however not taken to court, had counselling however feels this was not resolved - Aged 13 – bullied at school <p>K2 reported of withdrawal from social situations, she often experienced trust issues when entering into relationships and is aware of high expectations around College work, perfectionism to the point of “ripping up my Art work” if not done to her standard. This coincides with K2 feeling that others have high expectations of her A-level exams (e.g. teacher) however she doubted whether she would achieve good grades due to her</p>

	<p>mental health and lack of parental support. This was further exacerbated by her current romantic relationship, feeling that she was caring for him due to his own mental health concerns.</p> <p>A prominent struggle reported by K2 was sleep disturbance, this was often “broken, nightmares,” these were about CSA however she reported that at pre-treatment these were taking the theme of “everything going wrong.” K2 reported that constant fatigue, irritability and exhaustion affected her daily routine to the point that her College work was being affected due to absence (for which she did attend a “fitness to study” meeting and received SENCO support). During this phase, K2 did briefly run low on medication, at the time she was also completing her mock exams which worsened her sleep however was able to get an emergency appointment for her prescription.</p> <p>Key words taken from K2 during this phase appear to be “abandonment,” “failure,” “not good enough.” These were consistent with her cognitions and experiences; since the age of 7, when K2 and her sister were placed into care, she felt responsible for her sister’s care. K2 expressed that every adult that she feels should have cared for her has neglected her and hence resents all of them, except her Mum. K2 recalled memories of the abuse, the perpetrator name-calling, having to file Police reports and repeatedly provide evident which she thought may have caused desensitization.</p>
<p>Outcome measure results – descriptive statistics</p>	<p>Overall PTSD Clinical Symptomology (<i>relating to the IESR, WPS-CR question 8</i>)</p> <p>Despite reduction in IESR scores, K2 recognised a slight increase in her levels of guilt around the trauma when asked WPS-CR question 8 (“I feel guilty about things that have happened”), reporting “almost never” at pre’ and “a little of the time” at post-treatment, this may have been as phase 4 was interrupted due to COVID-19.</p> <p>IAPT non-caseness and reliable improvement was achieved in trauma symptomology as K2 commenced treatment with a score of 62 and ended with a score of 5, showing a 57-point decrease.</p> <p>Quality of Life Issues (<i>relating to the VLQ, WPS-CR questions 4-6</i>)</p> <p>K2 responded as follows to WPS-CR self-report questions:</p> <p>4) “I argue or fight with people” - pre “almost never” to post “a little of the time” treatment 5) “I get yelled at or get into trouble” - pre “a little of the time” to post “almost never” treatment</p>

6) "I get along with my friends" - pre "most of the time" to post "most the time" treatment

Though there were fluctuations in K2's VLQ outcome data, her self-assessment of quality of life issues (via the above WPS-CR responses) suggests that she did notice a general improvement in these reported areas of life from pre- to post- treatment. Though K2's overall VLQ personal sense of importance remained similar from 76/90 at pre-treatment to 71/90 at post-treatment (it is important to note however that scores inclusive of the parenting question, that which was taken out of this study, results would display an increase in overall quality of life).

Emotional and Behavioural Functioning (Anxiety, Depression and Low Self-Esteem)

IAPT non-caseness and reliable improvement were achieved for both anxiety and depressive symptoms within this case regardless of the disruption in EMDR due to COVID-19.

Anxiety (relating to the GAD7, WPS-CR question 2)

Consistent with the below graph displaying GAD7 outcome data, K2 recognised a decrease in her levels of anxiety when asked WPS-CR question 2 ("I feel nervous or worry about things"), reporting "most of the time" at pre' and "some of the time" post-treatment.

Depression (relating to the PHQ9, WPS-CR question 1)

Consistent with the below graph displaying PHQ9 outcome data, K2 recognised a decrease in her levels of depressive symptomology when asked WPS-CR question 1 ("I feel sad"), reporting "all of the time" at pre' and "some of the time" post-treatment.

Low Self-Esteem (relating to the RSES, WPS-CR question 3, 7)

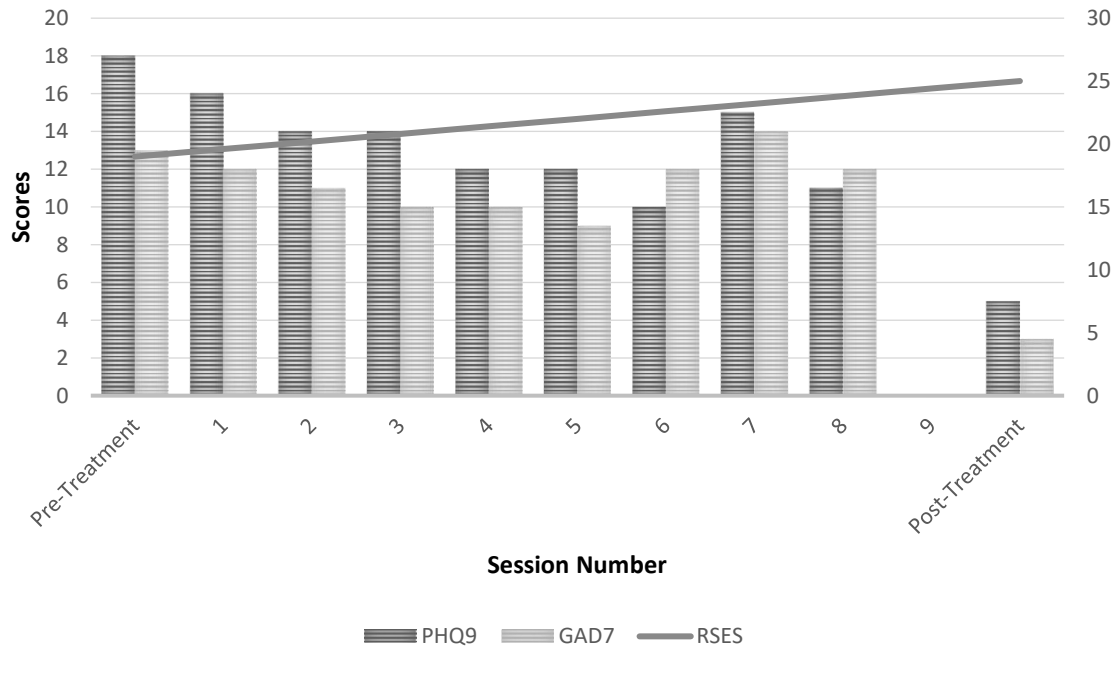
K2 responded as follows to WPS-CR self-report questions:

3) "I like myself" - pre "almost never" to post "some of the time" treatment

7) "I feel like I am as good as other kids/people" - pre "almost never" to post "some of the time" treatment

Consistent with the below graph displaying RSES scores increasing by 6-points, K2's self-assessment of levels in self-esteem via WPS-CR also suggest that she noticed an increase in confidence from pre- to post-treatment when answering the above direct questions about herself in comparison to others.

TABLE OF PRE-POST RSES AND SESSIONAL PHQ-9 & GAD-7 SCORES



Memory (relating to the WPS-CR question 9 - I am forgetful)

Pre-treatment: Some of the time

Post-treatment: Some of the time

Memory (relating to the Pre-Treatment PEBL Corsi Blocks Test (PCBT) Results)

Block Span: 5
Total Score: 54
Total Correct Trials: 9
Memory Span: 5.5

Attention (relating to the WPS-CR question 10 - I have trouble paying attention)

Pre-treatment: Most of the time
Post-treatment: A little of the time

Attention (relating to the Pre-Treatment PEBL Attentional Network Test (PANT) Results)

Total Errors: 147
Mean Accuracy: 0.48
Mean Response Time (milliseconds): 934.85
Alerting (all trials): 68.31
Orienting (all trials): 20.76
Conflict (all trials): 104.43
Alerting (correct trials): 97.89
Orienting (correct trials): 28.22
Conflict (correct trials): 141.97

Executive Functioning (relating to the WPS-CR question 11 - I have trouble planning ahead and following through on tasks)

Pre-treatment: Most of the time
Post-treatment: Some of the time

Executive Functioning (relating to the Pre-Treatment PEBL Iowa Gambling Task (PIGT) Results)

	<p style="text-align: center;">Mean Number of Good–Bad Card Selections per Deck</p> <table border="1"> <caption>Data for Mean Number of Good–Bad Card Selections per Deck</caption> <thead> <tr> <th>Mean (A+B - C+D) Card Selections</th> <th>Order of Card Selection Pre-treatment</th> </tr> </thead> <tbody> <tr> <td>0.1-20</td> <td>-6</td> </tr> <tr> <td>21-40</td> <td>6</td> </tr> <tr> <td>41-60</td> <td>2</td> </tr> <tr> <td>61-80</td> <td>0</td> </tr> <tr> <td>81-100</td> <td>10</td> </tr> </tbody> </table>	Mean (A+B - C+D) Card Selections	Order of Card Selection Pre-treatment	0.1-20	-6	21-40	6	41-60	2	61-80	0	81-100	10	
Mean (A+B - C+D) Card Selections	Order of Card Selection Pre-treatment													
0.1-20	-6													
21-40	6													
41-60	2													
61-80	0													
81-100	10													
<p>Number of completed EMDR phases out of 8</p>	<p>8</p>													
<p>Independent Research Rater information (actual notes from the IRR)</p>	<p>OVERALL CASE VERDICT</p> <p>Affirmative – Positive Improvement</p> <p><i>Independent Research Rater (IRR) Commentary</i></p>													

K2 seems to have had a good overall outcome with EMDR even though it was cut short due to Covid. K2 detailed that she had significant reductions in the nightmares and was experiencing normal dreams that did not impact her full day like the nightmares used to. It is as if 'normal dreams' were something she had not experienced in a long time (1. Changes in stable problems). K2 evidences (2. Retrospective attribution) when interviewed and discussing how she is no longer consumed with emotion when thinking about the events post-EMDR. K2 had some increases post-EMDR in feelings of guilt, arguing with others, though got along with her friends at the same level pre and post EMDR (3. Outcome to process mapping) with an overall improvement in scores consistent with her overall improvement (4. Event shift sequences).

1. To what extent did the client change over the course of therapy? (rated on a scale of 0-100% at 20-point intervals) 80%

1a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 90%

1b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

Client is no longer in caseness of IESR

Client met recovery on PHQ and GAD

Client reported significant decrease in nightmares during phases 3-8.

IAPT non-caseness / reliable improvement reached. VLQ, WPS-CR4-6 fluctuations in data yet general overall improvement pre to post treatment. PHQ9 Depression reduced pre 18 to 5 post. GAD7 Anxiety reduced from 13 (pre) to 3 (Post). RSES, WPES-C 3,7 "almost never" to "some of the time" in both questions.

2. To what extent is this change due to the therapy? (rated on a scale of 0-100% at 20-point intervals) 100%

2a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 100%

2b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

	<p>K2's interview details significant reductions in nightmares and increased normal dreaming. K2's safe space was something she used frequently and found benefit from.</p> <p>Client reflected in interview how EMDR enabled her to process memories and understood the theory behind this. She did not speak of any other factors that led to the improvement in her symptoms.</p> <p>3. Which therapy processes do you feel were helpful to the client?</p> <p>Psychoeducation, therapeutic relationship and re-processing.</p> <p>K2 (interview) said psychoeducation and awareness of how her bodily responses are normal.</p> <p>4. Which characteristics and/or personal resources of the client do you feel enabled her to make best use of her therapy?</p> <p>K2's active engagement with the safe space and reflection on how she felt while she used this technique throughout.</p> <p>Client demonstrated that she was well motivated, eager to understand her symptoms and how to address them. She also was a high achiever which may have enabled her to "achieve" in therapy.</p>
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K2 completed all 8 phases however with interruptions due to the COVID-19 pandemic and as her medication ran low at one point during treatment, which may consequently have affected her descriptive statistic figures, particularly for depressive symptoms. She had previously completed therapy (of a differing modality) and had reported of finding this unhelpful, which may also have contributed towards results, due to slight pessimism in relation to outcome. Regardless of these factors, overall, K2 saw general improvements in all domains, though reported of no change in memory.

4.1.3 K3 Case Presentation

Case identifier	K3
Brief demographic information	<p>Baseline DES score for dissociation: 34.57%</p> <p>Number of Sessions with Research Therapist: 6</p> <p>General Assessment and Treatment Overview</p> <p><i>Phase 1: History and Treatment Planning</i></p> <p><i>Previous Therapy;</i> had counselling the previous year due to same issue <i>Comorbidities;</i> anxiety, depressive symptoms <i>Moderating life stressors;</i> unsupported by family, felt alone/isolated as had no contact with immediate family in her country of origin, other than living with her Aunt in the UK who she described as ‘critical and judging’ and often threatened to make her homeless, financial constraints, newly started College to undertake GCSE’s however her biggest worry was that she would be rejected UK citizenship (resultant in again meeting her perpetrator) however due to COVID-19 such decisions had been delayed during treatment, exacerbating anxiety and fear <i>Age at onset and end of abuse;</i> approx. 15-16 years of age <i>Duration;</i> approx. one year, intermittent, started following loss of father and ended upon move to the UK <i>Frequency;</i> frequent incidents throughout the year <i>Nature;</i> sexual and physical <i>Intrusiveness (scale of 1-10, 10 being severe);</i> 9.5</p> <p><i>Risk:</i> K3 denied any use of recreational drugs currently or historically. No excessive use of alcohol or smoking. K3 denied any current issues of self-harm, risk to others or self, though she did discuss fleeting thoughts of cutting her wrists and taking an overdose (no plan or intent). K3 also reported of one previous suicide attempt in July 2019 following confirmation that her permanent UK status had been rejected by the home office; she had since re-applied for residency giving her a sense of hope and her religious beliefs had remained to be her</p>

	<p>protective factor.</p> <p><i>Triggers:</i> Being around unfamiliar men and places</p>
<p>Brief overview of presenting difficulties (taken from clinical notes)</p>	<p>K3 reports that the perpetrator (her paternal uncle) would openly search for her, at times going to her family home and asking for her hand in marriage, beating her in front of her mother, younger brother and grandmother (who was blind and frail hence could not intervene), leaving the family “scared,” to the point whereby neighbours got involved following an incident resulting in K3 becoming unconscious and waking up in hospital; she has no recollection of what happened during this time however remembers him trying to “take” her. K3 reports that her uncle did have a history of such acts with young girls (resultant in murder) and that he had also tried to “kidnap” her on occasions.</p> <p>K3 would readily avoid social situations and became avoidant of men and unfamiliar places due to fear, irritability and heightened anxiety, this would also often cause panic sensations. K3 reported of regular nightmares however since medication was started that these had slightly eased at the time of treatment, although her flashbacks continued on a regular basis. K3 also mentioned struggling with her studies due to issues with memory and concentration.</p> <p>During this phase, K3 further discussed her living situation, though she was residing with her Aunt she had applied for permanent UK residency for the second time and was awaiting a decision and this was due to be received during the course of this treatment. K3 was “scared” of moving back to her home country as her mother had already confirmed that she would marry K3 to her (perpetrator) uncle regardless of the past abuse/rape, this was mainly due to threats the family had received from him and also as he was a “powerful man.” Following a GP appointment, K3 was informed that her recent hair loss was due to stress.</p> <p>By session 3, K3 had reported of passing her GCSE’s however was still reluctant to engage in social activities (e.g. general socializing, prayers at her place of worship) in case others asked about her situation. K3 explored memories of hearing/seeing on TV what difficulties women in her country also have to face (outside of her immediate community) and how this may have impacted on her coping strategies/development of her fear of men.</p> <p>K3 and her therapist jointly agreed to work on: the sexual assault by her uncle; flashback to her father’s death; and an earlier memory of being followed and approached by a man when she was aged 10.</p>

<p>Outcome measure results – descriptive statistics</p>	<p>Overall PTSD Clinical Symptomology (<i>relating to the IESR, WPS-CR question 8</i>)</p> <p>Despite reduction in IESR scores, K3 recognised an increase in her levels of guilt around the trauma when asked WPS-CR question 8 (“I feel guilty about things that have happened”), reporting “almost never” at pre’ and “a little of the time” at post-treatment. This may have been as phases 3 onwards were not fully completed due to COVID-19 and moderating life stressors hence, adverse effects of BLS often cause a surge in emotion as trauma networks are reopened.</p> <p>Although K3 remained within IAPT caseness for anxiety and depressive symptoms, reliable improvement was achieved in trauma symptomology as K3 commenced treatment with a score of 78 and ended with a score of 52, showing a 26-point decrease.</p> <p>Quality of Life Issues (<i>relating to the VLQ, WPS-CR questions 4-6</i>)</p> <p>K3 responded as follows to WPS-CR self-report questions:</p> <p>4) “I argue or fight with people” - pre “almost never” to post “almost never” treatment 5) “I get yelled at or get into trouble” - pre “almost never” to post “never” treatment 6) “I get along with my friends” - pre “a little of the time” to post “a little of the time” treatment</p> <p>There appeared to be a dip in scores for the following life domains ‘family, social, recreation and self-care’ from pre- to post-treatment and no changes in work, education and spirituality similar to questions 4 and 6 of the WPS-CR. Whilst an improvement was seen in all other domains consistent with her above WPC-SR self-assessment of question 5 (unfortunately we cannot differentiate whether this is because K3 has changed her responses to individuals, i.e. her aunt with whom she resides, as an outcome of positive resourcing from treatment). Though fluctuations were seen, K3’s overall VLQ personal sense of importance score remained the same from pre- to post-treatment, 60/90, showing no apparent increase in her quality of life (it is important to note however that scores inclusive of the parenting question, that which was taken out of this study, results would display an increase in overall quality of life).</p> <p>Emotional and Behavioural Functioning (Anxiety, Depression and Low Self-Esteem)</p>
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K3 remained within IAPT caseness and reliable improvement had not been achieved for emotional functioning in this case however we must bear in mind that K3 had only completed EMDR phases 1-2 due to her level of looping due to external stressors and hence, the reprocessing was yet to commence post-COVID-19 and ending of her immigration case.

Anxiety (relating to the GAD7, WPS-CR question 2)

Though the below graph displaying GAD7 outcome data shows an overall minor 2-point decrease in her levels of anxiety, when answering WPS-CR question 2 (“I feel nervous or worry about things”), K3 reported “all of the time” at pre’ and the same at post-treatment, showing no change. This was consistent with her reported worry about external stressors during treatment and assessment, namely immigration status (also the key factor in EMDR looping).

Depression (relating to the PHQ9, WPS-CR question 1)

Though the below graph displaying PHQ9 outcome data shows an overall minor 1-point decrease in her levels of depressive symptomology, when answering WPS-CR question 1 (“I feel sad”), K3 reported “most of the time” at pre’ and the same at post-treatment, showing no change.

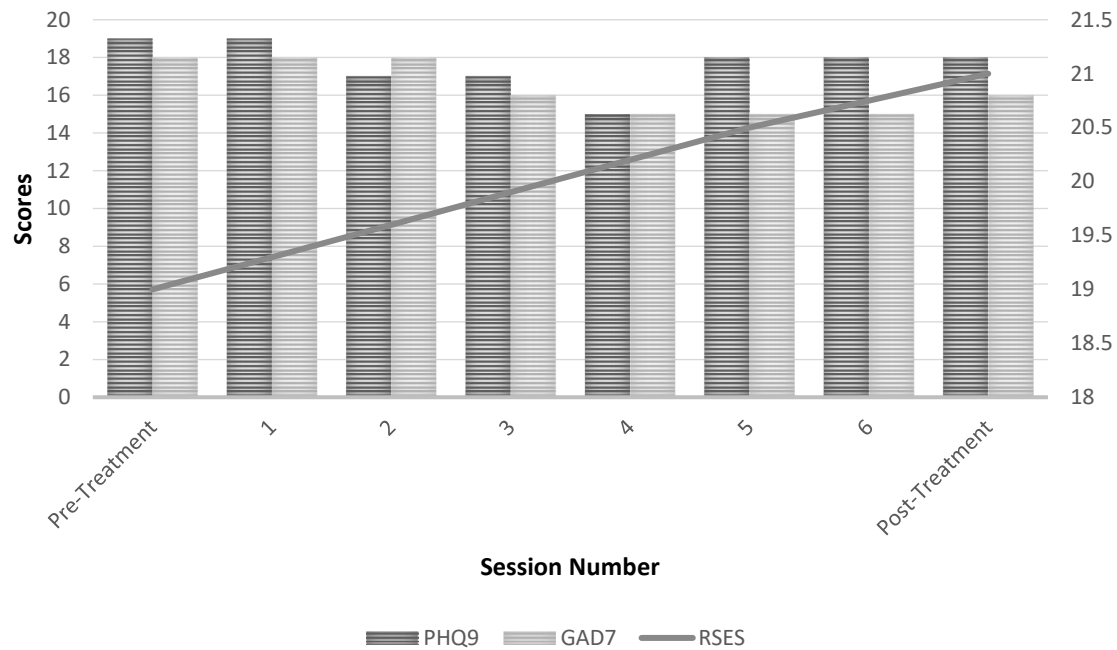
Low Self-Esteem (relating to the RSES, WPS-CR question 3, 7)

K3 responded as follows to WPS-CR self-report questions:

- 3) “I like myself” - pre “some of the time” to post “almost never” treatment
- 7) “I feel like I am as good as other kids/people” - pre “never” to post “never” treatment

Inconsistent with the below graph displaying a slight increase in her responses to the RSES, K3’s self-assessment of levels in self-esteem via the above WPS-CR responses suggest that she had noticed a slight decrease in confidence from pre- to post- treatment. It is important to mention at this point about her reported disappointment of looping during sessions as a result of delays in her immigration application due to the COVID-19 pandemic, which was causing an increase in anxiety and low self-worth, especially as the possibility of her returning to her country of origin directly linked with her trauma and potential future danger.

TABLE OF PRE-POST RSES AND SESSIONAL PHQ-9 & GAD-7 SCORES



Memory (relating to the WPS-CR question 9 - I am forgetful)

Pre-treatment: All of the time

Post-treatment: A little of the time

Memory (relating to the Pre-Treatment PEBL Corsi Blocks Test (PCBT) Results)

Block Span: 5

Total Score: 25

Total Correct Trials: 5

Memory Span: 3.5

Attention (relating to the WPS-CR question 10 - I have trouble paying attention)

Pre-treatment: A little of the time

Post-treatment: All of the time

Attention (relating to the Pre-Treatment PEBL Attentional Network Test (PANT) Results)

Total Errors: 186

Mean Accuracy: 0.35

Mean Response Time (milliseconds): 1176.04

Alerting (all trials): 94.37

Orienting (all trials): -48.69

Conflict (all trials): 61.36

Alerting (correct trials): 183.22

Orienting (correct trials): -266.22

Conflict (correct trials): -8.12

Executive Functioning (relating to the WPS-CR question 11 - I have trouble planning ahead and following through on tasks)

Pre-treatment: A little of the time

Post-treatment: A little of the time

Executive Functioning (relating to the Pre-Treatment PEBL Iowa Gambling Task (PIGT) Results)

	<p style="text-align: center;">Mean Number of Good–Bad Card Selections per Deck</p> <table border="1"> <caption>Data for Mean Number of Good–Bad Card Selections per Deck</caption> <thead> <tr> <th>Mean (A+B - C+D) Card Selections</th> <th>Order of Card Selection Pre-treatment</th> </tr> </thead> <tbody> <tr> <td>0.1-20</td> <td>0</td> </tr> <tr> <td>21-40</td> <td>-2</td> </tr> <tr> <td>41-60</td> <td>2</td> </tr> <tr> <td>61-80</td> <td>2</td> </tr> <tr> <td>81-100</td> <td>10</td> </tr> </tbody> </table>	Mean (A+B - C+D) Card Selections	Order of Card Selection Pre-treatment	0.1-20	0	21-40	-2	41-60	2	61-80	2	81-100	10	
Mean (A+B - C+D) Card Selections	Order of Card Selection Pre-treatment													
0.1-20	0													
21-40	-2													
41-60	2													
61-80	2													
81-100	10													
<p>Number of completed EMDR phases out of 8</p>	<p>2</p>													
<p>Independent Research Rater information (actual notes from the IRR)</p>	<p>OVERALL CASE VERDICT</p> <p>Sceptic – No Improvement</p> <p><i>Independent Research Rater (IRR) Commentary</i></p>													

K3 had ongoing issues with the Home Office and these appeared to result in genuine fears that she would be deported to an unsafe place where she would be at risk of abuse and harm (moderating factor). While these real fears were ongoing for her, it appears that the therapy was not effective for her. She also has an unsupportive family and is understandably unlikely to have benefitted in a meaningful sense from the therapy even though she did note some benefits in her interview (tapping/breathing helped, the empathy received from the therapist – possibly a rare occurrence in her circumstances, and that she felt she would like to resume EMDR at some point in the future – as mediators). Overall though, K3 did not seem to have any lasting or long-term change as her therapy was cut short due to covid and she could not continue the EMDR as she lacked a suitable place at home to do it online with the practitioner.

1. To what extent did the client change over the course of therapy? (rated on a scale of 0-100% at 20-point intervals) 10%

1a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 50%

1b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

Client showed little improvement during sessions for it to be deemed by sceptic. The treatment was incomplete due to uncertainty in client's residency. Therefore, client had started to experience an exacerbation of symptoms which is part of the therapeutic process.

K3 did not achieve IAPT overall non-caseness but some reliable improvement occurred in trauma symptomology (78 to 52 pre and post). VLQ, WPS-CR Q4-9, 4 stayed the same "almost never" pre and post, 5 "almost never" to "never" pre and post (though K3 had changed who she lived with), 6. Remained the same "a little of the time" pre and post. VLQ 'sense of importance' remained the same pre and post showing no apparent increase in quality of life. PHQ9 Depression only 1 point change (19 to 18) pre to post, GAD7 2 point change (18 to 16) pre to post. RSES, WPS-CR Q1-3 went from "some of the time" to "never" (self liking, pre to post), feeling sad remained the same pre to post. PEBL-Corsi, WPS-CR9 (memory) "all of the time" (pre) to "a little of the time" (post). PEBL-ANT, WPS-CR10 (pre) "a little of the time" to "all of the time" (post). K3 had ongoing problems with the Home Office so was potentially still in a traumatic experience while attempting to work on earlier trauma.

2. To what extent is this change due to the therapy? (rated on a scale of 0-100% at 20-point intervals) 40%

2a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 70%

2b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

K3 had serious ongoing problems with the Home Office that may have been ongoing trauma thus impacting the processing of past trauma as it may have been a trigger. K3 mentioned trauma cycling was occurring between sessions, possibly due to her ongoing difficulties with residency that would put her in harm's way if she was deported. EMDR online could not continue for K3 due to the lack of a suitable place at home to do it. The improvement K3 made was due to some changes but no lasting change.

Client was experiencing external distress due to uncertainty of residency and fears of being near to 172reatment172r. This may have impacted on increase on symptoms. Client struggled to process trauma due to these external factors which would have impacted on therapy. Some symptoms became heightened which would have been attributed to processing starting.

3. Which therapy processes do you feel were helpful to the client?

Psychoeducation and stabilisation (breathing techniques).

Tapping and breathing (empathy from the therapist).

4. Which characteristics and/or personal resources of the client do you feel enabled her to make best use of her therapy?

Client seems to have a good level of reliance, a lot of factors (isolated, financial problems) listed adding to her distress but is still functioning and engaging in therapy.

	K3 seems to be able to withstand extreme levels of trauma and ongoing trauma (possible) so is personally resilient.
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K3 was the only case to receive a ‘sceptic – no improvement’ verdict via IRR feedback. K3 had previously completed Counselling and had reported of little to no change; during the course of EMDR, she had fully completed phases 1-2, and had attempted phase 3 however, retrieved to phase 2 for further preparation, due to exacerbating moderating life stressors. K3 appeared very aware of blocking beliefs due to ongoing uncertainty regarding her immigration status, which could potentially have led to her return to her country of origin. If this was the case, K3 would have been forced to marry the perpetrator and hence, there was a real traumatic threat response to reprocessing, especially as her immigration case had once already been dismissed and furthermore, her appeal deferred due to the COVID-19 pandemic. This may explain why her outcome was lesser than expected. Overall, her scores remained within the moderate to severe range for the GAD7 and no change on the corresponding WPS-CR responses for anxiety. K3 also exhibited low memory retention and executive functioning with consistently high levels of both anxiety and depressive symptoms. As outlined in following sections of this chapter, K3 showed deficit in conflict monitoring and in orienting attention via the PEBL ANT subtest, which are generally the areas of concerns in trauma survivors; this was consistent with her WPS-CR responses. Similarly, there was no, to very little change, in both memory and executive functioning. K3 did however report of positive changes in managing trauma symptoms (e.g. dissociation) following Mindfulness Based Cognitive Therapy (MBCT), which is further discussed later in this chapter.

4.1.4 B1 Case Presentation

Case identifier	B1
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<p>Brief demographic information</p>	<p>Baseline DES score for dissociation: 16.78%</p> <p>Number of Sessions with Research Therapist: 20</p> <p>General Assessment and Treatment Overview</p> <p><i>Phase 1: History and Treatment Planning</i></p> <p><i>Previous Therapy; CAMHS in teens, brief DBT and CBT (also brief CFT)</i></p> <p><i>Comorbidities; B1 reported that she had recently had a Learning Disorder Screening assessment; Dyslexia and dyspraxia were ruled out; her brother has ADD; she has used tinted screens and glasses; short attention span; struggles to put sentences together and also with instructions; struggles with left/right directions and mixes-up items (e.g. knees and elbows). An assessment with an Educational Psychologist has been recommended however was completed post-University hence results to be received following treatment.</i></p> <p>Some "OCD" behaviours e.g. hair pulling; compulsive cleaning; rearranging things before she leaves the house.</p> <p>Also reports of Health and Social Anxiety, Low Self-worth, Panic Attacks which can be triggered by (1) her having sex and thinking that she has done something wrong, (2) separation anxiety e.g. worrying that people do not like her or that something bad has happened to them (3) if something has been happening for a few weeks and building up (e.g. sexual intercourse with boyfriend led to B1 crying/screaming and attempting to leave his house bare foot, if this had happened at home B1's coping mechanism would have been to listen to sad music and cry until she was exhausted.</p> <p>Ongoing acid reflux (causing previous hospitalization, and current severe pain and vomiting when consuming certain foods, no binging reported) and IBS due to previous eating disorder; B1 reported that she was "chubby" as a child and bullied hence lost weight which became an obsession for her not to eat; because she had so little control in other areas of her life she was proud that she could control her eating; longest period was lasting 2 weeks without food. Mum was more embarrassed than concerned that B1 was not buying lunch.</p>
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	<p><i>Moderating life stressors</i>; busy lifestyle (including being in the final year of degree; doing voluntary work; having a full-time job and when at home during holidays; being a Treasurer), managing IBS/acid reflux, changes in lifestyle due to COVID-19, possible ADHD/ASD.</p> <p><i>Age at onset and end of abuse</i>; approx. whilst living with her mum, aged 11-17 (perpetrator was mum's boyfriend)</p> <p><i>Frequency</i>; unknown however reported that this would happen "frequently"</p> <p><i>Nature</i>; emotional and sexual</p> <p><i>Risk</i>: alcohol and drug use: B1 reports of historically issues with alcohol; used to drink 30-50 units per night. Stated she did not feel the need to drink anymore; she was previously very lonely and did not want to be sober; at the time of treatment she was more active, had friends and felt more secure about her future; at most, she had a couple of units a week. Used to occasionally smokes cannabis for her anxiety however this was at a manageable level; no other drug use reported.</p> <p>B1 did report of occasional fleeting thoughts of "what's the point", no plan or intent, partner was strong protective factor. B1 also had a history of self-harm by namely cutting.</p> <p><i>Triggers</i>:</p> <ul style="list-style-type: none"> - People touching her possessions; would become really attached to inanimate objects - People touching her; did not like to be hugged; she would prefer someone to put their hand on her shoulder - Judgements about sex and men; feelings of low self-worth - Health anxieties/OCD; illnesses, infections and cleanliness - Social anxieties; difficulty with friends being away from her, questions their value of her
<p>Brief overview of presenting difficulties (taken from clinical notes)</p>	<p>Behaviour; avoidant of certain situations (men/unfamiliarity), Paranoia about judgement from others. Safety behaviours included time with teddy bear. B1 reported possible dissociative difficulties, e.g. in the middle of a conversation she would become vacant; quite often she would report 'nothing' in her head; it is 'blank.'</p> <p>B1 reports of issue with her long term memory, forgetfulness of significant events however that she had a good short-term memory, although then realised "but I have a spreadsheet for everything" – also identified checking behaviours, even when completing questionnaires, would check and double-check her answers "worries I'm doing it wrong" and then seeking reassurance that there is no wrong answer.</p>

	<p>Thoughts; judgement from others, low self-worth, traumatic memories of childhood and negative beliefs about self (I'm a bad person/I will never achieve anything in life) were at forefront of mind, worried that she will grab onto negative thoughts; silent and tense; it was difficult for her to control her emotions and she struggled to complete tasks.</p> <p>Sleep; B1 experienced bad nightmares in the morning; daily when stressed and once monthly when she is feeling fine. Oversleeping, not if she was busy but at other times she could oversleep for 4-5 days.</p> <p>Coping Strategies; B1 isolated self when distressed, however also enjoyed swimming and was aware of breathing exercises from CBT, also utilised work as distraction</p> <p>Psychological difficulties:</p> <ul style="list-style-type: none"> - B1 reported that she could feel that her whole life was a dream and that she had just woken up - B1 previously thought lack of memory was "normal" - B1 doubted herself, trust issues resultant in arguments with her partner - B1 often felt overwhelmed; linked to feelings of anxiety and frustration / irritation, if something has gone wrong, she would want to run away, if she could not fix it / felt that she had to fix it; slightly angry, overwhelmed; stated she is bad at describing emotions; usually felt weighed down (e.g. sad; if she had energy she must be happy; struggled to understand what was in her mind) - B1 reports that she is an unsympathetic person (especially towards herself / she will be strict e.g. good and bad) and that she would like to be more sympathetic; she will talk to others in a logical way e.g. give advice / be less emotional.
<p>Outcome measure results – descriptive statistics</p>	<p>Overall PTSD Clinical Symptomology (relating to the IESR, WPS-CR question 8)</p> <p>Consistent with reduction in IESR scores, B1 recognised a decrease in her levels of guilt around the trauma when asked WPS-CR question 8 ("I feel guilty about things that have happened"), reporting "most of the time" at pre' and "some of the time" at post-treatment.</p> <p>Although B1 only just missed the point of IAPT non-caseness and reliable improvement was most definitely achieved as B1 commenced treatment with a score of 77 and ended with a score of 36, showing a 41-point decrease in trauma symptomology.</p> <p>Quality of Life Issues (relating to the VLQ, WPS-CR questions 4-6)</p>

B1 responded as follows to WPS-CR self-report questions:

- 4) "I argue or fight with people" - pre "some of the time" to post "some of the time" treatment
- 5) "I get yelled at or get into trouble" - pre "a little of the time" to post "some of the time" treatment
- 6) "I get along with my friends" - pre "most of the time" to post "most the time" treatment

Though there were fluctuations in B1's VLQ outcome data, her self-assessment of quality of life issues (via the above WPS-CR responses) suggests that she did notice a slight improvement in various areas of life from pre- to post- treatment, especially in work and education via the VLQ. However, little change was seen in B1's overall VLQ personal sense of importance, scored 51/90 at pre-treatment and 51/90 at post-treatment (it is important to note however that scores inclusive of the parenting question, that which was taken out of this study, B1's results would display a slight increase in overall quality of life).

Emotional and Behavioural Functioning (Anxiety, Depression and Low Self-Esteem)

IAPT non-caseness had not been achieved in particularly the GAD7 measure nor reliable improvement achieved for both anxiety and depressive symptoms within this case however we must bear in mind that the trauma-work was interrupted by COVID-19 and hence, BLS did not take place due to technical issues with her phone camera to carry out remote sessions and equally, due to possible ongoing risk. Hence, the therapy contract very much focused on EMDR phases 1-2. Though, B1 was aware that she could re-refer at any time following a period of consolidation of current learnt preparation skills.

Anxiety (relating to the GAD7, WPS-CR question 2)

Consistent with the below graph displaying GAD7 outcome data, B1 recognised a slight decrease in her levels of anxiety as therapy went on reflective of her answers when asked WPS-CR question 2 ("I feel nervous or worry about things"), reporting "all of the time" at pre' and "some of the time" at post-treatment.

Depression (relating to the PHQ9, WPS-CR question 1)

Fairly consistent with the below graph displaying PHQ9 outcome data, B1 recognised only a slight decrease in her levels of depressive symptomology as therapy went on however her self-evaluation when asked WPS-CR

question 1 (“I feel sad”), suggested not changes at pre’ to post-treatment (reporting “some of the time” at both points).

Low Self-Esteem (relating to the RSES, WPS-CR question 3, 7)

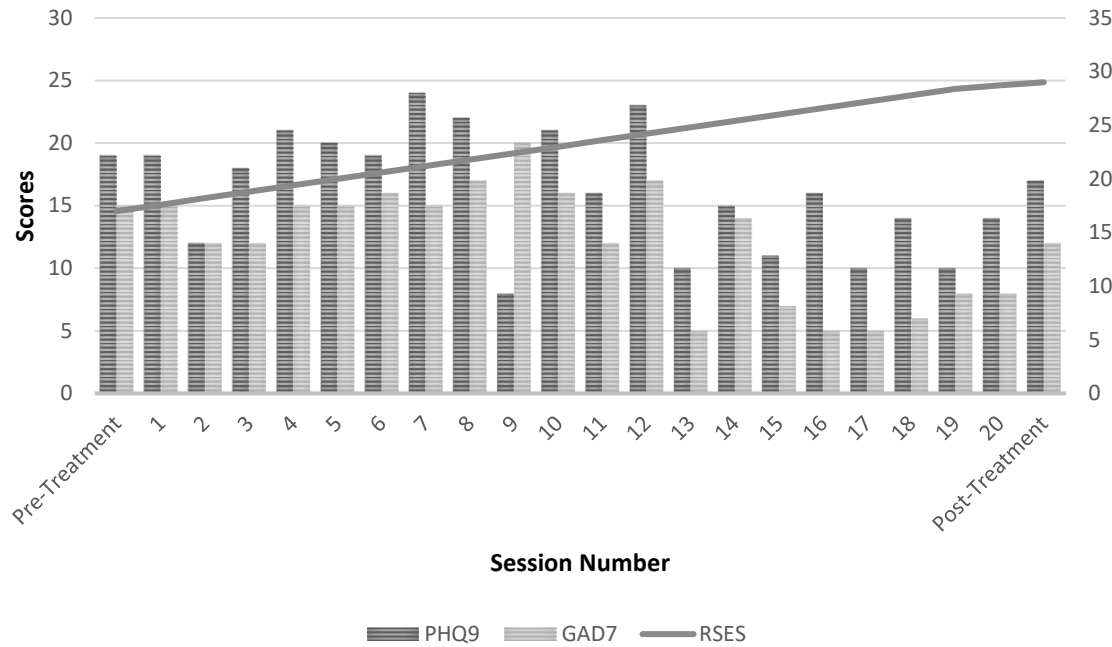
B1 responded as follows to WPS-CR self-report questions:

3) “I like myself” - pre “almost never” to post “almost never” treatment

7) “I feel like I am as good as other kids/people” - pre “almost never” to post “a little of the time” treatment

Though B1 self-reported a slight improvement when comparing self to others she did not report of any changes in liking herself as seen above; however as seen in the below graph displaying RSES outcome data, B1’s self-assessment of levels in self-esteem suggest that she noticed an improvement in confidence from pre- to post-treatment.

TABLE OF PRE-POST RSES AND SESSIONAL PHQ-9 & GAD-7 SCORES



Memory (relating to the WPS-CR question 9 - I am forgetful)

Pre-treatment: Some of the time

Post-treatment: Most of the time

Memory (relating to the Pre-Treatment PEBL Corsi Blocks Test (PCBT) Results)

Block Span: 5

Total Score: 40

Total Correct Trials: 8

Memory Span: 5

Attention (relating to the WPS-CR question 10 - I have trouble paying attention)

Pre-treatment: Most of the time

Post-treatment: Most of the time

Attention (relating to the Pre-Treatment PEBL Attentional Network Test (PANT) Results)

Total Errors: 25

Mean Accuracy: 0.91

Mean Response Time (milliseconds): 468.47

Alerting (all trials): 68.52

Orienting (all trials): 33.15

Conflict (all trials): 78.46

Alerting (correct trials): 64.92

Orienting (correct trials): 42.99

Conflict (correct trials): 104.87

Executive Functioning (relating to the WPS-CR question 11 - I have trouble planning ahead and following through on tasks)

Pre-treatment: A little of the time

Post-treatment: Most of the time

Executive Functioning (relating to the PEBL, Pre-Treatment PEBL Iowa Gambling Task (PIGT) Results)

	<p style="text-align: center;">Mean Number of Good–Bad Card Selections per Deck</p> <table border="1"> <caption>Data for Mean Number of Good–Bad Card Selections per Deck</caption> <thead> <tr> <th>Mean (A+B - C+D) Card Selections Range</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>0.1-20</td> <td>16</td> </tr> <tr> <td>21-40</td> <td>-8</td> </tr> <tr> <td>41-60</td> <td>-8</td> </tr> <tr> <td>61-80</td> <td>12</td> </tr> <tr> <td>81-100</td> <td>4</td> </tr> </tbody> </table> <p style="text-align: center;">— Order of Card Selection Pre-treatment</p>	Mean (A+B - C+D) Card Selections Range	Score	0.1-20	16	21-40	-8	41-60	-8	61-80	12	81-100	4	
Mean (A+B - C+D) Card Selections Range	Score													
0.1-20	16													
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<p>Number of completed EMDR phases out of 8</p>	2													
<p>Independent Research Rater information (actual notes from the IRR)</p>	<p>OVERALL CASE VERDICT</p> <p>Affirmative – Moderate Improvement</p> <p><i>Independent Research Rater (IRR) Commentary</i></p>													

B1 presented with a complex range of issues and her treatment was interrupted by Covid. One of her issues was OCD type fears related to “illnesses, infections and cleanliness” so this may have impacted her overall outcome as an additional stressor (Mediator variable). Identified moderator variables were some improvement (detailed in the interview and on some scores in her psychometric tests) that indicated a reduction in some of her self-reports and symptoms, e.g., Quality of Life = a slight increase in overall quality of life / Self-Esteem – an improvement in self-confidence / and self-reports at interview of EMDR being ‘invaluable’ and focussing more on the issues than other therapies she had undergone in the past). Increased feelings of being more in control even though some issues still remain in terms of increased self-reports of forgetfulness and some other indicators remaining the same (e.g., I get along with my friends / I have trouble paying attention – remaining the same pre and post treatment). That B1 said she would recommend EMDR to others and would revisit it in future to continue indicates an overall benefit of moderate improvement.

1. To what extent did the client change over the course of therapy? (rated on a scale of 0-100% at 20-point intervals) 40%

1a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 90%

1b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

B1 noticed a decrease in guilt (WPS-CR8 (pre) “most of the time” to “some of the time” (post). B1 only just missed IAPT non-caseness, however reliable improvement was achieved (41-point reduction) for trauma symptomology. VLQ, WPS-CR4-6 showed some fluctuation but general improvement overall. PHQ9 Depression and GAD7 showed Caseness but that this may be due to Covid interrupting treatment. There was some improvement pre and post treatment generally. RSES, WPS-C3,7 – “almost never” (pre) to “almost improvement” (post) indicating no change in self-liking. However, 7 demonstrated a change from “almost never” to “a little of the time” post treatment. PEBL-Corsi WPS-CR9 showed an increase in forgetting and PEBL-ANT, WPS-CR10 stayed improved pre and post 182 treatment at “most of the time”.

Clients measures (IESR, GAD and PHQ) change was minimal, client reported positive improvement in self soothing techniques and self confidence.

	<p>2. To what extent is this change due to the therapy? (rated on a scale of 0-100% at 20-point intervals) 100%</p> <p>2a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 100</p> <p>2b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?</p> <p>Client outlined that she can identify when moving into “child states.” She also reported she can self regulate and sooth rather than engage in self harming behaviour.</p> <p>B1 had OCD type fears at presentation so coronavirus may have impacted her ability to get maximum effect from the therapy if germs were a trigger of anxiety. However, B1 did state in interview that she would recommend EMDR to others.</p> <p>3. Which therapy processes do you feel were helpful to the client?</p> <p>Safe space, breathing, relaxation. Self soothing, STOPP (Stop, Take a step back, Observe, Pull back / Put in some Perspective, Practice what works)</p> <p>4. Which characteristics and/or personal resources of the client do you feel enabled her to make best use of her therapy?</p> <p>Developing a good therapeutic alliance and engagement with the therapy.</p> <p>Client’s readiness for change and engage in treatment.</p>
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B1 completed 2 phases of EMDR due to issues around interpersonal relationships, risk and possible underlying ASD. Therefore, B1 and her therapist jointly decided to concentrate on grounding and resource building techniques throughout the duration of her therapy contract, with view to re-refer for the remaining 6 phases of EMDR. B1 had previously experienced numerous modalities of therapy and hence, an idiosyncratic approach was taken by the therapist during this contract in order to broadly conceptualise her

comorbidities and steer away from diagnosis, as B1 reported that a linear approach had not previously helped. As expected, very little improvement was exhibited in terms of trauma symptomology however, it is clear that this was not the focus of treatment. Overcoming barriers in communication, installing resources to provide stability and preparation for future reprocessing were key objectives. B1 also reported of some worsening symptoms due to the ongoing COVID-19 pandemic, causing restriction in routines and connection with support networks.

4.1.5 B2 Case Presentation

Case identifier	B2
Brief demographic information	<p>Baseline DES score for dissociation: 39.07%</p> <p>Number of Sessions with Research Therapist: 19</p> <p>General Assessment and Treatment Overview</p> <p><i>Phase 1: History and Treatment Planning</i></p> <p><i>Previous Therapy;</i> Victim support (x1 session) before going to court 12 years ago; x2 sessions at drop-in service after losing father</p> <p><i>Comorbidities;</i> low mood, issues sleeping and anxiety</p> <p><i>Moderating life stressors;</i> works as professional dealing with sensitive family issues, living situation and isolation during COVID-19, house move, partner was involved in a car accident during treatment and B2 had witnessed this</p> <p><i>Age at onset and end of abuse;</i> earliest memory is at age 3, disclosed at age 13</p>

	<p><i>Duration</i>; approx. 10 years <i>Frequency</i>; “at least once a week” <i>Nature</i>; sexual and emotional (“grooming”) <i>Intrusiveness (scale of 1-10, 10 being severe)</i>; 10</p> <p><i>Risk</i>: no current issues of risk were identified and B2 stated that she had never engaged in any self-harming behaviours; she reported no issues with alcohol or drug use.</p> <p><i>Triggers</i>: mum being unwell, anything associated with Grandfather (e.g. walking/driving past his house), watching a TV programme, the smell of a particular aftershave, humbug sweets, whistling, people eating loudly, namely work-related stress</p>
<p>Brief overview of presenting difficulties (taken from clinical notes)</p>	<ul style="list-style-type: none"> - Reported an increase in nightmares; relating to effects of past traumatic events; feeling ‘something bad is going to happen’ - Anger towards her Dad because he is not here; his behaviour was selfish - Anger about not being offered support during the court case and at school. Participating in Jury service helped her realise that the verdict is determined by available evidence rather than the truth. Her family believed her when she told them what had happened to her. - B2 reported of feeling tearful, experiencing difficulties concentrating, restless, hypervigilance however now more aware/mindful of adult self though emotionally overwhelmed at times - When feeling low she would eat for the sake of it, not want to cook however was able to recognize it and push herself to see friends/be active - B2 experienced memories in the day and flashbacks/nightmares on a night; would “scream” in her sleep; has sleepwalked in the past; dreams about her Dad and her Grandad.
<p>Outcome measure results – descriptive statistics</p>	<p>Overall PTSD Clinical Symptomology (relating to the IESR, WPS-CR question 8)</p> <p>Consistent with in IESR scores, B2 recognised a decrease in her levels of guilt around the trauma when asked WPS-CR question 8 (“I feel guilty about things that have happened”), reporting “most of the time” at pre’ and “never” at post-treatment.</p> <p>B2 achieved both IAPT non-caseness and reliable improvement in trauma symptomology as she commenced treatment with a score of 65 and ended with a score of 8, showing a 57-point decrease.</p>

Quality of Life Issues (*relating to the VLQ, WPS-CR questions 4-6*)

B2 responded as follows to WPS-CR self-report questions:

- 4) "I argue or fight with people" - pre "almost never" to post "almost never" treatment
- 5) "I get yelled at or get into trouble" - pre "never" to post "never" treatment
- 6) "I get along with my friends" - pre "most of the time" to post "all of the time" treatment

Though the above responses show little change other than when with friends, B2's VLQ outcome data suggests that she noticed a slight reduction in general improvement in the outlined areas of life from pre- (scoring 76/90) to post- (scoring 63/90) treatment (it is important to note however that scores inclusive of the parenting question, that which was taken out of this study, results would display an increase in overall quality of life).

Emotional and Behavioural Functioning (Anxiety, Depression and Low Self-Esteem)

IAPT non-caseness and reliable improvement had been achieved in both the GAD7 and PHQ9 within this case regardless of shifts in BLS and delivery of treatment during COVID-19.

Anxiety (relating to the GAD7, WPS-CR question 2)

Consistent with the below graph displaying GAD7 outcome data, B2 recognised a decrease in her levels of anxiety when asked WPS-CR question 2 ("I feel nervous or worry about things"), reporting "all of the time" at pre' and "almost never" post-treatment.

Depression (relating to the PHQ9, WPS-CR question 1)

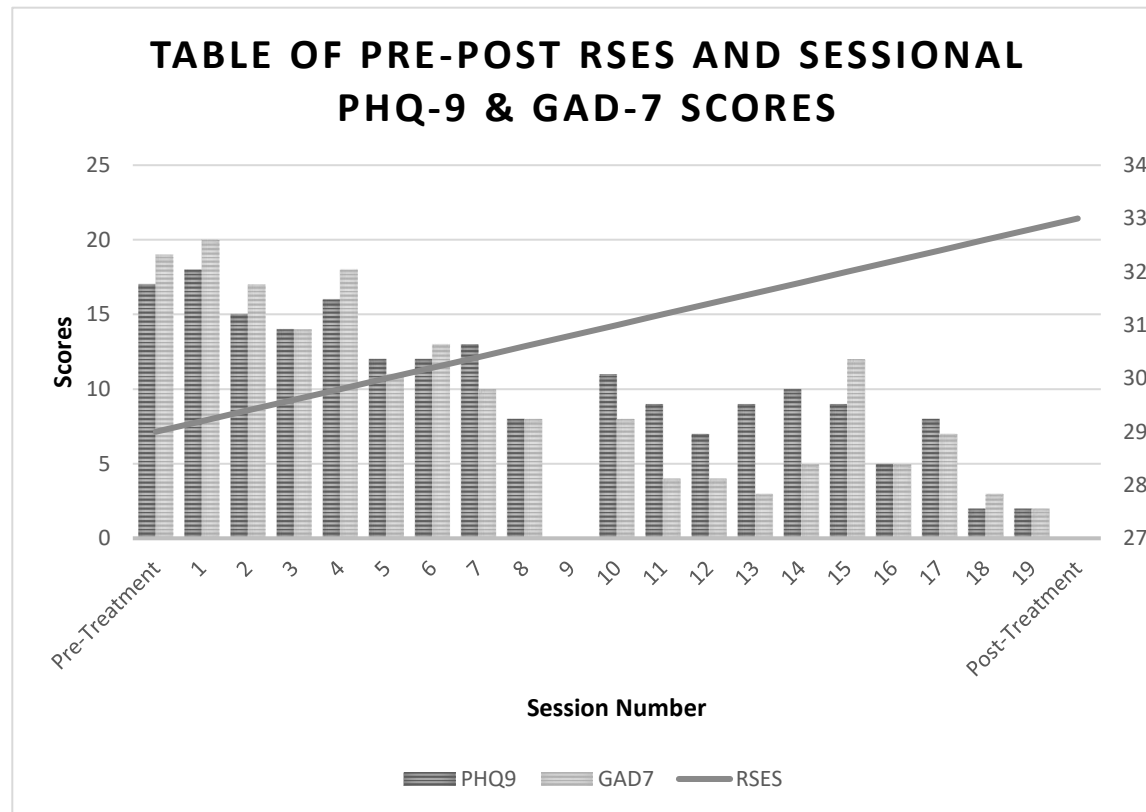
Consistent with the below graph displaying PHQ9 outcome data, B2 recognised a decrease in her levels of depressive symptomology when asked WPS-CR question 1 ("I feel sad"), reporting "a little of the time" at pre' and "never" post-treatment.

Low Self-Esteem (relating to the RSES, WPS-CR question 3, 7)

B2 responded as follows to WPS-CR self-report questions:

- 3) "I like myself" - pre "some of the time" to post "most of the time" treatment
- 7) "I feel like I am as good as other kids/people" - pre "all of the time" to post "most of the time" treatment

Consistent with the below graph displaying RSES outcome data, B2's self-assessment of levels in self-esteem suggest that she noticed an overall increase in confidence from pre- to post- treatment.



Memory (relating to the WPS-CR question 9 - I am forgetful)

Pre-treatment: Some of the time

Post-treatment: A little of the time

Memory (relating to the Pre-Treatment PEBL Corsi Blocks Test (PCBT) Results)

Block Span: 5

Total Score: 40

Total Correct Trials: 8

Memory Span: 5

Attention (relating to the WPS-CR question 10 - I have trouble paying attention)

Pre-treatment: All of the time

Post-treatment: Almost never

Attention (relating to the Pre-Treatment PEBL Attentional Network Test (PANT) Results)

Total Errors: 15

Mean Accuracy: 0.94

Mean Response Time (milliseconds): 871.08

Alerting (all trials): 54.87

Orienting (all trials): 49.68

Conflict (all trials): 110.26

Alerting (correct trials): 54.85

Orienting (correct trials): 31.90

Conflict (correct trials): 86.04

Executive Functioning (relating to the WPS-CR question 11 - I have trouble planning ahead and following through on tasks)

Pre-treatment: Some of the time

Post-treatment: A little of the time

Executive Functioning (relating to the Pre-Treatment PEBL Iowa Gambling Task (PIGT) Results)

	<p style="text-align: center;">Mean Number of Good–Bad Card Selections per Deck</p> <table border="1"> <caption>Data for Mean Number of Good–Bad Card Selections per Deck</caption> <thead> <tr> <th>Category</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>0.1-20</td> <td>-2</td> </tr> <tr> <td>21-40</td> <td>6</td> </tr> <tr> <td>41-60</td> <td>0</td> </tr> <tr> <td>61-80</td> <td>0</td> </tr> <tr> <td>81-100</td> <td>-14</td> </tr> </tbody> </table> <p style="text-align: center;">Order of Card Selection Pre-treatment</p>	Category	Score	0.1-20	-2	21-40	6	41-60	0	61-80	0	81-100	-14	
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21-40	6													
41-60	0													
61-80	0													
81-100	-14													
<p>Number of completed EMDR phases out of 8</p>	8													
<p>Independent Research Rater information (actual notes from the IRR)</p>	<p>OVERALL CASE VERDICT</p> <p>Affirmative – Positive Improvement</p> <p><i>Independent Research Rater (IRR) Commentary</i></p>													

B2 presented with a number of significant difficulties relating to nightmares and intrusive memories along with mediators such as a triggering job working with sensitive family issues, a house move and her partner having been involved in a road traffic accident. Nonetheless this is a positive improvement case as B2 had some awareness from jury service means that available evidence (rather than truth) is what determines the outcome of legal proceedings relating to crimes. Moderating factors are that B2 felt that the experience of EMDR had led to some significant improvements and these are reflected in the general pattern of her scores across all of the psychometric tests with the exception of those relating to arguing and yelling with others (which she didn't do prior to treatment). She had a significant improvement in the nightmares and intrusive memories and cognitive function too. When asked if she would recommend EMDR in the interview she responded that '100%' she would.

1. To what extent did the client change over the course of therapy? (rated on a scale of 0-100% at 20-point intervals) 100

1a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 100

1b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

Client is no longer in caseness in IESR, PHQ or GAD.

Overall trauma symptomology reduced (guilt) to "never" post treatment from "most of the time" (pre). IAPT non-Caseness and reliable improvement reached. VLQ, WPS-CR4-6 show general improvement. PHQ9 Depression (pre) 17 to 8 (post) and GAD7 19 (pre) to 6 (post) showing significant improvement. RSES, WPS-CR 3, 7 – overall increase in confident pre to post treatment. PEBL-Corsi, WPS-CR9 – "some" to "a little" showing a decrease in forgetting. PEBL-ANT, WPS-CR10 – attention / trouble paying attention "never" post treatment compared to "all of the time" pre.

2. To what extent is this change due to the therapy? (rated on a scale of 0-100% at 20-point intervals) 100

2a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 100

	<p>2b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?</p> <p>B2 in interview made it clear that she felt far better and had challenged a number of self-beliefs. She also said she would recommend EMDR “absolutely 100% yes.”</p> <p>Client evidenced in interview how EMDR helped her in making progress, emotional shifts and improving her quality of life.</p> <p>3. Which therapy processes do you feel were helpful to the client? Preparation and reprocessing.</p> <p>Preparation and reprocessing.</p> <p>Identifying her emotions and the preparation stage with techniques to use as treatment progressed and beyond if necessary.</p> <p>4. Which characteristics and/or personal resources of the client do you feel enabled her to make best use of her therapy?</p> <p>Readiness for change, client reported she is psychologically minded.</p> <p>B2’s motivation and personal insights. B2 appeared quite motivated to engage.</p>
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B2 had experienced limited prior therapeutic support, in total, 5 target memories were reprocessed. Although self-esteem, measured via WPS-CR responses had been reported to have reduced at post-treatment, B2 did report of an increase in self-compassion during the one-month follow-up interview. B2 reported of now being more aware of her needs and in identifying how to deal with these. B2 scored low on the PEBL subtest, PIGT, at pre-treatment however exhibited a significant improvement in executive functioning, which was consistent with her WPS-CR responses at post-treatment.

4.1.6 B3 Case Presentation

Case identifier	B3
Brief demographic information	<p>Baseline DES score for dissociation: 22.82%</p> <p>Number of Sessions with Research Therapist: 13</p> <p>General Assessment and Treatment Overview</p> <p><i>Phase 1: History and Treatment Planning</i></p> <p><i>Previous Therapy</i>; counselling in school, found unhelpful</p> <p><i>Comorbidities</i>; insulin dependent diabetes (at times, resultant in seizures) and celiac; when depressed B3's blood sugars increase and when anxious she loses her appetite; brain malformation had been detected in 2008, ongoing migraines; high risk due to COVID-19 hence isolation; Low Vitamin D hence prescribed tablets</p> <p><i>Moderating life stressors</i>; lack of employment, undertaking recruitment process during treatment, benefits application process</p> <p><i>Age at onset and end of abuse</i>; aged 5, uncle was perpetrator (he was also abusive towards other relatives and was charged)</p> <p><i>Duration</i>; one isolated incident</p> <p><i>Nature</i>; sexual</p> <p><i>Intrusiveness (scale of 1-10, 10 being severe)</i>; 8</p> <p><i>Risk</i>: at assessment B3 denied any use of recreational drugs currently or historically. No excessive use of alcohol. She reported of impulsive thoughts and behaviours about hurting self, queried "a voice that tells me to do things;" B3 recognised this to be her own voice, no hallucinations reported.</p>

	<ul style="list-style-type: none"> - B3 stated she will scratch her hands and head / that it is not intentional; if she is wound up she will dig her nails into her body to feel something; she will hit her head on a wall (had done this a few weeks ago stating “I feel like I’m trapped, enclosed, it’s like an impulse, I just want to feel something”) - Age 9 when she had a greater understanding of her parent's fights she tried to hang herself - During high school she overdosed on her insulin; on one occasion this caused her to have a seizure and an ambulance was called; mum realized and referred to a Child Psychologist; her parents told her not to talk about her home life so she only talked about her health and bullying at school. - She has cut herself a few times in the past (self-harming); she has not done this for 4 years because of her partner (they have been together for 6 years). - Protective Factors include boyfriend; they live with his parents; his mum understands that she is struggling and checks in on her - In the past she would disconnect her insulin pump and binge eat, B3 stated that if she had plans to end her life that she would take an Insulin overdose; difficult to reduce access as she has an Insulin pump; no current plans to do this and rated it as 2/10 on the IAPT measure <p><i>Triggers:</i> negative comments, described her Gran as “bullying her” via derogatory remarks, interpersonal issues with mum, childhood memories, visiting step-dad and mum and feeling that they are “avoiding me, I felt offended, why has she got the right to do that, what have I done wrong.”</p>
<p>Brief overview of presenting difficulties (taken from clinical notes)</p>	<p>Psychological Difficulties:</p> <ul style="list-style-type: none"> - Remembering the abusive experiences from her childhood; having dreams that she is back there. - Talking to people and seeing that her earlier life was not normal. - Themes of everything being her fault and her feeling that she is not worth anything; worrying that she has upset people; that she constantly blames herself. - Anxiety difficulties; she cannot deal with groups of people and she struggles with meeting new people. - Depression; she will feel exhausted and not want to leave the house; she will stay in her room and not eat and drink; a couple of times a week for a few hours she will not talk to people and will hate herself; she can pull herself out of it by drawing, listening to rain sounds, having soft toys, having a soft blanket or a hot water bottle. Whilst feeling depressed she will feel sorry for herself and think that she is not worth helping. The depression can make her want to hurt herself; she can also feel suffocated and it helps if she leaves the house; she will not take her purse with her so that she is unable to go far. She will bath and shower every day but not always get dressed if she is not going out; she can go hours without getting herself food and drink; she will avoid leaving

	<p>her room as she does not like to interact with her partner's parents although they are nice to her (she is aware of the negative impact on her Diabetes). She finds stroking animals helpful, for example, stroking her dog when she goes back home.</p> <p>- Memories of CSA - stated that she began to recall these memories within the last couple of years; she had remembered it in nightmares and then she started to remember bits but that it is fragmented; she feels that it may have been triggered by her being in her first relationship (she had previously not been interested in relationships or intimacy); she felt “weird” and started to put it all together.</p>
<p>Outcome measure results – descriptive statistics</p>	<p>Overall PTSD Clinical Symptomology (<i>relating to the IESR, WPS-CR question 8</i>)</p> <p>Consistent with in IESR scores, B3 recognised a slight decrease in her levels of guilt around the trauma when asked WPS-CR question 8 (“I feel guilty about things that have happened”), reporting “all of the time” at pre’ and “most of the time” at post-treatment, (despite her treatment contract consisting of solely EMDR phases 1-2).</p> <p>Although B3 did not achieve IAPT non-caseness, reliable improvement was achieved in trauma symptomology as she commenced treatment with a score of 66 and ended with a score of 57, showing a 9-point decrease.</p> <p>Quality of Life Issues (<i>relating to the VLQ, WPS-CR questions 4-6</i>)</p> <p>B3 responded as follows to WPS-CR self-report questions:</p> <p>4) “I argue or fight with people” - pre “some of the time” to post “a little of the time” treatment 5) “I get yelled at or get into trouble” - pre “a little of the time” to post “a little of the time” treatment 6) “I get along with my friends” - pre “most of the time” to post “most the time” treatment</p> <p>Though only little improvement was seen in the above WPS-CR data, B3’s VLQ outcome data suggests that she did notice a general improvement in almost all areas of life from pre- to post- treatment; her overall personal sense of importance rose from 31/90 at pre-treatment to 44/90 at post-treatment, evidently showing an increase in her quality of life.</p> <p>Emotional and Behavioural Functioning (Anxiety, Depression and Low Self-Esteem)</p>

B3 remained within IAPT caseness for the GAD7 and reliable improvement had not been achieved for anxiety however, this was achieved for depressive symptoms. Though, we must bear in mind B3's multiple trauma history in accordance with risk concerns, further complicated by the switch from face-to-face to remote sessions due to COVID-19; for which the therapist undertook additional training to adequately manage risk and hence phases 3 onwards were not started.

Anxiety (relating to the GAD7, WPS-CR question 2)

Inconsistent with the below graph displaying GAD7 outcome data, B3 recognised a no change in her levels of anxiety when asked WPS-CR question 2 ("I feel nervous or worry about things"), reporting "most of the time" at both pre' and post-treatment.

Depression (relating to the PHQ9, WPS-CR question 1)

Again, inconsistent with the below graph displaying PHQ9 outcome data showing slight decrease in depressive symptoms, B3 recognised no change when asked WPS-CR question 1 ("I feel sad"), reporting "most of the time" at both pre' and post-treatment.

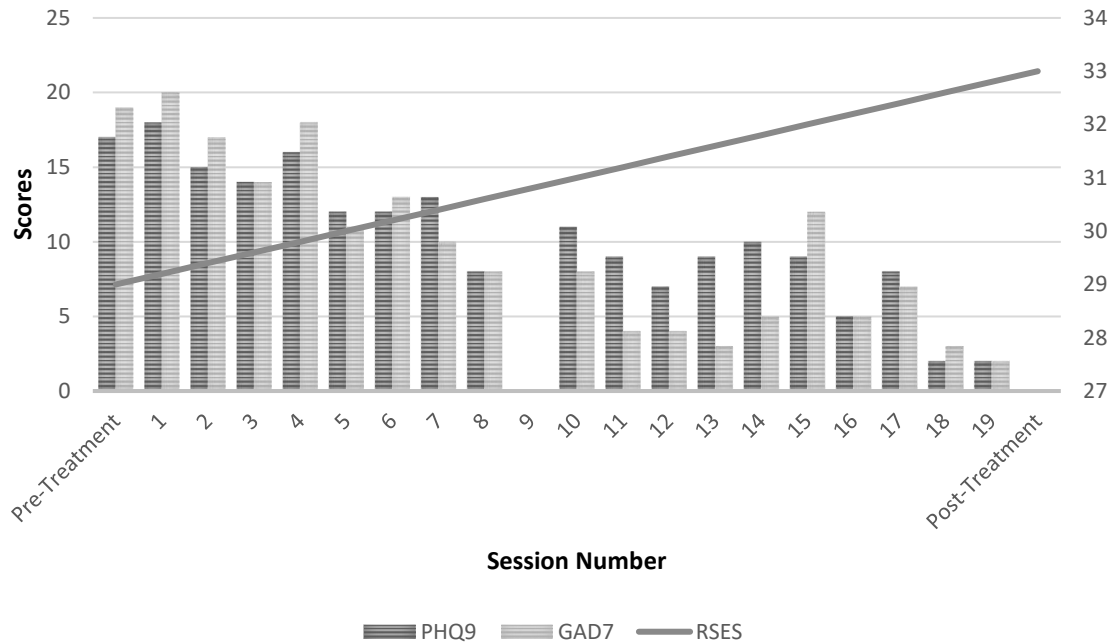
Low Self-Esteem (relating to the RSES, WPS-CR question 3, 7)

B3 responded as follows to WPS-CR self-report questions:

- 3) "I like myself" – at both pre and post-treatment she reported "almost never"
- 7) "I feel like I am as good as other kids/people" – pre- "never" to post- "almost never" treatment

Inconsistent with the below graph displaying no change in RSES outcome data, B3's self-assessment of levels in self-esteem suggested that she noticed a very slight if increase in confidence from pre- to post- treatment.

TABLE OF PRE-POST RSES AND SESSIONAL PHQ-9 & GAD-7 SCORES



Memory (relating to the WPS-CR question 9 - I am forgetful)

Pre-treatment: A little of the time

Post-treatment: Some of the time

Memory (relating to the Pre-Treatment PEBL Corsi Blocks Test (PCBT) Results)

Block Span: 6

Total Score: 48

Total Correct Trials: 8

Memory Span: 5

Attention (relating to the WPS-CR question 10 - I have trouble paying attention)

Pre-treatment: All of the time

Post-treatment: Some of the time

Attention (relating to the Pre-Treatment PEBL Attentional Network Test (PANT) Results)

Total Errors: 12

Mean Accuracy: 0.95

Mean Response Time (milliseconds): 714.64

Alerting (all trials): -41.75

Orienting (all trials): 27.79

Conflict (all trials): 394.79

Alerting (correct trials): -39.41

Orienting (correct trials): 12.76

Conflict (correct trials): 384.24

Executive Functioning (relating to the WPS-CR question 11 - I have trouble planning ahead and following through on tasks)

Pre-treatment: A little of the time

Post-treatment: Some of the time

Executive Functioning (relating to the Pre-Treatment PEBL Iowa Gambling Task (PIGT) Results)

	<p style="text-align: center;">Mean Number of Good–Bad Card Selections per Deck</p> <table border="1"> <caption>Data for Mean Number of Good–Bad Card Selections per Deck</caption> <thead> <tr> <th>Age Group</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>0.1-20</td> <td>-8</td> </tr> <tr> <td>21-40</td> <td>14</td> </tr> <tr> <td>41-60</td> <td>-4</td> </tr> <tr> <td>61-80</td> <td>14</td> </tr> <tr> <td>81-100</td> <td>4</td> </tr> </tbody> </table>	Age Group	Score	0.1-20	-8	21-40	14	41-60	-4	61-80	14	81-100	4	
Age Group	Score													
0.1-20	-8													
21-40	14													
41-60	-4													
61-80	14													
81-100	4													
<p>Number of completed EMDR phases out of 8</p>	<p>1-2</p>													
<p>Independent Research Rater information (actual notes from the IRR)</p>	<p>OVERALL CASE VERDICT</p> <p>Affirmative – Moderate Improvement</p> <p><i>Independent Research Rater (IRR) Commentary</i></p>													

Mediator factors for B3 are that her self-harm may have reduced somewhat due to the influence of her current partner's presence rather than the effect of the treatment. After failing the (job) interview, a panic attack ensued and so did self-harm (another mediator). She also had generalised anxiety surrounding life events like the interview (the psychometrics evidence GAD remains high). Covid may also be a factor influencing anxiety due to having an underlying health condition. Another mediator may be the diabetic fit B3 had but B3 did use some of the techniques (moderators) from EMDR such as distress tolerance in the form of the safe space, tent, self-soothing and rain sounds. However, in terms of other slight improvements in terms of the psychometrics and general behaviours / feelings (depression, self-esteem and a slight decrease in guilt related to self-blame) B3 did appear to have some benefit from the intervention. She has complex issues hence the therapist identified and offered 4 additional sessions. B3 similarly reported that she had ideation of self-harm but knew she wasn't going to do it. Trauma symptomology reduced even though overall B3 remained within IAPT caseness. Fighting with others reduced and there was a general improvement in all areas of life from pre to post treatment as did self-liking slightly. B3 (research interview) identified self-soothing was useful, as was discovering that there is no shame in feeling vulnerable (another form of self-soothing). B3 stated that the therapist assisted with her learning to self-validate and that there was a long way to go, but it was a start (better than the other therapies she'd had which she didn't find as helpful).

1. To what extent did the client change over the course of therapy? (rated on a scale of 0-100% at 20-point intervals) 60%

1a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 80%

1b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?

Client's scores on IESR reduced significantly, client reporting increase in self soothing and emotional regulation techniques.

WPS-CR8 slight decrease in guilt (pre) 'all of the time' to 'most of the time' (post). B3 remained within IAPT Caseness but reliable improvement was achieved. VLQ, WPS-CR4-6 suggested a general overall improvement in her quality of life. PHQ9 Depression reduced from 22 to 19 post treatment and GAD7 from 19 to 13 (pre to post). RSES, WPS-CR 3, 7 – indicate no general improvement yet B3 self-assessment reports a

	<p>very slight increase in self-confidence. PEBL-Corsi, WPS-CR9 – forgetfulness from (pre) “a little of the time” to “some of the time.” PEBL-ANT, WPS-CR10 – pre “all the time” to “some of the time” post.</p> <p>2. To what extent is this change due to the therapy? (rated on a scale of 0-100% at 20-point intervals) 80</p> <p>2a. How certain are you? (rated on a scale of 0-100% at 20-point intervals) 100</p> <p>2b. What evidence presented in the affirmative and sceptic cases mattered most to you in reaching this conclusion? How did you make use of this evidence?</p> <p>Client identified specific interventions which were of use to her</p> <p>B3 said that self-soothing and distracting helped her most and that her safe space (the tent) that she learned in therapy was of use to her. She self-reports that her self-harming has reduced and that she now pauses prior to self-harm and questions “what’s that gonna do?” with a reduced desire to act upon the thoughts.</p> <p>3. Which therapy processes do you feel were helpful to the client?</p> <p>Assertiveness, STOPP, identifying emotions, ego states.</p> <p>B3’s ability to use the safe space and reflect on her self-harming actions without immediately acting on them.</p> <p>4. Which characteristics and/or personal resources of the client do you feel enabled her to make best use of her therapy?</p> <p>Developing a good therapeutic alliance and her willingness to trust a safe enough person (the therapist) as trust can be difficult to do post-trauma. Previous therapy helped her to develop coping strategies.</p>
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B3 had previously experienced therapy at school which she had found to be unhelpful, she disclosed that she was not entirely honest nor felt she could engage with therapeutic support due to fear of the consequences, if there were breaks in confidentiality.

The therapist and client within the current therapy contract, prioritised risk and stability due to her presentation and long-term health condition of diabetes, which was especially important as she fell within the high risk group during her treatment (at the time of the COVID-19 pandemic). Although little improvement was displayed in her depressive symptoms via the PHQ9 and no change in WPS-CR responses; at interview, she reported that the preparation phase had helped with mood regulation, which in turn had supported her in managing her diabetes. Similarly, her RSES scores showed no difference in self-esteem however at interview, she reported that her confidence had somewhat improved, this may have been as she had been allowed time to reflect upon changes. Consistent with others that had experienced moderating life stressors, B3 displayed low levels of memory and executive functioning, and high levels of anxiety and depression. In terms of attention, alertness was scored low at pre-treatment however, improved as measured by her WPS-CR responses, at post-treatment.

4.1.7 Independent Research Rater (IRR) Outcomes

IRR's were able to provide an unbiased opinion of their analysis which indicated overall improvement in the participants functioning following treatment, as follows:

TABLE 2: INDEPENDENT RESEARCH RATERS (IRR'S) OUTCOME

Case	Rater	Outcome	Consensus
K1	Carla	Affirmative	Affirmative – Positive Improvement
	Zaynab	Affirmative	
K2	Carla	Affirmative	Affirmative – Positive Improvement
	Zaynab	Affirmative	

K3	Carla	Sceptic	Sceptic – No Improvement
	Zaynab	Affirmative	
B1	Carla	Affirmative	Affirmative – Moderate Improvement
	Zaynab	Affirmative	
B2	Carla	Affirmative	Affirmative – Positive Improvement
	Zaynab	Affirmative	
B3	Carla	Affirmative	Affirmative – Moderate Improvement
	Zaynab	Affirmative	

During discussion with an IRR, she stated *“Regarding K3 the 20% improvement (on my part) was due to some changes but no lasting change. As with any intervention, some change or improvement is the goal, so the slight changes K3 had could have been due to this, without achieving lasting change. (11/11/20 via email).”* This suggests that even the sceptic case showed some improvement which may have continued if barriers had not been presented in treatment. Therefore, knowing that she can return to complete EMDR (should she be allowed to remain in the UK) was encouraging.

4.2 QUALITATIVE THEMATIC ANALYSIS FINDINGS

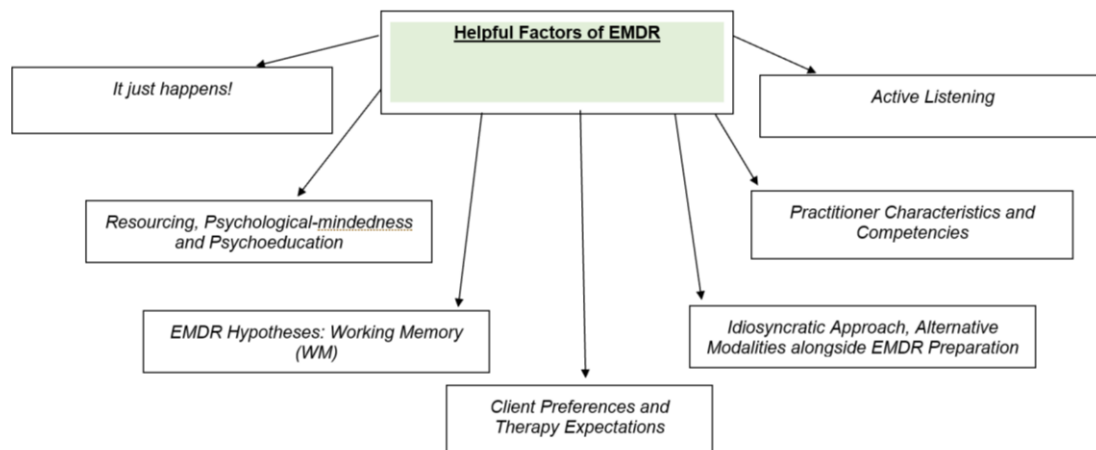
As outlined in literature (Bohart, 2000; Duncan et al, 2004), the client is an active change agent in therapy, adding variance in ways of conducting sessions and consequently, in any gains attained from the process. Although the therapeutic alliance is a key component, this is harvested by the client's self-awareness as a main derivative in session work and much therapeutic progression (Rennie, 2001).

The impact of this case series analysis may be limited in comparison to the gold standard of RCT's (Beutler and Forrester, 2014) however prior research provides a wealth of qualitative data in assessing therapeutic change agents such as those highlighted in this study e.g. active listening, welcoming and confidential atmosphere to share concerns, impartial or non-judgmental environment and emotional connectivity (Ringel, 2014; Elliott and James, 1989; Gallagher, Tracey, and Millar, 2005; Omylinska-Thurston and Cooper, 2014; Simonsen and Cooper, 2015). Thus, illustrating a complex picture of the improvements seen in clients, one which evidence-based practice, whereby the idea of evidence itself is fundamentally seen as unproblematic (Bohart and House, 2008) may struggles to quantify (Scott, 2010) due to the need for complex dialogue (Stiles, 2013).

Three key themes for this study emerged from the analytical steps of TA (Braun and Clarke, 2006) outlined in the Methodology Chapter; all main- and sub-themes considered to be significantly recurrent will be detailed below, with the addition of transcript extract quotations to exemplify individual participants.

4.2.1 Key Theme 1: Helpful factors of EMDR

FIGURE 6: KEY THEME 1 - HELPFUL FACTORS OF EMDR



4.2.1.1 Resourcing, Psychological-mindedness and Psycho-education

Evidently clients are active as opposed to passive recipients of therapy (Wampold, 2012) and their input elicits change (Norcross, 2012) which happens resultant of their interpretations of therapy sessions (Mackrill, 2009). This may explain why some participants in the present study required more sessions than others (as outlined in individual rich case records, please see Results), since change occurs at varying points throughout treatment hence preparedness, motivation or psychological-mindedness and resourcing play a significant (estimated at 40%) role in outcomes (Duncan et al. 2010). In consideration of Barrett *et al.* (2008) review of attrition indicating 65% drop-out rate and that of the National Audit of Psychological Therapies (RCP, 2011) with a median of 19%, with up to 50% in some IAPT services; drop-out rates for the current study remained at a minimum in align with Reis and Brown (2006) study indicating lower drop-out for those who display preparedness.

Contrary to some research (Jones and Pulos, 1993; Coombs, Coleman, and Jones, 2002), suggesting ineffectiveness in educational or directive processes in therapy; it appeared that consistent psycho-education, of not only the therapy itself however, extra-therapy factors, helped participants in the current study to understand therapeutic processes and apprehend the bigger picture of change, possibly also a contributor to the minimal drop-out (Walitzer, Dermen and Connors, 1999; Guajardo

and Anderson, 2007). As displayed in the descriptive statistical results, broader quality of life issues (e.g. socio-economic status as per clinical assessment/treatment notes, lack of support network as per the VLQ responses and interview feedback etc) contribute to the participants engagement in sessions and improvements in their clinical outcome (Sprenkle and Blow, 2004). However, in agreement with Coombs, Coleman, and Jones (2002), evidently such results had equally been achieved due to the collaborative emotional exploration of stressors within the context of a safe, non-judgmental, empathic therapeutic relationship, as backed by the current research.

Interestingly, though an array of techniques were employed and positively commented on during interviews (e.g. general psycho-education around trauma for K1, K2; distraction for B3; emotional regulation for B2, B3; parts/ego-state work for particularly B1 and B3) during this phase however all participants positively commented on namely safe place (K2 reported *“she (therapist-2) allowed me to create like some space and then we went back and forth a few times. I don't know, so we go from the actual therapy (referring to phases 3-6) itself to then thinking about that (safe) place (phase 7) and that helped a lot in terms of just sort of levelling me.”*) and mindful-breathing (MB) (K3 reported *“I think, breathing techniques she told me before going to sleep and then that one was very helpful... Then sometime if I worry, I breath slow and it help me... You know the image with that in our mind”*) as being helpful which is a function of Mindfulness-Based Cognitive Therapy (MBCT), just as Ems are a function of EMDR. Although these approaches are dissimilar, there appear to be procedural similarities in that clients are asked to recall disturbing images, not to challenge/contain but accept these and then undertake a dual task (e.g. Ems in EMDR or MB in MBCT). van den Hout and Engelhard (2012) applied reaction time (RT) tasks to determine whether MB taxes working memory (WM); correspondingly, participants' RT rose considerably when undertaking both MB and Ems. Furthermore, two independent experiments were conducted to determine the influence of MB on disturbing imagery. In study 'One,' both Ems and MB decreased emotionality of memories, with Ems also decreasing vividness. In study 'Two,' neither Ems or MB had an effect on emotionality however, both on vividness. Hence, both interventions similarly tax WM to an equal extent and likewise, approximately

similar for both vividness and emotionality of disturbing imagery. This may be one reason why so many participants responded well to preparation work, especially MB alongside EMDR.

Importantly however many other factors in the outcome of treatment were present, some commented on their personal traits as a factor of change orientation, as summarised by B2:

“I think you have to be ready to do this, like obviously what happened for me, this therapy is happening 12 years after the event and it happened for 13 years of my life. I didn't feel able to have the therapy and I didn't allow myself to even admit that I was upset or affected by abuse until I was an adult until I don't know (started her professional studies), like Masters. So, I think for me, I think you need to be able to allow yourself to feel those emotions and acknowledge that actually you might be struggling a little bit. It's like you have to be in a place to accept help. And yeah, I definitely am very psychologically minded, which definitely did help. I think because I'm open minded and I like abstract ideas; I think my personality type, these definitely helped.”

4.2.1.2 Practitioner Characteristics and Competencies

As displayed in interview data, potency in the therapeutic alliance positively impacted upon treatments outcomes, as did high levels of therapist adherence (Elkin, 1994; Elkin et al, 2006), teamed with flexibility in the therapist's approach in applying EMDR change mechanisms and alternative modalities of treatment (e.g. CBT, DBT), if needed. Although those exhibiting greater severity in quality of life issues observed lesser improvement, they did display overall pre- to post-treatment enhancements in their clinical presentations, unlike the suggestion from Sotsky *et al.* (1991), debating the client's capacity to make use of therapy, as associated with their degree of impairment in such areas. This clearly exhibits the strength in EMDR fostering the therapeutic alliance as a flexible and progressive treatment.

Feedback was also received around interpersonal and professional therapist attributes/skills, including how the individual therapists were perceived by their client's. For instance, B2 reported that her therapist was *"very understanding. I didn't feel judged"* and B3 reported that her therapist was *"the most helpful actual therapist I've had 'cause I've... found them always probably not intentionally, but they felt quite condescending... (therapist-1) is genuinely more engaging and speaks...It's more like having a chat with a friend than feeling clinical and judged...It gave me the motivation to work harder on the techniques"* (B3).

The level of empathy and shared connection (e.g. K2 reported *"it's just her character... for me it felt safe the treatment"*) in the therapeutic alliance was equally paramount in feedback. Similarly, K1 stated that *"there was one particular session which I found really, really hard and sort of got quite emotional...it just helped be able to know that there wasn't no sort of judgment from her side... just her whole attitude towards it really helped me... I think by her letting me carry on and just try and get through it 'cause I found that sometimes I kind of, I'd freeze up and I don't really know how to finish saying what I want to say because it's not something that's easy to talk about but by her allowing me to just have that space, it just really helped in the end, although it was hard at the time... like we did a whole hour of actual processing and she always says sort of how hard that is to do and like, well done throughout it, so I think just that kind of encouragement as well..."*

Such attributes associated with professional conduct however rather, those perceived by clients as 'natural' positive qualities of their therapist as a human e.g. neutrality, composure, tolerance, consistency, welcoming, and foremost upholding emotional connectivity with their clients, were all cited as significant characteristics in allowing the client to feel a sense of 'belonging' in the therapeutic alliance (Jones-Smith, 2018; Bachelor, 2011), and subsequently encouraging the outcome of the therapy (Whitehouse, 2019; Owen, Wong, and Rodolfa, 2010).

The power balance between client-therapist was additionally a key component in the change process with many commenting on how they trusted their therapist to lead sessions however that regardless of occasional reflection, query and challenging of beliefs, the relationship was collaborative and valuing of client responses (Gallagher, Tracey, and Millar, 2005); this was further consolidated by B1 reporting:

“Before (during prior treatments) I had been told several times by counsellors and professionals that it was this problem and I should go get this fixed but in those circumstances I was listening to them but with her (therapist-1), while you know she does work with us like together, I was more this is exactly how I feel, these are my issues and her giving this is the area we should focus on next session etc. She’d say this is the area we might focus on in this session and then we can touch on this thing in the next couple of sessions, rather than it just being like this is your problem, this is what we’re gona to do and you’re gona to do it without questioning things.”

However, this was evidently also due to an extension of a safe environment and client’s level of engagement (Anderson, Patterson, and Song, 2013; Frankl, Philips, and Wennberg, 2014), as below mentioned (specifically, due to COVID-related changes from face-to-face to remote sessions, causing issues with confidentiality etc).

In the present study, there was a wealth of both qualitative data and descriptive statistics signifying that such association between *interpersonal therapist attributes* and *professional competencies* were suggestive of the improvements seen in cases reviewed (Castonguay, 2011). Whereas, this may otherwise have been lost in an alternative methodology such as the RCT control for variables design, similar to that of the evidence-based practices’ endeavor to disregard individual variables by standardising practice (Norcross and Lambert, 2011).

4.2.1.3 Client Preferences and Therapy Expectations

Although participants in the current case study were not presented with a choice of therapist, rather this was based on locality and caseload capacity, they did however personally research/query EMDR in accordance with their treatment choices, consequently, no drop-out was observed during this project and good outcomes were derived, consistent with research from Swift, Callahan and Vollmer (2011). All participants had clear, realistic expectations of therapy however some more pessimistic of outcomes than others due to prior negative therapy experiences tainting their image of the current treatment. This echoes Constantino et al. (2011) study whereby a small, although noteworthy, positive effect was reported from hopeful predictive and realistic expectations about the happenings and outcomes of therapy.

4.2.1.4 Idiosyncratic Approach, Alternative Modalities alongside EMDR Preparation Techniques: Working with Presenting Symptoms

As per rationale provided during chapter 1 and 2 around need for a 'symptoms' approach, rather than a 'diagnosis' approach, participant B1 sums this up whilst reflecting on her present and prior experiences:

"In the past, not blaming the therapists but they just thought I was socially anxious because of the way I was referred in, they put me in a box, like this is a problem with anxiety and depression whereas this kind of course of therapy has very much been like not going to put labels on things and we won't focus on summat in particular - we're going to give you the skills you need to be able to deal with this before we even start with reprocessing. Yeah, I think just the more general approach of looking at maybe specific problems that are applied to different areas rather than saying oh this is 'anxiety or trauma' – it's really helped it develop... that obviously could really potentially affect how my brain works...like techniques that would be very helpful for maybe people without any kind of learning impairments, but for me, uh, it just don't work, but at the same time because we spoke about it quite early on, I think she (therapist-1) kind of tailored it more towards autism or Asperger's conditions...it's not really a recommendation, it's just maybe these things aren't being picked up

sometimes.”

Though this was not directly related to EMDR, it appeared to be extremely beneficial to the participants understanding of self and her struggles in improvement (potential barriers in her communication style and understanding of/response to certain techniques). Consequently, her preparedness to then undertake the remaining phases of EMDR. However, there are equally potential challenges in detecting such issues due to lack of funding for training staff in doing so and also possible issues around service pathways (e.g. long wait-times) in seeing the most appropriate clinician/service to identify such concerns.

Likewise, the EMDR preparation phase (2) for many was immensely helpful in that EMDR techniques were amalgamated with CBT/DBT techniques in helping improve *“interpersonal skills...literally like the basics of how you tell someone they have upset you...my emotional regulation isn't great, I don't really understand what I'm feeling all the time. So usually that translates into like frustration, which then makes me violent towards people...we touched on emotional regulation again and interpersonal skills because of feeling in crisis (B1),”* evidently, risk-related behaviours decreased in almost all participants that exhibited these *“the frequency has gone massively down whilst we've been doing this because before it was like a real problem and now it's the kind of just the whole waiting and seeing how the situation plays out. So, whereas before I'd just feel like I want to self-harm, then go to self-harm like whatever came into my mind, the yeah, the technique really works for me now. (B1)”*

However importantly, *“Learning about my beliefs, the psycho-education around myself...I think I didn't realize how many self-beliefs I had around emotions that were quite negative, such as, you know, thinking that you need to have a reason to cry and I think, just really unpicking those self-beliefs at the start, throughout that stage really helped me and be more open-minded to when we actually did the processing and allowed me to feel what I was feeling rather than blocking it. (B2)”* This equally

aided perceptions and manageability of unpleasant experiences (e.g. nightmares, intrusions), as reported by over half of participants – and set groundwork for particularly phases 3-6.

4.2.1.5 Active Listening

Every participant commented on the therapists intuitive listening skills, with K1 stating:

“I think at the time I couldn't even really even get the words out because I didn't know how. I was basically scared of her [the therapists] reaction and I think she was able to pre-empt that because she could read sort my mind and I think her acknowledging that helped in explaining it, I think again it just helped sort of strengthen that relationship as well because I knew that she was going to support me, just actual listen to me and there wasn't any judgment in that”

As discussed in the below depression section, target memories were attached to negative beliefs and in the therapist's clarification without assertion of their personal values and assumptions in how such links had been generated the participants reported feeling at ease in moving forward, giving means to their experiences (Gostas et al, 2012). Thus, such verification consequently elicited diverse ways of working and dialogue, in turn encouraging positive change (Gallagher, Tracey, and Millar, 2005; Lambert, 2007; Simonsen and Cooper, 2005), in a sense, acting as validation as described by B3 *“...speaking about these experiences that are negative... Recognising that wasn't a normal childhood. It is validating 'cause you don't feel as much as like sometimes you feel like, 'Oh it's my fault and I'm lying' but speaking and hearing that then feels a bit of a weight lifted off everything”* leading to increased self-worth (Fitzpatrick et al, 2009). A recent study (Jones-Smith, 2018) examining therapist perceptions indicated that a key theme in feedback was the therapist's perception in importance given to building a quality rapport, listening and teaching clients positive coping mechanisms.

4.2.1.6 It just happens!

A third of participants reported of EMDR working (regardless of some reservations) however that they did not understand how they had transitioned from experiencing emotional charge linked with traumatic memories to then memory recall with little/no or more manageable charge “*you’re able to process in a way knowing you can’t get rid of the memory, but if it does come up in life and you think about it, yeah, you’ll be able to deal with it, because it doesn’t affect you in the same way anymore. So, I think that’s kind of a really, again that powerful thing to be able to do that. You know, live with something that’s happened and carry on in life and not have it come up and cause issues (K1).*” Additionally, fragmented memory recall was another reported factor “*things would come back to me, I don’t know why...I can’t really articulate it too well, but it’s just to fix it where it needs fixing and then whatever else comes after (K2).*”

4.2.1.7 EMDR Hypotheses: Working Memory (WM)

There is argument for taxing the WM (Calancie et al, 2018; De Jongh et al, 2013; Gunter and Bodner, 2008; Lilley et al, 2009) and vice versa, to 'go slow' when a client dissociates. In the case of participant B2, she stated “*There were times when she (therapist) could see I was probably reliving the moment when we were doing the re-processing, those times she could see I needed support and to bring me down I know she slowed down her movements sometimes... I guess I didn’t really pay that much attention to it because it worked! I wouldn’t say that that really stuck out for me. I just went with it. She changed the direction and speed sometimes.*” The therapist made a clinical decision to continue to tax the WM (e.g. continued with BLS following the participants period of being ‘outside of the window of tolerance’) when she had possibly dissociated, consolidated by BLS during a slightly shorter period of time, based on the client’s presentation.

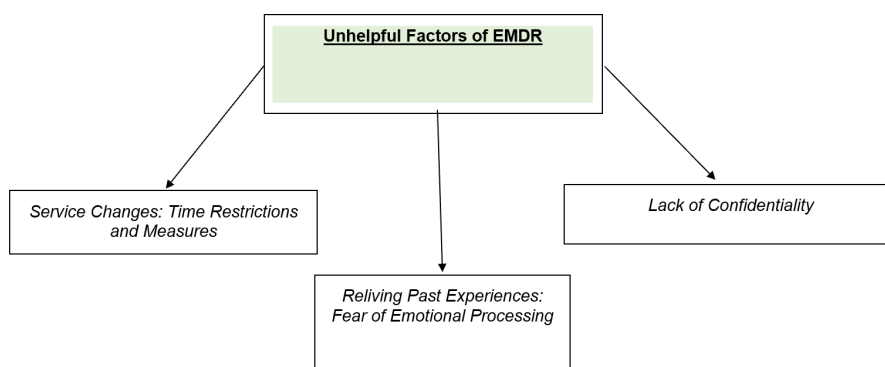
This was explored within the 'EMDR and Anxiety/Panic' Workshop (Fudge and Pike, 13/09/19) and is consistent with evidence suggesting that EMDR interacts with WM processes (e.g. visuospatial sketchpad and central executive) due to its dual-attention approach (split between BLS and a traumatic memory; Andrade, Kavanagh, and Baddeley, 1997) it is thought that performance declines when the WM is used for more than one task (e.g. writing, thinking; van Veen, Engelhard and van den Hout, 2016), and in the case of EMDR both eye movements and memory recall tax the working memories visuospatial sketchpad (Maxfield, Melnyk and Hayman, 2008), which consequently affects the traumatic memory held within this area (Baddeley, 2003). It is theorised that due to limited means within the WM to envisage the traumatic memory, the memory is then reconsolidated with lesser emotional intensity than prior to EMDR. Interestingly, of the 50% of participants that undertook the entire 8-phase EMDR protocol, only B2 attempted use of both arm movements during face-to-face sessions and also butterfly hugs during remote sessions (whereas the others used arm movements solely), the interview responses suggested that B2 recognised that the more the WM was taxed, the more distant the traumatic memory appeared, without feeling overwhelmed.

In extension to the previously discussed EMDR hypotheses (as per the Introduction chapter), it is evident that associating EMDR to testable predictions such as the adapting response, hemispheric communication and WM many in fact draw us closer to the understanding that one sole mechanism is not at work here however, that there may be an amalgamation of all (Gunter and Bodner, 2009). For instance, although the 'WM' model conveys the broadest expanse of evidence in understanding the desensitisation phase, it fails to explore the reprocessing aspect of EMDR as indicated in Shapiro's (2007) AIP model. Interestingly though, Maxfield, Melnyk and Hayman (2008) outlines an alternative interpretation of the 'WM' mechanism in that he proposes the deterioration of WM may allow the client to distance themselves from the trauma and reconsider their interpretation of this, without feeling conquered by their experience. He claims this occurrence takes place as connections are established between related material and the initial memory, consequently altering the manner in which the traumatic image is stored in memory networks, as seen in the above participant case example and Shields (2015) study.

Nevertheless, such investigation was too large for the scope of this project and regardless of no solid understanding of the mechanisms at work (Herbert et al., 2000), EMDR is an evolving and highly indorsed therapy within the NHS, especially for treating trauma within IAPT services.

4.2.2. Main Theme 2: Unhelpful factors of EMDR

FIGURE 7: KEY THEME 2 - UNHELPFUL FACTORS OF EMDR



Significantly, no EMDR-specific hindering factors were highlighted however it may be that the sample in this study was too small, or that clients felt a sense of loyalty towards their therapist as they were aware of results being published as part of the research project (Rennie, 1994; Elliott, 2008). Additionally, although one outcome displayed only 'sceptical' improvement, the participant did not report of rupture or lack of repair in their alliance with the therapist (Norcross and Wampold, 2011). Nor was therapist disregard for their experiences (von Below and Werbart, 2012) or unresponsiveness (Glass and Arnkoff, 2000) reported.

4.2.2.1 Service Changes: Time Restrictions and Measures

Although session time was not an overriding issue and those in this research were provided possibly more sessions than some afore-mentioned literature (indicating limited-dosages correlated to poorer-outcomes), it has been the consensus that restriction in session time (e.g. generally up to 16 sessions for 60-90mins allocated

within GMMH IAPT) and flexibility (e.g. x2 missed sessions resultant in discharge within GMMH IAPT) has been dismissive of client needs in fostering the change process (Glass and Arnkoff, 2000; Barkham et al., 2006; von Below and Werbart, 2012; McManus et al, 2010). Participants within this study received between 6-20 sessions (as per rich case records, please see Results), with a third of participants highlighting their anxiety around limited session time; *“I thought that wouldn’t be enough (time)”* (B3) and wait times; *“But it long time to wait again on list to do this (treatment) again[HB1]”* (K3). This was consistent with research of Cape et al. (2010), indicating poorer results for time-limited therapies in primary care due to funding shortages and evidence-based practice (Layard, 2012; Tomlinson, 2013) in comparison to those of longer duration thus debating insufficiency in therapy time as per the BACP report (2014) appraisal of uniformity between mental and physical complaint whereby 50% of participants felt the number of sessions offered was inadequate.

From the present study, practice-based evidence must be highlighted in the need for additional face-to-face (Mander, 2014) and general treatment session time (Antune-Alves et al, 2018) as many participants had previously attended services in seeking alternative therapy before commencement of their EMDR, with 50% re-referring for additional sessions following completion of the current EMDR contract. Hence, questioning whether this would have been necessary if longer time was initially allocated, consistent with findings from Gyani et al. (2011) within IAPT services and Antune-Alves et al. (2018) study, indicating least 12 to 20 therapy sessions required for real world change. GMMH IAPT treatment time appears more adequately placed than alternative Trust providers, beggin the question whether IAPT is consistent with Mearns and Thorne’s (2000, p41) perspective of the "politics of appearances," suggesting the importance of being seen to be ‘doing something’ even though this is considerably less than required. Accordingly, the profuse research of all valid therapies as effective (Lambert, 2013, p.43) would suggest the quandary that either such services are refined to provide adequate treatment dosages to lesser people or alternatively invest more resources into meeting client demand.

Additionally, though feedback collected from interviews and session notes

suggested; more welcoming/less clinical rooms, issues with changing/cancelling appointments and more flexibility around student holidays to account for risk during these times as there are two major Universities within the vicinity; the key theme of feedback was around the waiting time between EMDR phases 1-2 and EMDR phases 3-8 if discharged and re-referred. For instance, B3 stated; *“It would’ve been nicer to go from techniques to re-processing...like with waiting because I’ve had a set of sessions which I understand; it’s like syncing myself up again because it’s like going back into those memories again.”* Also, completion of the IAPT dataset, this was viewed as intangible for some in consideration of the already time-restricted sessions in addressing the clinical-work agenda (if unable to complete beforehand). However, this generally forms a mandatory part of IAPT services, whereby the client is asked to complete all measures prior to their treatment appointment via an online portal in order to avoid the possible ethical dilemma of taking time on measures versus actual treatment interventions.

Further, feedback suggested that 1-2 week/s between completion of IAPT-measures was not long enough to see a difference, B3 stated, *“Maybe monthly questionnaires instead of weekly so then we’re getting more of an average of the days because like now, one day a bad thing happens and that’s a seventh of your opinion down whereas in a month it’s a better overview and it’s like 30 days so if one bad things happened then it’s like oh, that’s not bad at all. I think there’s also a bit of a gap in the questionnaires where there’s good but then also a big jump in the answers – like one day and then several”*). The large shift in answers, in particularly the GAD7 and PHQ9 was also highlighted, as follows: *“it was like one of the markers was like ‘never’ and then jumped to like ‘several days.’ And it’s quite a jump to go from never to several days ‘cause like I could have marked ‘several days’ for some of them but that could have just been one day (B2)”*. This does illuminate practice-based issues in the conduction of measures with those struggling to complete the standard IAPT data-set due to the exclusion criteria highlighted within the present research (e.g. those with language barriers, special educational needs etc). Hence, demonstrating the inadequacy in parity between the socio-cultural client needs and that of the biomedical agenda of evidence-based practice (Kadam et al, 2001), possibly

indicating the outcome measure as superior over the client needs. Though equally, such need of measures for the purposes of research must be stressed.

As a side note, one participant fed back during interview and another during general communication in relation to the research methodology, particularly highlighting the research VLQ parenting question being slightly confusing as they could not comment on the subject of children/such responsibilities and hence it was decided to remove this question from the data-set as not to skew results.

4.2.2.2 Reliving Past Experiences: Fear of Emotional Processing

Some clients reported general unease at the thought of identifying negative beliefs associated with EMDR themes such as 'safety' and 'threat' when bringing up traumatic memories (Shapiro, 2011). This caused internal conflict in some and was somewhat worsened by looking to their therapist for guidance however realising that they would work through their own experiences and may have to rely on outside sources for support, especially in the case of K3 whereby external factors were massively affecting/blocking her in moving to the next phase of EMDR, she was heavily reliant upon external agencies to decide her future fate in relation to possibly re-meeting her perpetrator. Although barriers in remembering difficult experiences were addressed at commencement (during the history-taking, psycho-education phase), evidently some participants although acknowledging of information, remained to find it difficult to 'let go' of their inner fear leading to peaks from the accomplishment and advancements in their presentation (McManus et al, 2010) though troughs from the anxiety of undertaking the process (Berg et al, 2008; Timulak et al, 2010). Imperatively however, all participants reported positive changes in expectations and/or preparedness following EMDR phases 1-2, coupled with safety in therapist and environmental factors (Marich et al, 2020).

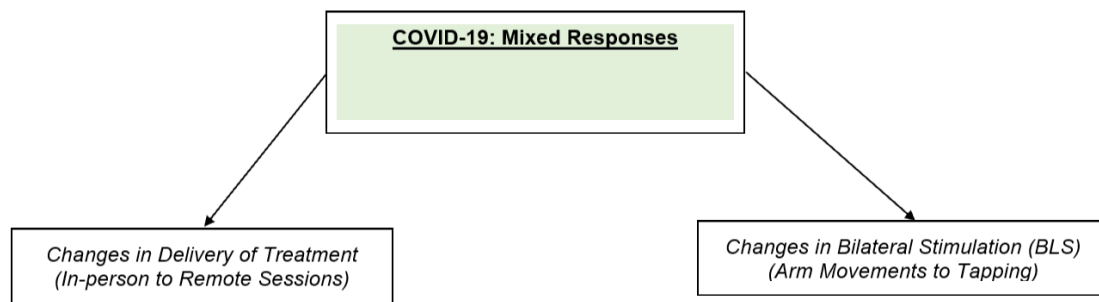
4.2.2.3 Lack of Confidentiality

Although risk and confidentiality were thoroughly assessed during induction of research as an essential ethical and legal obligation (Bond and Mitchels, 2014),

understandably over 50% of participants raised concerns of their resistance in sharing information due to the fear of breaks in confidentiality (Courcy and McCarthy, 2003), especially since sessions were moved from ‘face-to-face’ to ‘remote’ means due to COVID-19 (K3: “*It was all safe when I come in the building with [therapist] and it help but not good here, people listen you know*”), causing unintentional breaks in confidentiality on the clients part if people in their home environment were listening in. Much of this was due to subject sensitivity (i.e. the extent of negative traumatic experiences they had endured) hence tailored, collaborative care is essential (Courtois et al, 2009; Rothschild, 2011). Clients did report of overcoming their concerns once the relationship had evolved however in the event of a breach in confidentiality due to active risk management, therapists must counterbalance therapeutic rupture in adherence to both actual *client* risk to self and others and *service* schedules in restricting liability’ as inadequate weight of either could potentially result in deterioration in treatment or termination of career.

4.2.3 Key Theme 3: COVID-19: Mixed Responses

FIGURE 8: KEY THEME 3 - COVID-19: MIXED RESPONSES



4.2.3.1 Changes in Delivery of Treatment

A predominant sub-theme appeared to be around face-to-face vs remote sessions, with only one participant expressing an interest in remote sessions due to convenience of not having to travel, around university/work timetables etc however others also highlighting better/more direct communication with the therapist via email

as opposed to having a middle-man (i.e. admin) in receiving resources *“it wasn't just learning the techniques but I could revisit them because she emailed me them which was more helpful (B3)”* since the COVID-19 changes. However the remainder of participants raised issues around lack of confidentiality (as above-mentioned) when undertaking treatment at home, alongside a merge in their personal/safe life with exploration of what they may have initially perceived to be unsafe traumatic memories *“she (therapist-2) said that we could if I wanted to try and continue the sessions by like a video but the first thing that I said was that this (bedroom) is kind of like one of my safe places so I wouldn't want to bring that home and discuss it here, especially because I'd be in my bedroom (K1).”* Other factors in their preference for face-to-face sessions included connectedness with the therapist and a third of participants also reported of *“the nature of the (therapy) room, it was quite clinical, neutral, it helped being in a different environment (K2).”*

4.2.3.2 Changes in Bilateral Stimulation (BLS)

Only one participant had the opportunity to undertake both eye movements and tapping as part of their BLS and she expressed a preference for eye movements, not due to the medium itself however because tapping became increasingly triggering hence the data presented within this study is too little to conclude strengths/weaknesses of either.

4.3 TRIANGULATION OF DESCRIPTIVE STATISTICS

As highlighted in a recent meta-analysis (Rafiq, Campodonico, and Varese, 2018) whereby the extent and continuity of the connection between childhood maltreatment (sexual, emotional, physical abuse, neglect, bullying and violence) and dissociation across severe mental illness (SMI) were investigated; results indicated that childhood adversities correlated with increased dissociation within SMIs, *‘Positive significant associations were also found between specific childhood adversities and dissociation, with aggregated effect sizes in the small-to-moderate range.’* Likewise, within the present study the analysis and positive outcomes of all domains (neuropsychological, behavioural, emotional functioning) and significant reduction in

that of IESR scores from baseline to pre-treatment are suggestive of diminishing levels of trauma symptomology. Levels of dissociation cannot be commented upon as the DES measure was utilised as only an assessment tool at pre-treatment.

4.3.1 Exploring whether engagement in EMDR results in any changes in quality of life issues

4.3.1.1 VLQ: Quality of Life Issues (WPS-CR Q4-6)

Much research (Kliethermes, Schacht, and Drewry, 2014; Coyle et al, 2014; Colangelo, Keefe and Cooperman, 2012) is indicative of those having experienced CSA as also presenting with a reduction in their quality of life, including barriers in forming and maintaining relationships, issues with maladaptive coping mechanisms and dysfunctional sleep patterns as seen in the current study. Amid additional normative trauma symptomology (e.g. flashbacks, arousal and disproportionate fear), sleep disturbance was an ongoing theme for most participants (K2, B1, B2, B3), as triangulated in the qualitative interviews, due to recurrent nightmares and issues of insomnia. Sleep disturbance (e.g. B2 initially reported at interview *“I’m neglecting my own needs and that’s leading to me feel all this anxiety at times and affecting my sleep”*) and improvements were exhibited throughout treatment, according to session content and interview data; some of which dependent upon moderating life stressors. However, overall, similar to Raboni, Tufik, and Suchecki’s (2006) study, a gradual decrease in such issues was observed in most as treatment progressed (e.g. B2 later reported *“I’ve learnt to light a nice candle next to my bed and I have a self-care journal that I write down in ... like your safe place and I still use that now before bed without realizing. Like, if I have a bad night sleep to help clear my head, like just imagine it.”*)

Though limited literature (Hefez, Metz and Lavie, 1987; Ross et al, 1989), it is suggested that this is consistent with much trauma research due to the reliving of traumatic memories (Rose et al, 2002) and the nature of ‘REM’ sleep (Mellman et al, 2002), whereby the brain and mind practice conveyance and processing of

traumatic/distressing memories, conjoint with stress- and survival-related emotional regulation (Otte et al, 2005); possibly why there were greater changes reported by those that had completed the entire 8-phase EMDR protocol (K2 and B2) than those that had not.

The use of Ems in EMDR mimics that of REM sleep in activating neural processes in order to establish awareness and perception of the said event (Stickgold, 2002). REM sleep is thought to intensify (the ratio amid rapid Ems during REM sleep) during times of active learning or when resilient towards emotional experiences. Studies into PTSD sufferers have often concluded decrease in mean periods of REM sleep, arousal in response to sound stimuli, insomnia, recurrent bad dreams/nightmares in relation to the trauma (Stickgold, 2008; Shapiro, 2001; Pagel, 2000; Friedman, 1989). Such changes in broken sleep and heightened arousal are thought to be due to augmented adrenergic and noradrenergic diffusion, displaying dysfunction in the brains capacity to constrain noradrenergic and serotonergic activity during sleep (Bremner et al, 1999).

In understanding improvements in fragmented sleep for the current study, research (Friedman, 1989) suggests EMDR generates emotional and physiological adaptations indicative of a soothing reaction, as seen in decreased heart palpitations, respiratory synchronization, raised systolic pressure from commencement; to then gradual reduction in abreactions towards the end of sessions/treatment. This is thought to be consistent with the decline of skin galvanic response and build-up of skin temperature (Wilson et al, 1996), as per research on working with emotional memory (Hutchison and Rathore, 2015) and implications attached to sleep deprivation (Medic, Wille, and Hemels, 2017).

4.3.2 Exploring whether engagement in EMDR results in any changes in emotional and behavioural functioning (in relation to trauma, anxiety and depressive symptoms)

4.3.2.1 Emotional and Behavioural Functioning (Low Self-Esteem, Anxiety and Depression)

(GAD-7, PHQ-9, WPS-CR, RSES)

Although research suggests repetitive IAPT measures generate contradictory results due to replication bias (Westwood, 2017; Pan, Shell and Schleifer, 1994; Bergh and Vrana, 1998), in the current study a majority of participants exhibited mid-high ranging IAPT (GAD-7 and PHQ-9) and WPS-CR (with exception of the final three questions consistent with neuro-PEBL subtests) baseline scores, which in the most part fluctuated in peaks as therapy progressed and decreased towards final sessions, especially for those that had experienced all 8 EMDR phases. This may be due to baseline 'containment' of traumatic memories, followed by the maximum peak in 'anxiety' as trauma was explored, consistent with the 'window of tolerance' (Siegel, 1999) concept in understanding the peaks and troughs of the brain-body reaction to stressors, essentially the equilibrium individuals require to process trauma.

Although individual participant effects were dissimilar in degree (perhaps due to mitigating life issues as suggested by Silverman, Reinherz, and Giaconia, 1996; Jamshidi, Rajabi, and Dehghani, 2020); overall improvement in both emotional and behavioural functioning throughout EMDR was distinguished. Subsequently, consistent with Dyregrov and Yule, (2006) research with CSA, participants who did not exhibit high moderators and instead, presented with good levels of peer support, treatment preparedness and no longer had contact with their abuser/the abuse situation generally displayed greater positive progression.

4.3.2.2 Anxiety

(GAD7, WPS-CR Q2)

Recent RCT studies into the efficacy of EMDR therapy when working with anxiety have concluded positive results (Staring et al., 2016; Doering et al, 2013; Triscari et al, 2015), while mixed results prevailed in Goldstein et al. (2000) RCT when

investigating panic disorder with agoraphobia. Findings from the present study are consistent with these results, even that of the latter study as although Goldstein et al. (2000) recommended against use of EMDR with primary treatment for panic disorder with agoraphobia, they suggested that EMDR was superior to waitlist with a medium to large effect for all anxiety measures. Although no participants exhibited specific panic/agoraphobia within the current study, there appeared to be overall marked improvements in anxiety measures throughout treatment, especially for those that had undertaken the entire 8-phase EMDR protocol in comparison to those that had completed EMDR phases 1-2 alone. Interestingly, those having reported moderating life stressors reported higher levels of anxiety consistent with exhibiting lower executive functioning and memory functioning. This is consistent with research (Bergmann., 2008; Shapiro, 2001; Stickgold, 2002; Hefez, Metz and Lavie, 1987; Ross et al, 1989) suggesting EMDR mechanisms prompt a physiological process that stimulates memory and information functioning, activating the link between distinct neuronal networks and consequently permitting insight into the traumatic events, subsequently triggering some form of stress response.

4.3.2.3 Depressive Symptoms

(PHQ9, WPS-CR Q1)

Dissimilar to findings from the van der Kolk (2007) study illustrating the efficacy of EMDR with trauma-based depression whereby 75% adult-onset and only 33% child-onset PTSD and Depression resolved, in the current study all participants reported of some improvements in depressive symptoms to some extent via PHQ9. However, it is somewhat difficult to compare findings from alternative studies as there appears to be a stark contrast in question 1 of the WPS-CR outcomes between those that had completed EMDR phases 1-8 (K1, K2 and B2 reporting significant reduction in sadness and also in PHQ9 scores) and those undertaking EMDR phases 1-2 alone (K3, B1 and B3 showed no change in sadness and only slight reduction in PHQ9 scores) in the current research. However, although B3 had completed only EMDR phases 1-2, at interview, she had reported that her quality of life had improved, in association with depressive symptoms, which was indicative of the slight reduction in

her PHQ9 scores. B3 explained how learning techniques to support her in attaining greater stability in her mood had subsequently impacted upon her management of diabetes (e.g. less fluctuation in blood sugars, which consequently reduced the rate of infection). She made reference to the link between physical and mental health and wellbeing, and how the preparation phase of EMDR treatment had positively impacted her management within both these domains. Another factor in comparison is also the length of treatment as only eight sessions of EMDR were provided in van der Kolks study whereas a maximum of sixteen were allowed in the current study, suggesting inadequacy in treatment dosage, potentially explaining why those in the present study that had completed a bulk of the EMDR protocol all reported a significant positive difference between pre- and post-treatment.

Further, often negative self-perception is systematically checked throughout EMDR treatment consistent with Beck's (1976) CBT concept of dysfunctional or core beliefs, this is commonly acknowledged amid EMDR clinicians in the treatment of depressive symptoms (Shapiro, 2009). As seen in session notes from the present study, practitioners helped participants recognise evidence for such beliefs, leading to their target touchstone memories (e.g. the belief "*I'm vulnerable*" was identified with K1 when working with her feelings of fear relating to men, eliciting the memory of dad holding her following domestic violence towards mum) hence creating a basis of work with negative emotions, cognitions and somatic reactions, ultimately leading to healthier beliefs ("*I'm brave*").

As also mentioned in the literature review (Ehring et al, 2014; Rothbaum, Astin, and Marsteller, 2005; Wright and Warner, 2020) and consistent with both this and other studies (De Bont, Van Den Berg, and Van Minnen, 2016), EMDR is viewed as an effective treatment for depressive symptoms however generally as a comorbidity of PTSD. However, there is limited overall evidence for the efficacy of EMDR as a stand-alone treatment for those holding a first-line diagnosis of Depression except in Grey (2011), no RCTs in predominantly the English language have been issued to determine response to this subject (Wood and Ricketts, 2013). This comes with the exception of two RCTs; the first of which conducted via the European Depression and EMDR Network (Hofmann, 2012), results indicate that EMDR is an effective

treatment for chronic recurrent depression, of the sixty-six participants who completed, no significant difference was found between those treated with EMDR and CBT. The second study (Wood, Ricketts, Parry, 2018) however conducted through the University of Sheffield EMDR and Depression Investigation (SEDI) department in exploring the effectiveness of EMDR with depressive symptoms and social functioning in identifying whether there is similarity in client responses to the treatment of Depression to that of PTSD in domains such as memory functioning has recently published results. Although daily mood ratings were highly variable, seven of eight participants exhibited clinically significant and statistically reliable improvement on the Hamilton Rating Scale for Depression, concluding EMDR as a feasible treatment for recurrent and/or long-term depression.

4.3.3 Exploring whether engagement in EMDR results in any changes in self-worth

4.3.3.1 Low Self-Esteem

(RSES, WPS-CR Q3 and 7)

There appears to be limited research on lack of self-esteem and the efficacy of EMDR (Griffioen et al, 2017; De Jongh, Ten Broeke and Meijer 2010; Dziegielewski and Wolfe, 2000; Sanders and Ten Broeke, 2011; Sprang, 2001) however overall, as previously discussed in the introduction and consistent with the literature review findings (Melton et al, 2020; Chen et al, 2018; Kliethermes, Schacht, and Drewry, 2014), the Adverse Childhood Experiences (Chapman et al, 2014) Study risk factors were present in most cases examined during the current study; neglect, dysfunctional family environment, parental characteristics (i.e. disadvantaged), economic deprivation namely served as indirect components in the clients lowered self-esteem. This falls in accordance with Maslow's (1943) humanistic theory of the hierarchy of needs whereby he indicated insufficiency in client actualisation (living nor working to their full potential), dismissive of satisfactory physiological needs, or the need for safety, love/belonging, and self-esteem.

EMDR phases 3-7 interactively address such issues (Shapiro, 2001; Rousseau et al, 2019) in an attempt to process trauma and promote one's positive self-cognition through reinstating clients' reward mechanisms (Hopper et al., 2008). As seen in this research, it is imperative that developmental deficits are confronted for those presenting with multiple childhood traumas via the refined selection process of *representative* memories; leading to beliefs such as *"I'm damaged (as seen in K1)"* and *"I have no choice/I'm a nuisance (as seen in B2),"* once challenged these subsequently address associative memory networks and secondary issues (e.g. terror, overpower in lack of control of circumstances, and low self-esteem can all be conceptualized as the result of early childhood experiences that are dysfunctionally stored in the clients memory networks) in the wider context of a client's treatment plan (Shapiro and Laliotis, 2011).

Though a recent trial (Starling et al., 2016) compared EMDR therapy and competitive memory training (COMET) in the treatment of anxiety disorders with aim to improve self-esteem however failed in this task, conversely, the current study showed marked improvement in RSES results from client scores with a mean range of 20 at commencement of therapy to 26.6 at ending of therapy. Malfunction in the Starling (2016) trial results may possibly have been due to firstly, the limited sessions of EMDR equating to six as an inadequate dosage (whereas in the current study, the mean treatment dosage was 12.5 with scope to work beyond this figure) and secondly, the inconsistency in treatment between EMDR and COMET as there was difference in results depending on which therapy was applied primarily (e.g. EMDR when conducted before COMET exhibited reduction in self-esteem and depression hence it could be assumed that EMDR may weaken the efficacy of the COMET intervention). Moreover, there is debate over whether the targeted memories perceived to contribute towards lack of esteem within their study possessed enough emotional charge thus participants were insensitive to EMDR (Littel et al, 2017). Hence, it could be theorised, those with multiple diagnosis and intense pathology linked with their self-esteem (Silverstone and Salsali, 2003) may exhibit memories of higher emotional charge, resultant in more positive outcomes from EMDR treatment.

Further, a recent study into the efficacy of CBT vs. EMDR on low self-esteem (Griffioen et al, 2017) demonstrated significant improvements on the RSES measure of self-esteem in both modalities as equally seen in the current study (as most of the EMDR preparation phase 2 factored in aspects of CBT) however it was stressed that ‘when offering an adequate number of sessions, both EMDR and CBT have the potential to be effective treatments for clients with low self-esteem’ suggestive of the importance of correct treatment time to facilitate positive change; something which was fed-back at interview as a hindrance in the current study due to IAPT treatment time constraints.

Results may have been further clarified by a longer one-year follow-up however this would be inconsistent with the present study design since participants were requested not to undertake additional therapy in the interim as an exclusion-criteria to deter subsequent changes in client perspectives of therapy for interview (hence a longer follow-up time may have caused restrictions in their personal circumstances). Therefore, there is no way of knowing maintenance in improvements. Equally, as the RSES was conducted at only pre- and post-treatment (due to time restrictions), as opposed to numerous timepoints throughout treatment as originally planned, there may have been a subsequent lack of data throughout treatment and at follow-up.

4.3.4 Exploring whether engagement in EMDR results in any changes in neuropsychological functioning (memory, attention, executive functioning)

Neuropsychological (Attention, Memory and Executive) Functioning (WPS-CR Q9-11, PEBL Battery Subtests)

Neuropsychological functioning was planned to be assessed in two different ways: self-report via the WPS-R (questions 9-11) to evaluate short-term memory and monitored performance on the PEBL computerized battery-task measures to evaluate WM (though unable to conduct at post-treatment due to COVID-19).

Variable changes amongst participants were indicated in neuropsychological functioning throughout treatment via WPS-CR however positive improvements were highlighted for all when comparing pre- to post-treatment measures, with those having undertaken the entire 8-phase EMDR protocol displaying greater levels of change (especially in IESR scores). Overall, diversity was demonstrated across fractions when investigating the general traumatic stress response (a) five of six participants reported some improvement in attention via WPS-CR or interview (b) specifically those that had undertaken BLS reported the greatest improvement in executive functioning, and (c) memory generally worsened, especially for those exhibiting moderating life stressors. Interestingly, self-report measures indicated the participant's perception of deterioration in these areas for those experiencing life-stressors thus suggesting that such anxiety may have impacted these domains, consistent with well-documented research (Porter, Lawson, and Bigler, 2005; Beers and De Bellis, 2002; Moradi et al, 1999).

Importantly, as indicative of the traumatic stress response conceptualization and although it is impossible to certainly determine whether an individual's neuropsychological reaction to a traumatic event impairs neuropsychological processing and consequently influences various domains (e.g. emotional functioning), the results from the present study display correlation between the WPS-CR self-report and IESR (with post-data missing from the PEBL to solidify results), especially for those that had experienced consistent BLS; illustrative of the trauma response (Gerardi et al, 2010). These findings are suggestive of the participants change in neuro-processing (e.g. attention, executive functioning) impacting upon a variety of domains (namely emotional functioning) of their traumatic experiences.

Likewise, changes (e.g. being able to connect with indirect triggers to the traumatic event without avoidance) as observed and reported (*"I find that I don't avoid situations as much so if there's a problem"*) in participants within the current study, are subtly consistent with research conducted by Farina et al. (2015, p.460) investigating "the potential role of EMDR in enhancing the integration of traumatic

memories by measuring EEG coherence, power spectra and autonomic variables before (pre-EMDR) and after (post-EMDR) sessions during the recall of client's traumatic memory." Results indicated EMDR treatment leads to "an integration of dissociated aspects of traumatic memories and, consequently, a decrease of hyperarousal symptoms" (Farina et al, 2015, p.460) suggestive of positive changes in neuropsychological, emotional and behavioural functioning.

4.3.4.1 Attention

Participants struggled in variance across all three tested areas of attention however K3 (consistent with her WPS-CR self-reporting) significantly more so than the others in both orienting and conflict, similarly B3 in alerting, again reflective of those experiencing the greatest difficulties with moderating factors (hence only undertaking EMDR phases 1-2) struggled with attention the most; though, B3 did show improvements at post-treatment via WPS-CR responses.

Prior research (Pineles et al, 2009; Polak, Witteveen, Reitsma, and Olff, 2012; Posner and Petersen, 1990; Qureshi et al., 2011) with the 'Attentional Network Task, ANT' (originator of the 'PEBL Attentional Network Task, PANT),' generally investigates lower levels of attention in three areas; (a) 'alertness' for forthcoming stimuli, (b) 'orienting' facilitates the selection of appropriate information for processing and (c) 'network' functioning in the resolution of errors however only three key behavioural studies (Block et al, 2016) to date have investigated the ANT in PTSD, one indicative of deficits in conflict monitoring (Leskin and White, 2007), and the other in orienting attention (Barlow-Ogden and Poynter, 2012). In the present study, no differentiation could have been made between which component was affected more so due to time restrictions in administration (i.e. initially planned conduction during only pre- and post- treatment as opposed to additionally during differing times-point in therapy), which was regrettably made worse by the COVID-19 restrictions whereby this was employed at pre-treatment only, leading to lack of data to make sound deduction. However, it is evident that overall data analysis displayed improvements in attentional functioning over time (although to differing degrees amongst participants), four of six participants observed improvements, from pre- to

post-treatment when answering the relevant WPS-CR question relating to attentional dysregulation and furthermore, another (B1) reported of improvement in attention at commencement of treatment however then gradual disintegration resultant from lifestyle restrictions due to COVID-19. Hence, arguably five of six participants reported positive changes in this domain.

Moreover, although literature presents an inconsistent portrayal regarding the correlation between emotion and alertness, or whether emotional stimuli develops or disrupts activation of the attentional networks (Dennis, Chen, and McCandliss, 2008; Cuthbert et al, 2000; Keil et al., 2002; Schupp et al., 2004; Schupp et al, 2006); it is however evident that giving significance to a threatening emotional stimulus or failure to deregulate its effect on behaviour can result in formation of maladaptive behaviour as seen in sufferers of trait anxiety (Bishop, 2009) and PTSD (Hayes et al, 2009), also consistent with this study portraying normalisation of such threatening stimuli (e.g. abusive memories) resultant in emotional regulation (e.g. participants over time acting in accordance with the threat as opposed to over-alertness, reduction in threat avoidance was reported at interview by B3).

4.3.4.2 Memory

In accordance with the 'Corsi Block Tapping, CBT' task (the original version of the 'PEBL Corsi Block Task, PCBT') whereby Kessels et al, (2000) conducted research with both participants suffering with some form of brain damage and those presenting with a healthy brain; healthy adults exhibited an average block span of 6.2 blocks (SD=1.3) indicating a block span of anywhere between 5-7 blocks as normal as '68% of the population scores 1 standard deviation from the mean' (Berch, Krikorian, and Huha, 1998; Kessels et al, 2000); intriguingly, all participants scored within this range (B1, B2, K1, K3 scored 5; B3, K2 scored 6) at pre-treatment regardless of issues with memory however unfortunately we were unable to compare scores for enhancement at post-treatment due to COVID-19/lack of face-to-face sessions. Generally, alternative memory functioning research (Flaks et al., 2014; Sozda et al, 2014; Vasterling et al., 2006) suggests improvements in memory impairment amongst trauma survivors. Findings in the current study vary in terms of

the relevant WPS-CR self-report question whereby those that had reported enduring moderating life stressors/comorbidities; B1 and B3 exhibited worsening memory and K2 no change however K3 reported of a significant improvement in memory which at interview she stated no changes were observed. Hence, debatably 50% of participants witnessed positive results in memory. Although factors, such as the lack of control, heightened hypervigilance, fear and threat related to the COVID-19 pandemic may have been especially triggering for people with a trauma history, the pre-treatment PEBL Corsi subtest was conducted prior to the initial lockdown and hence, very little was known about the pandemic at this stage. This suggests that the the pandemic may have been a potentially confounding variable as results may have been more accurate at pre- as opposed to post-treatment. This is because at post-treatment, delivery of the PEBL subtests was no longer allowed due to government restrictions in meeting face-to-face. Therefore, only the relevant WPS-CR questions were used to compare results. Furthermore, participants reported of worsening memory and attention following the lockdown. For instance, B1 reported *“My memory hasn’t improved at all. Um, probably gotten worse, but I’m going to attribute that having less of this structure because of lock down.”*

Though participants chose to take the test either relaxingly through the day or rushing first thing due to other commitments, inopportunately, we were unable to test Croschere et al. (2012) results which indicate variability in conduction of this test during differing times of the day; those participants reported as being associated with greater tiredness at pre- and post-treatment did not appear to have affected memory, practice effects were not found in Croschere et al. (2012) study due to the Corsi Block Test being stable over time. However, again as this is an under-researched area, especially within the specified age range (18-25) and clinical presentation (survivors of CSA), there is little comparative data for a comprehensive conclusion to be derived.

4.3.4.3 Executive Functioning

In previous studies the 'Iowa Gambling, IGT' task (the original version of the 'PEBL Iowa Gambling Task, PIGT') has namely been utilised to assess decision making around addictions (from gambling to substance abuse) and general elements of learning and executive functioning (Dunn, Dalgleish, and Lawrence, 2006; Brand, Labudda, and Markowitsch, 2006; Noël et al, 2007), with recent studies now also focusing on sexually risky behaviours (Golub, Thompson, and Kowalczyk, 2016; Margaret et al, 2010). However, studies pertaining to PTSD and decision-making skills are scarce although research indicates initially impaired performance on the IGT as repeated attempts are required for such participants to commonly differentiate between the beneficial from unbeneficial decks (Aupperle et al, 2012; Hawthorne and Pierce, 2015; Steingroever et al, 2013) which was not possible in the current study due to the COVID-19 situation.

The mean number of good–bad card selections per deck indicated the following mean scores over all x5 decks, per participant; B1 = 3.2, B2 = -2, B3 = 4, K1 = -4.6, K2 = 2.4, K3 = 2.4. Similar to research relating to progression in performance levels on a variety of reward profiles (Bowman and Turnbull, 2003; Schmitt, Brinkley, and Newman, 1999), it appeared that participants exhibiting the poorest decision-making via PIGT scores at commencement of treatment (by far B2 and K1), improved most as indicated on the relevant WPS-CR question; intriguingly, they were two of three that had undertaken the full 8-phase EMDR protocol, the third of which also showed significant improvement via WPS-CR self-reporting. Bechara et al. (1997) found that those with the poorest decision-making via PIGT at pre-treatment generally gained rewards via rapid learning and awareness of which decks were 'good' and 'bad' at post-treatment, indicative of improvement in decision-making throughout treatment, regardless of completely developed knowledge of the manner in which the task worked, and the emotional valence connected with specific decks; unfortunately, there was no scope to test whether improvements in their WPS-CR scores matched post-treatment PIGT scores due to lack of data (because of COVID-19).

Bechara et al. (1994) suggests neurologically typical individuals are eventually able to move towards an inclination for the 'good,' rather than the 'bad' decks (e.g. learning to pick minimal short-term rewards in an attempt to minimize loftier long-

term losses) which is thought to be connected with an increased anticipatory autonomic response prior to making poor choices on the task, associated with the assimilation of emotional information during the decision-making process (Bechara et al, 1999; Carter and Pasqualini, 2004). This is something to consider in future research, undertaking this task during various time-points in treatment would provide the best idea of validity.

Conversely, good levels of performance on this task may have been due to its sole visual-spatial problem-solving context (clients solved visual problems) since participants were not required to make association with dissimilar forms of information processing (e.g. verbal processing alongside visual-spatial to resolve problems) which may otherwise have led to poorer task performance, as documented in much traumatic stress literature (Teicher et al, 2002). Perhaps an area for development for future research.

As mentioned in the chapter 3, it is equally important to understand the connection between therapist and client views (Riede, 2018; Whitehouse, 2019). In a recent study (Jones-Smith, 2018) whereby therapist perceptions of EMDR therapy on adult female survivors of CSA were explored; findings were suggestive of EMDR working faster than alternative therapies and for clients to resolve traumatic memories through non-invasive techniques (as also discussed in Shapiro, 2014). Key themes within this study included 'empowerment' of the client, the client's reduction of initial 'resistance to treatment' and the therapists highly regarded view that working towards reduction in emotions such as 'shame' and to allow the client to develop more positive coping mechanisms would help alleviate both short and long terms effects of CSA; all of which was apparent in analysis within the current study and aspects of which have been discussed in this chapter.

4.4 SUMMARY OF RESULTS

The present study provides a unique contribution to EMDR literature due to its exploration of young adult survivors of CSA, the perspectives of such a sample age range (18-25) appears to be a somewhat under-researched area. To-date no study

has evaluated the outcome of EMDR therapy for survivors of CSA within routine IAPT settings. Nor has previous literature investigated client perspectives of equally un/helpful aspects of the EMDR therapy process within routine IAPT practice.

Diversity in research methods and questions across previous case studies, in consideration of the specific EMDR with CSA sample make comparison of results difficult to apprehend however findings suggest overall efficacy of EMDR as the case series analysis produced clinically significant changes, especially in trauma symptomology (as displayed in IESR data); three positive, two moderate outcome cases and one sceptical no-improvement case (based on IRR's feedback). The cases also compliment the consensus in EMDR literature (Edmund, 1999, 2004) in validating trauma resolution and positive outcomes of EMDR therapy. Diversity in research methods and questions across previous case studies makes comparison with the results of this study using EMDR with a CSA sample challenging. However, findings suggested overall efficacy of EMDR as the case series analysis revealed that clinically significant changes, especially in trauma symptomotology (as displayed in IESR data), were observed with three positive, two moderate, and one sceptical no-improvement case, based on feedback from the IRR's. The cases also complement EMDR literature (Edmund, 1999, 2004) in validating trauma resolution and positive outcomes of EMDR therapy.

Chapter 5: Discussion

The main findings for this study will be highlighted in two parts (1) thematic analysis of qualitative data and (2) descriptive statistics via outcome measures; in association to the research questions, and in consideration of prior research. Potential limitations of the study, implications for future theory and practice in conjunction with a reflexivity will then be provided.

5.1 QUALITATIVE RESULTS: THEMATIC ANALYSIS

Descriptive statistics (as below mentioned) were triangulated with qualitative data (namely follow-up interviews in understanding participant perspectives of their therapy experience). Themes for each case-record have been presented in the 'Results' chapter outlining client experiences. Evaluation of therapist's notes and semi-structured 'Helpful Aspects of Therapy' interviews generate richness in case-records and equally exhibit variety in utilised EMDR techniques. Data were analysed in conjunction with weekly pre- and post-treatment outcome measures to emphasise specific event-shift sequences (Elliott, 2002). Nonetheless additional enquiry to examine the impact of contextual elements on the outcome of these therapeutic mechanisms was necessary. Key emergent qualitative themes that were derived from analysis of the data, most essential to productive EMDR outcomes, are outlined as follows:

- The client's optimism for therapy is not necessarily indicative of better outcomes as all participants had experienced prior therapy (except K1) and in the most part, exhibited reservations in its workability, however they reported EMDR to be more useful than anticipated. Consistent with IRR and outcome measures, K3 was the only participant to report worse outcomes than expected.
- Client choice in treatment and therapist interpersonal and professional skills; emotional connectivity/understanding, active listening, a safe, empathic, non-judgemental, and importantly confidential environment are essential

components in positive outcomes, specifically in succumbing barriers to reliving

- Resourcing (with inclusion of an idiosyncratic approach), psychological-mindedness and psycho-education are essential mechanisms in the preparation phase and later in the amalgamation of neuropsychological, emotional and behavioural processes that are linked by an evolving conceptualisation of the clients' symptoms/presentation and extra-therapy factors.
- The 'magic/it just happens' portrayal of EMDR may well be linked with the working memory hypotheses; taxing WM when outside the window of tolerance has proven to support reprocessing of difficult imagery however the sample range in this study was not great enough to solidify findings
- Time restrictions in treatment length and confusion around understanding/completion of measures may potentially cause anxiety and poorer outcomes; hence service changes around these factors and the possibility of clearer trauma pathways to avoid long waits has been suggested alongside variance in delivery of sessions; one participant found remote sessions to be more flexible whereas others reported of issues with confidentiality.

5.2 DESCRIPTIVE STATISTICS

In terms of the definition of Chambless and Hollon's (1998) 'evidence-based' therapy, the present project has produced evidence of the efficacy EMDR when utilised with young adult survivors of CSA. Results indicate a capable modality in treating trauma symptomology, deserving of further research.

Findings from the key descriptive statistics are as follows:

- IESR – although it was hypothesised that greater levels of trauma-related clinical change would be observed in participants presenting with higher trauma clinical symptomology at baseline, the findings indicated that all clients who had undertaken EMDR phases 1-8 (inclusive of reprocessing) benefited when compared with those who took EMDR phases 1-2 (history taking and preparation) alone. For instance, K1, K2 and B2 were of those that had reprocessed and saw a 42-57 point drop in IESR scores even though K1 had scored the lowest of all x6 participants at pre-treatment; those that had undertaken EMDR phases 1-2 without consistent desensitisation (the remaining EMDR protocol) also exhibited a significant reduction in scores however, not as large as the above-mentioned - indicating the positive impact of all therapeutic work.
- RSES – all but one participant (B3, who did not report any difference during self-report RSES responses though interestingly did report of an increase in confidence at interview) exhibited overall improvements in self-esteem from pre- to post-treatment. Similarly, WPS-CR responses to questions 3 (liking themselves) and 7 (feeling as good as others) indicated that a majority of participants noticed improvement in either one or both of these areas, with only three responses showing slight reduction in self-esteem (in Q7 for both K1 and B2; Q3 for K3). Importantly, in contrast K1 did also express an overall increase in confidence not only via RSES however also during interview (*“...I couldn’t really communicate as well as I wanted too, or I couldn’t find the words, but I feel like at the moment, that’s kind of coming back a bit more. Now I’m becoming more confident”*) and B2 was able to identify *“I’m more kind to myself (since therapy).”* Overall, all participants reported of enhancements in self-esteem through at least one of all three means (RSES, WPS-CR or interview).
- VLQ – significant improvements were seen from pre- to post-treatment in K1 and B3, no change was observed in K3 and B1 though a slight reduction in scores were exhibited in K2 and B2. However, it is noteworthy that data

inclusive of the deducted VLQ parenting question, would have displayed an overall increase in quality of life for all participants (sadly not all participants could relate to/answered this question at both pre- and post-treatment and hence it was removed from overall analysis). Similarly, all WPS-CR responses to questions 4-6 highlighting interpersonal difficulties with others were positive bar one answer whereby B1 noticed a very slight increase in getting into trouble/shouted at by others however this may be a matter of perception possibly due to underlying characteristics of an autistic spectrum disorder (ASD) or cognitive distortions around various external scenarios experienced whilst in treatment resultant in arousal of strong emotions (e.g. sexual intercourse with partner acting as a trauma trigger in their relationship). She did however report positive changes in this area at interview "*it never really affected the quality of my life because I just kind of got on with things...but I guess now I don't feel like I'm going through the motion of things anymore...I'm actually looking forward to things in life. I'm not so worried about the past. I don't feel like I'm trying to really narrowly control my outlook on things or like prevent emotions from happening...it's made certain aspects like feeling overwhelmed a bit more manageable.*") Therefore, in general, though varied responses, quality of life improved for most as declared in WPS-CR, VLQ and interview feedback.

Furthermore, sleep issues were an ongoing theme affecting quality of life for K2, B1, B2, B3 of which, those having experienced the full 8-phase EMDR protocol reported the greatest positive changes (e.g. B2 stated safe place/grounding helped improve sleep and that she had learnt to cope with this via self-soothing as per interview feedback and K2 reported improvements however medication may have equally contributed towards this); overall most participants reported sleep disturbance around the time of moderating life stressors (e.g. house-move, work, COVID-19).

- GAD7 – unfortunately most participants experienced moderating life stressors to some extent however, those with enduring stressors and comorbidities

during treatment whereby EMDR phases 1-2 were carried out (K3, B1, B3; K2 also reported long-term difficulties however was the only participant of this nature to undertake the entire 8-phase EMDR protocol) reported higher levels of depression and also anxiety. For instance, B2 was the only participant having completed all 8-phases of EMDR that scored high on the GAD7 at pre-treatment, though positively witnessed the largest reduction of 13-points by post-treatment. In the most part, those that had completed the full 8-phase EMDR protocol observed the most reduction in anxiety, except K1 who reported a reduction of 1-point, however scores were mild - almost within IAPT recovery. Consistently, all responses to WPS-CR question 2 indicated improvements in feeling nervous/worry from pre- to post-treatment, except no changes were observed in K3 and B3, reporting that this is experienced all or most of the time, GAD7 scores suggested 'moderate-severe' levels of anxiety even by end of EMDR phases 1-2.

Evidently, those having completed the entire 8-phase EMDR protocol saw the greatest positive changes.

- PHQ9 – overall improvement in depressive symptoms from pre- to post-treatment were observed in PHQ9 scores. However, consistent with the ongoing theme as above-mentioned, K3, B1 and B3 showed no change in levels of sadness when asked WPS-CR question 1 whereas those that had undertaken all 8-phases (K1, K2 and B2) reported of substantial improvements. This was consolidated when analysing interview data whereby B3, though only phases 1-2 had taken place, did mention that, in particular EMDR phase 2 (preparation), did improve her quality of life in association with her depressive symptoms hence her slight reduction in PHQ9 scores, stating; *“I have diabetes and my mental health was deteriorating, like really bad depression makes my blood sugars go really high and I get infections so managing emotions helped me manage my physical health too; it kind of all links.”*

- PEBL and WPS-CR – advancements were presented in all areas of neuropsychological functioning, however dissimilar in domains:
 - a) Attention – significant improvements in attention were seen in those that had undertaken the entire 8-phase EMDR protocol (K1, K2 and B2), only B3 of those having received solely EMDR phases 1-2 showed progression regardless of moderating life stressors/comorbidities as per WPS-CR self-report; with K3 reporting of worsening attention and B1 of no change at all (though for B1 at interview did report “*I’m gonna attribute this to lock down like having less of a structure, but I can’t pay attention to anything anymore but therapy did help at one point just before lockdown, it was really just looking after myself, like the kind of basic things that you recommend, like you know, I was trying to give myself a purpose every day and that really helped to improve focus for me...*”). Therefore, debatably all but one participant (K3) reported no positive changes at all in WPS-CR and interview; K3 also scored significantly less than others at pre-treatment on the PEBL.
 - b) Memory – though all participants scored within healthy average range on the PEBL, WPS-CR data indicated, that for those who had reported enduring moderating life stressors and/or comorbidities; B1 and B3 exhibited worsening memory and K2 no change however surprisingly, K3 reported of a significant improvement in memory which in contrast with her interview feedback (“*I think it’s same*”) suggests that perhaps her memory had returned to that at pre-treatment, one-month following therapy (though no direct research can be found to evidence that this is a regular outcome of treatment, alternative explanations may include the increase in her traumatic threat response in consideration of blocking beliefs/moderating life stressors, since the real possibility of meeting her perpetrator resultant in actual danger).

- c) Executive Functioning – all those that had undertaken all 8-phases of the EMDR protocol (K1, K2 and B2) reported of improvements in WPS-CR, in contrast to those having received EMDR phases 1-2 only, of which consistent with interview feedback, K3 reported of no change at all; B1 and B3 worsening levels of executive functioning.

5.3 OVERARCHING RESEARCH CONCLUSIONS

5.3.1 Triangulation

Triangulation is often utilised to improve the credibility and validity of research findings (Cohen, 2000), by combining methods, theories, and/or observers in a research study; to offer a more balanced explanation to readers (Joppe, 2000). Triangulation in the current study, added to the depth in data (Heale and Forbes, 2013) however, it is important that the value of triangulation is not overestimated and that a balanced view is taken (Johnson et al, 2017; Thurmond, 2001); in combining research methodologies, inevitably triangulation was not achieved in a consistent manner, as in some cases, comparison of sources was conflicting. For instance, although K3 (the only no improvement case) showed little difference from pre- and post-treatment in outcome measures, she did however report of positive changes in the qualitative interviewing – this may have been as treatment measures are not definitive of an individual presentation (e.g. expression of cultural difference, specific to an ethnic background), nor do they allow elaboration due to the nature of multiple-choice questioning, whereas the open-ended interview questions enabled her to talk freely regarding additional concerns (e.g. immigration status/accommodation), which were a real-life threat to her being, and importantly, directly linked with her traumatic experience. Evidently, the qualitative aspect related to participants internal views whereas descriptive statistics concentrated on a linear view of the studied subject; like others (B1, B2), K3's feedback suggested that barriers in treatment were outside the parameters of EMDR, rather, they were in service time restrictions and external stressors (e.g. impact of COVID-19, underlying health concerns).

In the most part, participants reported overall positive improvements in both outcome measures and qualitative results; all but one participant, B3, who did not report any difference during self-report RSES responses (though interestingly did report of an increase in confidence at interview) exhibited overall improvements in self-esteem from pre- to post-treatment. The largest improvement in both was seen in trauma symptomology, as seen in the IESR outcome measures and also, in interview responses via IRR assessment. A significant finding was that those that had undertaken all stages of EMDR (K1, K2 and B2) generally reported of better outcomes in every domain (including neuropsychological functioning) than the remaining participants, who reported of higher levels of anxiety and depressive symptoms. However, although no reprocessing took place for B3, she did mention that the EMDR preparation phase 2 did improve her quality of life in association with her depressive symptoms hence her slight reduction in PHQ9 scores, stating; *“I have diabetes and my mental health was deteriorating, like really bad depression makes my blood sugars go really high and I get infections so managing emotions helped me manage my physical health too; it kind of all links.”* Both parts of this study indicated positive improvements in the traumatic stress response, resultant from EMDR treatment.

5.3.2 Overarching Research Question

What are the experiences of adult survivors of CSA who undertake EMDR treatment – do their symptoms improve and what are their perceived experiences?

Diversity across results in the present study causes difficulty in generalising what accounts for ‘effective therapy’ (Stiles et al, 2008) however rich qualitative data taken from the participants interview transcripts allowed the researcher to facilitate subjective (though non-scientific, rather assured) responses via TA, crucial in understanding unique definitions of efficacy (Lambert, 2007). The practitioner’s level of understanding (Hilsenroth and Cromer, 2007; Oliveira, Sousa, and Pires, 2012) and empathic listening (Horvath, 2013; Omylinska-Thurston and Cooper, 2014) were cited as the most common factors in fostering the therapeutic alliance, participants

reported of 'opening up' in response to the non-judgmental atmosphere which aided their recovery; feedback from all participants was in the majority positive. Moreover, progressive improvements in outcome measures were exhibited, indicating reduction in explored domains (clinical trauma, anxiety, depressive symptoms), which led to change orientation in participant presentations. Interestingly, greater levels of clinical change in trauma symptomology (via IES-R results) were observed in participants who had undertaken the entire 8-phase EMDR protocol as opposed to EMDR phases 1-2 alone, indicating efficacy in the full protocol.

Such results are closely related with Herman's (1992a; 1992b) tripartite model (as earlier discussed in the Introduction chapter) as although researchers such as De Jongh et al. (2016) assert that stabilisation alone is unnecessary in the treatment of complex trauma; in accordance with Herman's (1992a, 1992b) recommendations, a majority of participants within the present research highlighted the importance and positive impact of EMDR phase 2 whereby safety techniques were delivered in order for the participant to practice stabilisation of often overwhelming symptoms (Parnell, 2013). Herman refers to three dialectical aspects of trauma: hyperactivity, intrusions (flashbacks), and prolonged constriction (dissociation) – explored via Herman's phase 2 ('Remembrance and Mourning') – as per EMDR phases 3-8 (Gomez, 2012). Similar to Herman's second phase, participants that undertook EMDR phases 3-8 in the current study in particular saw significant improvements in the afore mentioned three dialectical aspects of trauma. Results were collaborated with IRR feedback indicating three positive, two moderate outcome cases and one sceptical no-improvement case.

Sadly, as above-mentioned, neuropsychological functioning was somewhat difficult to track due to COVID-19 restrictions and elements such as 'reliving,' 'confidentiality' and 'time restrictions' were highlighted as disadvantageous, some more so on a service level rather than from a clinical standpoint; these will be discussed further in the below sections, alongside prospective improvements in study methods.

5.4 POTENTIAL LIMITATIONS OF STUDY

5.4.1 Impact of COVID-19

Limitations in the current research included the detrimental impact of COVID-19 on the continuation and outcome of EMDR for those participants that opted out of or were unsuitable for online EMDR therapy. Such participants had to mid-treatment try a new medium of communication (online) from the regular face-to-face (in person) contact they and the therapists were so familiar and comfortable with, some of who found this difficult to undertake, leading to a premature end to their treatment. This may possible have been a negative variable in outcome as participants may have had the opportunity to access more sessions, had the COVID-19 pandemic restrictions not have affected session delivery. Although they have been presented with the option of recommencing EMDR after the pandemic, results for the present study included EMDR techniques and therapy conducted during only the participants current therapy contract.

Other limitations similarly include the three participants that initially opted to continue after phase 2 however struggled due to complexity in their presentations and hence did not have the opportunity to work beyond EMDR phase 2 throughout their contracted treatment term, with an option to re-refer for the remaining EMDR protocol, following consolidation of resourcing. However again, to include their second period of therapy would be too large for the scope of this project and therefore only their current contacted therapy term has been referenced too in the current research.

Though, both the above limitations highlight the difficulties faced by clinicians working in real-life clinical settings. They also inform us that the transition from 'face-to-face' to 'remote' therapy sessions may be difficult for some however somewhat preferable for others: e-consultation technology may be the future or certainly part of it.

One final issue COVID-19 posed was the limitation in undertaking post-treatment PEBL assessments as these had to be undertaken face-to-face due to technical issues when downloading software onto participant home devices and also bias in

completion as the researcher could not monitor completion if undertaken in their home environment. Unfortunately, following the further regional toughened lockdown restrictions, announced on 31/07/20 and again nationally, on 21-22/09/20, face-to-face sessions were made increasingly difficult to deliver with advice being to offer remote sessions until possibly the following year amid fear of a second-wave of COVID-19, alongside additional barriers around participant safety due to some falling into the high-risk category. Hence, the decision was made not to include post-PEBL data due to such challenges, instead changes in memory, attention and executive functioning were evaluated via participant interview and WPS-CR responses. The matched timings of lockdown restrictions with the stage that each participant was at within their treatment can be found in the table below:

TABLE 3: PARTICIPANT JOURNEY IN CORRESPONDENCE WITH THE COVID-19 PANDEMIC

Participant Identifier	Stage of EMDR Ending due to COVID-19
K1	K1 opted out of the continuation of reprocessing as her 'safe space' was her actual bedroom, the only place from which she could confidentially complete ongoing remote treatment sessions during COVID. However regardless of this, she did complete all eight phases of EMDR.
K2	K2 completed all 8 phases however with interruptions in Phase 4 due to the COVID-19 pandemic.
K3	The COVID-19 pandemic delayed K3's immigration verdict and hence, caused an increase in hypervigilance of possibly returning to her country of origin – consequently, reuniting with her

	perpetrator. Only two phases of EMDR were fully completed. Equally, K3 reported that she could not continue the EMDR as she lacked a suitable place at home to do it online with the practitioner.
B1	BLS did not take place due to technical issues with the participants phone camera, preventing her from engaging with remote sessions.
B2	Moderating life stressors included B2's living situation and isolation during COVID-19. B2 was the only participant to engage in a change of BLS (both arm movements and tapping were attempted). All eight stages were completed.
B3	B3 was deemed high risk in accordance with COVID-19 government guidance. Hence the need to isolate with no possibility of face-to-face sessions. Additionally, risk concerns were further complicated by the switch from face-to-face to remote sessions due to COVID-19; for which the therapist undertook additional training to adequately manage any issues and therefore, phases 3 onwards were not started.

5.4.2 Validity

The validity when utilising descriptive statistics (Shadish, Cook and Campbell, 2001) places prior supposition that the construct validity of the diagnostic category of

PTSD, statistical validity of the outcome measures and the actuality of EMDR as an individual psychotherapy were formerly founded, thus not the primary concern of this investigation. Rather efficacy of EMDR in relation to the trauma symptomatic sample resultant from CSA was cause for exploration.

Moreover, although a practice-based, naturalistic effectiveness study hence allowing the individual clinicians to practice their unique therapy style, an adherence scale (EFRS) was utilised and therapy was conducted in accordance with a pre-established treatment manual to ensure consistency in a standardised protocol of EMDR whilst maintaining their unique style of delivering therapy as opposed to conduction of strictly prescribed therapy, causing validity in results (Eifert et al, 1997).

Though the case series design used an amalgamation of data sources, delivered through a well-defined research methodology; absence of the experimental control of variables (e.g. control group) may have compromised increase in internal validity. Conversely, a high degree of external validity can be determined as the present research explored the efficacy and client perspectives of EMDR therapy with therapists conducting treatment in routine settings representative of the norm, at liberty to conduct 'therapy as usual' (within the prescribed length of treatment IAPT framework).

5.4.3 Credibility

5.4.3.1 Momentary Recovery and Relapse

Although longer follow-up times have been highlighted as effective in the literature review (Jamshidi, Rajabi and Dehghani, 2020) these also cause issues of drop-out (Edmond and Rubin, 2004) and within the present study, the aim of follow-up interviews was specifically related to client perspectives of their therapy experience

rather than maintenance of results (reflective of no outcome measures being conducted during this time and also exclusion criteria of alternative interim treatment between ending of therapy and follow-up to deter distortion in client views). Hence a shorter follow-up time of one-month was sufficient in avoiding loss of qualitative data from prolonged follow-up times and consequently, potential insufficiency in analysis. Additionally, since trauma symptomology is reoccurring as with its associated comorbidities e.g. Depression (Piccinelli and Wilkinson, 1994) it is inevitable such symptoms may return regardless of follow-up length and equally due to transient factors or quality of life issues (e.g. family/financial constraints).

5.4.3.2 Advances in Credibility: Data Attrition and Client Fulfilment

Interestingly drop-out during follow-up interviews was non-existent regardless of COVID-19 and life-stressors hence expected barriers in transition from ‘face-to-face’ to ‘remote’ sessions and possibly in accordance with their choice of self-isolation during lockdown if this was out of area, and equally caseload demands. Credibility of results is further heightened by the minimal deficit in data gathering as almost all scores were fully present throughout the study regardless of diversity in session number.

5.4.4 Trustworthiness

5.4.4.1 Possible Recall Bias

It was theorised that participants may find prolonged assessment sessions (in addition to the standard IAPT data-set) strenuous in both time (e.g. family/life commitments) and resources (e.g. finances/transport) hence certain measures (e.g. IESR, RSES) with inclusion of the PEBL were planned to be undertaken at only pre- and post-treatment in order to account for participant needs and IAPT appointment slot arrangements (i.e. an hour in addition to the general one hour assessment

session time was allocated for participants in completing the PEBL however this was only conducted at pre-treatment due to COVID-19, possibly consequently negatively affecting results). Subsequently, fewer timepoints in conduction of these measures may have resulted in slight unreliability and recall bias (Raphael, 1987) as imperative changes in clinical symptomology and neurocognitive functioning during therapy may have been lost hence future research would ideally include repeated measures at commencement and throughout treatment, suggestive of stability (Longwell and Truax, 2015, Kazdin, 1981).

Further, PEBL tasks were purposefully selected due to time constraints in administration and to pursue neuropsychological areas thought to be provoked by the traumatic stress response in individual abuse experiences thus causing discriminate validity as alternate forms of functioning (e.g. motor-abilities) may have equally been affected. Consequently, further research is required to test such areas to identify associations between them and the observed domains in this study, namely in recognising supplementary neuro-chemical chain reactions hence the involvement of the prefrontal cortex and limbic system proposed by the traumatic stress response.

As identified in the literature review of Aranda, Ronquillo, and Calvillo, (2015) study, increasing the variance in PEBL battery-tasks would have allowed for a more rigorous examination of construct validity with this assessment measure and the items added to the WPS-CR, to investigate alternative neurocognitive changes. Likewise, in consideration of the small sample and since the RSES was conducted at solely baseline and pre-treatment sessions, loss in data may have slightly compromised the generalisability of low self-esteem findings for this study hence future research would ideally take account for such deficit.

Moreover, the qualitative part of this project was heavily dependent upon participant responses which may have been challenging for them to portray due to the emotional disturbance attached to reconnections or alternatively, loss of recall and hence the researcher could only analyse that information which was offered (Riach,

2009). Additionally, participants may have wanted to represent their clinician in a good light thus tainting their responses to questions (Elliott, 2008).

Although research conducted by Barkham et al. (2007) exploring stability of scores across measures (e.g. BID and CORE-OM) from referral to commencement of treatment displayed constancy of up to 6 months, absence of lengthy pre-treatment data (measurement period and/or a control group) in the present study makes it difficult to affirm deductions due to loss in comparative information. Thus, change in clinical presentations may have been due to gradual natural recovery or unprompted recuperation rather than suggestive of considerable impact of treatment.

5.4.4.2 Researcher Allegiance

The principal researcher provides her thoughts and concerns through use of the 'Reflexivity' section later in this chapter. Due to lack of resources, staffing issues and time constraints (setting up honorary contracts) within IAPT, two voluntary IRR's (trained and experienced in such techniques) to rate outcome measures and cross-examine qualitative data were/will be employed in place of the adjudication panel as suggested in much systematic case study design (Elliott, 2009). This served well in the current study as resources had been stretched in the sense that two IAPT therapists were employed to work on the project to avoid researcher allegiance as the researcher herself was initially planned to conduct treatment with participants potentially causing bias in results. Although this dual-role was not taken by the principal researcher, she further allowed each case-record to be independently reviewed by the client-clinician themselves to ensure accuracy in write-up and independent raters to provide an objective opinion of data analysis. However indicative of much research (Hollon, 1999; Luborsky, 1984; Singer and Luborsky, 1975; Rosenthal, 1963, 1966) low levels of unintentional bias may have been present due to the researcher also sharing allegiance with the phenomena under exploration.

5.4.4.3 Treatment Adherence

No session recordings were provided in keeping with the naturalistic study design and apprehension of drop-out considering the already small sample size in relation to subject sensitivity hence this crucial part of the EFRS was not adhered to, instead the EMDR Consultant Rater (ECR) formed judgment on the therapist self-evaluation SSS and TPT forms alone; however perhaps objective reflections of actual treatment delivery (Bellg et al, 2014; Moncher and Prinz, 1991; Perepletchikova and Kazdin, 2005).

In contrast to IRR mainly positive case outcomes, ECR results suggested that treatment fidelity for cases was lower than anticipated (mean average, 1.53) due to namely a lack of session recordings, emerging risk/complexity in cases coupled with abrupt changes/endings to treatment following the COVID-19 outbreak, and hence the treatment and study itself was deemed to have “*some adherence but inadequate.*” The below rating are in accordance with a EFRS Manual (2018) guidance, suggesting that a rating of 2.0 is “*adequate*” (Korn et al, EFRS Manual, 2018) and anything lesser than this as inadequate. The ECR reported scores as follows:

K1 (3H000108) - score: 1.46

No comments

K2 (NS004391) – score: 1.55

No comments

K3 (NS004231) – score: 1.66

“They were unable to continue EMDR processing due to current trigger of unavoidable contact with the perpetrator that they could not avoid.”

B1 (CS002467) – score: 1.95

“There was no reprocessing due to risk. Emotional regulation and coping strategies only. Marked purely on manualisation of treatment.”

B2 (CS004036) – score: 1.29

No comments

B3 (KM001365) – score: 1.27

“In this particular case it was due to the impact of COVID on client and therapy... The therapy didn't proceed due to self-harm and seizure. Stabilisation only. Marked purely on manualisation of treatment approach.”

Future research should account for lack of treatment recordings in methodology to improve quality assurance (Miller and Rollnick, 2014) as this played a huge role in difficulty in determining accuracy of scores, alongside a second ECR marker to collaborate scoring and the unavoidable COVID-19 pandemic.

5.4.4.4 Advances in Trustworthiness; Triangulation and Independent Researchers

Amalgamation of both qualitative data and descriptive statistics, within incorporation of both therapist and client's voices, expedites triangulation in this research design in generating rich case records. Quality control of data analysis and interpretation was assembled through use of two independent raters (from diverse psychological backgrounds) to elicit dissimilarities in emergence of overall themes and one external EMDR Consultant Rater (ECR) for analysis of EFRS in order to reduce researcher allegiance, and member checking protocols in ensuring the trustworthiness and credibility of results were employed.

5.4.5 Transferability

5.4.5.1 Variety in Sample

Transferability of results is limited due to the lack of diversity in both therapists and that of clients, all of whom were White, British and based within the UK – aside from one participant who was South East Asian in origin and did not hold permanent UK residency. This may have perhaps largely been due to the exclusion criteria of non-English speakers to avoid prolonged time spent on translator services or bilingual ethnic persons hesitant to enter therapy due to the above mentioned confidentiality issues surrounding cultural norms and stigmatization (Courcy and McCarthy, 2003), possibly skewing results further. Thus, findings for this study may be culture-bound. In loosening exclusion criteria, a broader set of results may have been deduced portraying a wider client-base from diverse socio-cultural backdrops.

5.4.5.2 Possible Selection Bias

Participants for this study were partially selected in that invitations to participate were posted to only those on the EMDR waiting list, based upon age range and inclusion criteria, after which participants voluntarily responded with queries and consent (amounting to $n = 6$, all of whom entered into the study). Although participants willingly participated, no doubt established upon their balancing of costs and benefits (Bourne and Robson, 2013), this may have created bias consequently affecting results (Mitchell and Jolley, 2013).

Therapists in the current study were convenience sampling in consideration of IAPT workloads (e.g. capacity to partake in the study) and locality (e.g. therapists were based in dissimilar teams to the researcher to reduce allegiance hence participant's residual details were taken into account when placing them with a therapist) and therapists with a range of personal styles were directly approached by management based on caseload availability. Though there is no indication in qualitative analysis that their skills were too broad for this study as both had a background in Clinical Psychology.

5.4.5.3 Advances in Transferability: Conduction of Research within Routine Clinical Practice

This efficacy research explored the outcomes of EMDR and was delivered in routine practice with utilisation of a naturalistic design, significantly improving external validity of results. Participants equally chose EMDR as their preferred treatment option and were assigned to therapist in accordance with IAPT locality and caseload capacity. All those fulfilling the inclusion/exclusion criteria who provided consent were included in the study in order to expand external validity and provide rational evidence for the efficacy of EMDR in the treatment of CSA as it is readily administered, in conjunction with real-life supervision time (monthly basis), in comparison to many RCTs whereby clinicians receive a high ratio of supervision than commonly available in practice settings.

TABLE 4: KEY ASPECTS OF RESEARCH DESIGN

Credibility	Trustworthiness	Transferability
Discussion of researcher bias with independent raters, therapists and supervisor/s as counterbalance	Constant discussions with both academic and fieldwork supervisors to ensure consistency in approach	Utilisation of both universal and EMDR-specific approaches to account for results
Triangulation of data	Triangulation of data	Triangulation of data
Interview transcript excerpts provided in appendices and cited in text	Interview transcript excerpts cited in text	Sample and therapist reflective of routine IAPT settings
Use of independent raters to impartially verify outcomes and recognise	Use of independent raters to impartially verify outcomes and recognise	Both 'practice-based evidence' and 'evidence-based practice' representation of results

main moderator and mediators	main moderator and mediators	
Member checking protocol (affirming accuracy in rich case records with both clients and therapists)	Member checking protocol (affirming accuracy in rich case records with both clients and therapists)	Rich contextualisation of client, therapy setting and therapist in case record
Communication with supervisors to confirm adherence and competence of therapists	Communication with supervisors to confirm adherence and competence of therapists	-
Use of an EMDR adherence manual to evaluate both treatment and study fidelity via an independent rater	Use of an EMDR adherence manual to evaluate both treatment and study fidelity via an independent rater	-
Comparative approach of cross-case data analysis	-	-
Lack of attrition/drop-out and high degree of client fulfilment reported	-	-

5.5. IMPLICATIONS FOR CLINICAL PRACTICE

The present research was conducted with a practice-based sample and explored the efficacy of EMDR in routine practice using a systematic case study research design, with therapists also practicing externally to an educational institution research clinic thus suggesting a valid resolution in closing the research-practice gap (Crooke and Olswang, 2015; Morrow-Bradley and Elliott, 1986). The active engagement of two trainee researchers in the analysis process following basic training is also indicative that this is a realistic approach in conducting experiential, practice-based research education.

This section concentrates on the evaluation of cross-examination of analysis in conjunction with abductive reasoning and Stiles (2007) theory-building approach to propose implications for EMDR theory and practice.

5.5.1 NICE Guidelines: Progression in 2018 EMDR Guidance for PTSD and Assimilation across Therapeutic Modalities

Consistent with recent meta-analysis (Moreno-Alcázar, 2017; Paylor and Royal, 2016), the World Health Organization (WHO, 2013) and International Society for Traumatic Stress Studies (ISTSS, 2018, 2019) recommendation, it is apparent general guidance for PTSD treatment value EMDR as an equal trauma-treatment to TF-CBT which differs from literature outlined during conduction of the initial literature review (NICE, NG116; 1.6.18-21, 2018). The above findings equally add strength to the recent changes made in guidance as EMDR has flourished in all investigated domains when working with young adults.

Although two areas of focus are fundamental in chosen interventions in varying modalities when investigating client conceptualisation and mechanisms of change, such as 'cognition and behaviours' in Cognitive-Behavioural Therapy (Beck, 1967). Equally alternative modalities such as that of Psychodynamic (APA, 2018) and Emotion-Focused Therapy (albeit differing theoretical foundations; Fromme, 2011) endorse change principally via the affective-relational domains. In comparison, as viewed in this case series analysis, EMDR is unique in both case conceptualisation and encouraging change in neuropsychological, emotional, and behavioural domains whilst applying an idiosyncratic and intelligible structure, correspondingly adept in catering to each participant's needs (both clinical issues and personal preferences), especially for those that undergo the entire 8-phase EMDR protocol.

Pointedly, participants seemed uninterested in the name of the treatment 'model' and as such did not utilize psychological terminology (unless mimicked/learnt from clinicians) as maybe conveyed by clients of CBT, perhaps this is due to their lack of

'needing to know' in comparison to their 'wanting to get better' (Ahn and Wampold, 2001; Lambert, 2007).

5.5.2 Future Template

Though no participants directly developed 'future templates' within this study, evidently the verbalisation of future goals in most cases allowed participants to optimise their capacity to respond adaptively and flexibly in future situations; develop and strengthen specific skills, behaviours, emotional/sensory responses; prepare for challenge situations; address anticipatory anxieties: to reveal hidden fears, blocking beliefs, inadequate responses in the hope of developing templates of desired responses to access adaptive memory networks (as discussed in Paterson, Workshop, 30/11/19).

In consideration of the participant's initial cynical perspectives of their future, this feeds directly into a theoretical extension linked with the third prong of EMDR, namely the 'future template' in allowing the client to positively envisage facilitation of anticipated future events (Shapiro, 2001). Interestingly, those who attained better outcomes were those who observed change-orientation throughout the full 8-phase EMDR protocol and consequently, displayed optimism in their expectations of therapy and reliably future aspirations. Thus, the need to stress importance of thorough conduction of this prong in managing constructive yet realistic expectations both internal and external to therapy settings.

5.5.3 Client Choices

Consistent with a recent poll of therapist opinions (Farrell, 2018) greater treatment choice in EMDR was an influencing factor in their recovery. Alongside the need for systematic psycho-education and/or resources around the process of therapy to provide calibration and particularly EMDR phase 2 in understanding of preparation,

the participants in this study additionally took value in therapist skills (e.g. knowing their clinical background in accordance with their approach to manage primary treatment agendas and clinical engagement).

5.5.4 DSM Baseline Diagnosis: Taking a Symptoms Approach

There appears to have been historical disagreement surrounding what forms the key factors underlying trauma reactions, within both the ICD-11 (2018) and DSM-V (2013); whether it is the event itself, the unconnected memories, the related meaning, or individual vulnerability (Hermann Oppenheim, 1858–1919; Jean Martin Charcot, 1825–1893; Pierre Janet, 1859–1947; Sigmund Freud, 1893). As largely referred to within IAPT, regardless of the numerous DSM revisions in concluding the current DSM-V (2013) description there has been debate between namely the latest two versions of the DSM (2000; 2013), over ‘Criterion A’ of this definition which implies PTSD is unique to other psychiatric disorders (e.g. Depression, BPD) due to its need for an identifiable aetiological element, a peripheral event (criterion A: the stressor criterion) which links with the traumatic symptoms. Equally, Criterion A(2) of DSM-IV indicating that the experience must have concurred with feelings of fear, helplessness, or horror was also questioned (Roemer, Orsillo, Borkovec, and Litz, 1998; Palmer et al, 2004) as PTSD has been known to develop without the said emotions and further with non-fear related emotions such as guilt/shame (Brewin, Andrews, and Rose, 2000); these are often principally experienced in the maintenance of PTSD (Andrews et al, 2000; Lee, Scragg, and Turner, 2001; Resick, 2004). Further, there was an indication (Avinand and O’Donohue, 2002; Dattilio, 2004) that PTSD can be caused by ‘small t’ trauma whereas epidemiological research and meta-analyses of PTSD risk factors (Brewin et al, 2000; Ozer et al, 2003, Ozer et al, 2008) indicated that greater deviancy is owing of peri-traumatic processes (e.g. emotionality, cognitive processing etc), psychological history, and post-trauma influences as opposed to the nature of the traumatic event. Though numerous notions have passed in understanding ‘PTSD’ via the DSM (APA, 2000; 2004; 2013), the current DSM-V (2013) has maintained Criterion A and B, indicating

certain symptoms (e.g. flashbacks) are unique to PTSD unlike anything seen in other disorders (e.g. major depression).

Although PTSD as defined by the DSM-V (2013) criteria depends upon a range of symptoms to produce the diagnosis, this ideology has been criticised by many (Double, 2019; Insel, 2013; Luyten et al, 2006 and Johnstone et al, 2018, as per the PTM Framework, as previously discussed) as numerous additional elements including aetiology, clinical dominion and external factors may substantially contribute in understanding treatment outcomes. To address such concerns, a diagnosis of PTSD was not an inclusion-criteria for the present study, rather therapists worked with participant symptomology to attain as large a sample as possible without subsequent labelling and stigmatisation. Decisively, although these are valuable heuristics, loss in data may have been present in analysing changes in solely outcome measures, therefore the need to apply qualitative methods (although somewhat limited to the participants recall of events and subjective lens to fully articulate change mechanisms) to capture the clients lived experience of EMDR therapy in relation to CSA.

This slight loss in data significantly accounts for the value in coherency with the BPS PTM Framework (Johnstone et al, 2018), whereby clients presenting with trauma symptomology, however those too vulnerable to have previously sought help through Mental Health services or presented with prior disengagement in services due to feelings of shame and confusion (as with many young CSA survivors), deterring their chance of a concrete diagnosis, have now been given a voice when discarding rigid DSM diagnosis and rather, working with the clients presentation in symptomology alone. IAPT commendably cater for such client needs and this study has proven the benefits of EMDR when working with such a group.

Employment of additional advances derived from the BPS PTM Framework (Johnstone et al, 2018) such as client preparation via utilisation of key domains e.g. taking account of the service user voice when assessing "...typical patterns in the ways people respond to the negative impacts of power...patterns of meaning-based

responses to threat.” (PTM Summary, 05/11/18) would further strengthen replication of this study in working with trauma symptomology as opposed to a diagnosis of PTSD or C-PTSD in determining efficacy of EMDR. Such research will also look to consider quality of life stressors in that social, cultural, discriminatory problems partially form deregulatory clinical presentations e.g. insomnia, low self-esteem, fear of shame and rejection, when dealing with oppression (Korn, 2009).

Evidently, those having experienced EMDR phases 1-2 (regardless of not having completed EMDR phases 3-8) reported of greater clinical recovery in comparison to their prior experiences when working within alternative treatment domains, whereby they felt little or no psycho-education had previously been provided. Hence, in agreement with all three components of Herman’s (1992) tripartite model (as previously discussed) in treating C-PTSD (ICD-11, 2018) and PTSD (DSM-V, 2013), psycho-education appears to be a much needed and an integral aspect of therapy. Although, factored into the initial phases, standardised orientation resources e.g. leaflets and information sheets may help edification of the theoretical process and prevent stigmatisation in exacerbating the clients understanding of the ‘normalisation’ of symptomology.

5.5.5 Therapy Preparation and Adaptations in Psycho-education

Therapy preparedness was a key theme in this project thus the potential need of a pre-stabilisation trauma group (which would account for EMDR phases 1 and 2) to scan for client psychological-mindedness and provide general psycho-education as implemented in other IAPT services, as to inform clients of trauma-related symptomology and care before commencement of 1:1 trauma-informed sessions (essentially completing the remaining phases, 3-8). This would avoid distressing client catastrophising and waste in precious time and staffing resourcing when covering such groundwork on a 1:1 basis. It would additionally be strengthened by the need for a trauma-specific pathway in such services as currently all trauma clients are compiled onto a mainstream stepped-care based treatment waiting list regardless of their differing needs (e.g. anxiety vs trauma clinical presentation).

However, although participants did not opt for their therapist (aside from gender preference in conjunction with sensitivity to past traumatic events i.e. if the abuser was female, individuals may feel uncomfortable working with that gender), their control of treatment choice was reported to play an active role in therapy engagement and positive outcomes; the emphasis of this learning must be highlighted as although it may not be resourced to create a sole trauma-pathway, unique characteristics of this client group must be considered via their individual treatment choice.

Equally changes in therapy utilities may be adequate in consideration of dysfunction in neuro-processing whereby as seen in this study, particularly memory and executive functioning may be affected by the traumatic stress response causing deficit in the client's ability to apprehend information. Hence, the need for shorter/more intense sessions, at times longer sessions, simplistic content, or essentially a change in dialogue if struggling with language deficits, from verbal to pictorial communication (e.g. visual aids) and repeated educational prompts for those exhibiting reduction in processing time are essential in providing a nurturing environment and subsequently, in successful treatment outcomes. Such adaptations in communication also extend to socio-cultural and educational settings, as demonstrated by the VLQ, those exhibiting life stressors are generally hypothesized slower recovery times thus the need to facilitate possible issues with recall of information, problem-solving skills, commitment to work/relationships in their general lives; with the current sample age range such management would commend psycho-education rolled out across schools/colleges, universities and workplaces as well as to primary caregivers and family and/or friends (Cook-Cotton, 2004).

5.5.6 Development of IAPT Service Pathways

From the six participants recruited via the standard IAPT assessment procedure, though factors including changes in delivery of sessions due to COVID-19 and external stressors were highlighted, namely issues around treatment length for three participants due to level of complexity was a barrier in progression; IAPT appeared too short-term in its model to provide the adequate amount of thorough sessions to

practice the 'history-taking' and 'preparation' (essentially, EMDR phases 1-2) and 'assessment' to 're-evaluation' (EMDR phases 3-8) phases consistently nor the entire 3-pronged protocol (past, present, future template) ethically hence, their treatment contracts only enabled them to be seen for EMDR phases 1-2, with view to re-refer for further the remaining phases.

Feedback received from clinicians indicated that these were general presentations worked within IAPT at both Step 3 and 3+ (as there is no official criteria in presentation between the two steps) and for this reason, we decided to keep these participants in the study as it is representative of real-world clinical settings.

For instance, client B3 experienced domestic violence which was viewed as a risk factor as early relationships model adult relationships hence, the EMDR themes worked with when processing this were also partly consistent with her experience of CSA. Also, in case B1 the EMDR preparation phase 2 was utilised in terms of EMDR grounding techniques such as safe place which highlighted issues with whether 12-20 sessions as per the standard IAPT model is appropriate in treating such cases or whether an individual 'Trauma Pathway' should be developed in considering secondary symptomology of trauma/comorbidity (e.g. dissociation, interpersonal issues, depression, anxiety, low self-esteem) as at times in IAPT clinicians are unable to complete the full 3-pronged protocol however they are able to work on certain aspects/stages before discharge and possibly continuation of treatment if re-referred at a later date.

5.5.7 Relapse Prevention and Treatment Timeframes

All valuable therapies must be viewed equally tangible to increase client choice, something IAPT has battled to convene (Pearce et al, 2012). Equally, although not a major issue in the current project, participants exhibiting poorer outcomes or potential onward/re-referral were those who ended treatment earlier than the set timeframe of available sessions (due to personal reasons/COVID-19) or displayed anxiety around ending therapy within IAPT parameters, as previously outlined in the discussion section insufficiency in session time is an ongoing issue within IAPT

services (NHS England, 2015; BACP, 2016), possibly due to restricted resources (BACP, 2014), often leading to poorer outcomes (Cape et al, 2010). Perhaps therefore the need for maintenance therapy (Frank, 1991; Hollon, Thase, and Markowitz, 2002) and equally both treatment choice and session time allocations in accordance with individual presentation and recovery.

Although sessions for the participants varied in length due to variable speeds of recovery and external factors, all outcomes were relatively good however better for those in longer-term treatment, having undertaken all eight phases. However, in consideration of the small sample, affirmation in conclusions cannot be fully attained meriting the need for further research to explore optimal therapy length. Consistent with studies investigating gaps in therapy (Reardon et al, 2002; Kraft, Puschner and Kordy, 2006), although somewhat unavoidable in circumstances, it is evident that breaks in therapeutic work may be crucial in outcomes. IAPT is laudable in providing adequate pre-treatment information on protocols to avoid absence and avoid therapeutic rupture however this is also derived from the additional agenda of high IAPT treatment demands in a financially constricted programme (House et al, 2011) which may equally lead to clients being discharged from therapy due to x2 unavoidable absences regardless of their dire need for help. Hence once again, resourcing and stabilisation work to account for unforeseen breaks in therapy work well as means of contingency planning.

5.5.8 Resilience in Trauma

This sample age range was indicative that at times individuals are referred to therapy due to their experiences as opposed to their traumatic stress responses to that experience and hence, may not always present with clinical dysfunction in domains. Rather practitioners should promote such non-damaged areas in behavioural, emotional and neuropsychological processing as resilience in the trauma survivor, often as a means to provide stability and confidence in safe recovery, rather than focusing on solely 'resolving' dysregulation.

5.6 FUTURE RESEARCH DIRECTION

Due to lack of control group (since TF-CBT is not largely a recommended treatment within GMMH IAPT for multiple/complex trauma) together with the small expected sample size (in consideration of overlap in services between IAPT and CAMHS when treating clients aged 18-25 and also subject sensitivity diminishing client disclosure/openness to research); the research design accommodated that of a case series analysis as opposed to a comparative outcome study since there may not otherwise have been enough participants to compare descriptive statistics effectively (minimum sample, $n = 4$).

Consistent with the study design, this was not an exercise to seek large amounts of statistical data, based on controlled variables via the use of inferential statistical techniques to produce broad generalisations of causality. Rather the objective of this research was to produce rich practice-based data with a small sample of several naturalistic cases. However, this may be a limitation that appropriates findings, these will be addressed below.

5.6.1 Therapeutic Change Process Research

Larger scale studies with a similar sample age range however broader sample size and a wider therapist spectrum are required, whilst addressing limitations (e.g. lack of sessional data through audio-video recordings to provide insights into EMDR micro-change mechanisms) posed in this study. Similarly, research with socio-cultural diversity amid clients and therapists is warranted to explore greater variables in results. Moreover, case series may provide richness in results to gradually dispute the vast array of positivist research with practice-based evidence from those verifying their own experiences of EMDR however equally we must consider possibly building up to RCTs in the pursuit to cover generalisability in results.

Replication in research would also be helpful across a two-fold study with groups of both children and adolescents due to adaptations in maturation of brain structures (Barron et al, 2019; Matthijssen et al, 2020; Teicher et al, 2002) impacted by the traumatic stress response. Conjunctively, increase of the RSES measure and namely the PEBL subtests throughout various time-points in treatment would support

in the analysis of changes at pre, during and after therapy; with addition of a more inclusive neurocognitive battery (e.g. motor skill, attention, executive in the form of visual-spatial integrated with verbal processing when problem-solving, language, learning/memory, and cognitive functional dominions) in future research in order to capture dissimilarity between domains and increase both convergent and discriminate validity of the effects of the traumatic stress response. As per the current study, this would not be practicable to conduct within the current IAPT timeframes and certainly not on a weekly-fortnightly session basis hence ideally therapists would communicate the best times of conduction with researchers to administer in an attempt to reduce therapist allegiance in the interpretation of findings.

Ultimately, key contributions within the present study were provided via client perspective's and insight into the therapeutic change process, why EMDR was a valid approach, and specifically illuminating what was helpful and unhelpful from their viewpoint. The methodology used in the current study (practice-based evidence) is a great starting point to then justify build-up to a RCT (evidence-based practice) in order to provide progressive data coverage of a modified protocol for EMDR treatment based on the phenomenological experience of the clients; particularly after replication of this study in other treatment facilities and ideally outside of the pandemic in order to understand whether this may change the client experience.

5.6.2 Individual Clinical Impact on Outcomes

Evidently participant change was exhibited in a variety of forms within the present study however also through interpersonal adaptations, although the DES was implemented within this study as a baseline to gauge entry into the study (as mentioned in the Methodology), no pre-treatment scores were taken causing loss in data.

No measure identifying specifically personality traits was administered due to the exclusion criteria of diagnosable axis II disorders hence though no indication of this in the present research such conditions e.g. self-critical perfectionism (Blatt, 1995;

Blatt and Zuroff, 2005; Zuroff et al., 2000) and neuroticism (Kendler, Kuhn, and Prescott, 2004) could potentially have impacted upon treatment response (Westen, Novotny, and Thompson-Brenner, 2004; Luyten, et al., 2006). Thus, outcome measures related to this area are warranted in further research such as the *Inventory of Interpersonal Problems* (Horowitz, et al., 1988), ideally conducted at both pre- and post- treatment.

Exclusion criteria was an evident pattern in literature also whereby incidents of trauma were varied (e.g. physical abuse, single-incident rape) and equally, comorbidities (e.g. suicidal ideation, substance abuse and psychiatric disorders e.g. borderline personality disorder as outlined in Shields, 2015 case series). Therefore, by relaxing exclusion criteria and in analysing specific variables in outcome, a broader set of results may have been deduced portraying a wider client-base from diverse socio-cultural backdrops.

5.6.3 Case Analysis Procedure

In an attempt to offset potential researcher allegiance and bias effects, similar to prior research conducted with the HSCED approach, both affirmative and sceptic assertions have been generated by the researcher and a confederate or alternatively a group of four graduate students (Elliott, 2009). The current study adopted elements of this process in that two completely independent researchers (contradictory to previous research whereby those within the same modality judge cases; Stephen et al, 2011) rated interventions and cross-analysed qualitative data as a full adjudication panel was not resourced within IAPT services. Dissimilar to the conventional HSCED design however similar to one previous study (Widdowson, 2013), independent researchers were also requested to provide a decision on the overall outcome of each case (based on clinical improvement) via thorough data analysis whereas prior studies have concentrated on judge's opinions surrounding client levels of change and attributes to therapy. This amended manner in working amplified credibility and trustworthiness of results.

5.6.4 Limitations of HSCED Method

Lack of sessional recordings due to avoidance of compromising the naturalistic design of practice-based research may have essentially bridged the gap in recognizing client narratives/micro-processes in treatment that may have gone unchecked due to flaws in the HSCED approach, as although it thoroughly attends to the query of efficacy, this is heavily based on outcome (Elliott et al, 2013).

In this study both moderator and mediator aspects were cross-examined alongside descriptive statistics and qualitative TA interview themes however small losses in treatment session content and administration of interventions may not have been present which would otherwise have been captured in session recordings.

5.6.5 Administrative Duties

Though issues with measures, namely the one question which was deducted from data analysis and the general IAPT data-set. Administrative issues and breaches of confidentiality were raised as concerns in counterbalance with the already difficult process of determining therapeutic goals, hence being mindful of such issues to put the client at ease provides cultivation of comfort.

5.7 REFLEXIVITY

I was especially cautious around validity and considered whether having one external EMDR Consultant providing supervision may have been too little to ensure adherence to the protocol and therefore, sourced another external EMDR Consultant for conduction of the EFRS. Although, due to the naturalistic research design, it was difficult to accurately assess/rate session content because of the lack of recordings however, I took comfort in delivery of treatment being within routine clinical settings; something which clinicians can relate too, to help fill the practice-research gap. Credibility and trustworthiness in results was equally imperative, I was concerned that attrition would be high due to the COVID-19 pandemic (e.g. if participants were required to isolate or if there were issues with technology used for remote sessions), more so between the final treatment session and follow-up interview. However, surprisingly, there was no drop-out, indicating credibility. Though, to my dissatisfaction, deductions in particularly post-treatment PEBL subtests due to

COVID-19 caused possible loss in micro-changes to neuropsychological functioning and in comparative information. I tried my best to search for downloads of the subtests so that participants could complete these at home however, I was mindful of bias and trustworthiness. Therefore, although the present study was deficient in post-treatment PEBL subtests, I was overjoyed and slightly relieved that there was minimal missing data in all other areas and that I had taken researcher allegiance seriously. The difficulty in recruiting therapists to conduct EMDR treatment (as opposed to analysis of my own session delivery), to further avoid bias - and equally, the sourcing of IRR's was well worth it in ensuring unbiased data analysis. Moreover, I believe that triangulation of data was necessary in the representation of both PBE and EBP perspectives in results, especially given the significance of both domains (as discussed in this thesis); rich case records of typical clients received within IAPT settings further consolidated findings, though I was hoping for more uptake in recruitment. The small sample made me more determined to immerse myself in the data, to understand the participants individual perspective however, the cultural difference between particularly K3 in comparison to the other participants was apparent. I could not help but ponder whether such difference in background was a contributing factor in her 'sceptic - no improvement' outcome. For instance, K3's background whereby there was an apparent power imbalance amid gender and her clarity in discussing common themes she was exposed to whilst growing up, often reporting the inadequacy of the female gender and how these generalisations formed part of her belief system. It would have been interesting to explore the therapeutic alliance in terms of the power dynamic in more detail (e.g. the therapist's adaptations in treatment to address gender/cultural issues, sense/lack of control, possible empowerment in working with a female therapist). However, these topics were too large for the scope of this project as my objective was to understand the clients view, whatever they wanted to share without direct guidance. Though, this does warrant future research within this context, the therapists alignment with, for instance, the PTM Framework (Johnstone et al, 2018) as discussed in present study.

My agenda from the outset was to undertake this research in order to project meaningful results to the profession of EMDR. However external itineraries in the

form of the Layard report (2012) in promoting psychological treatment (via IAPT) and limitation by economic constraints, resultant in lack of NHS resources (BPC and UKCP, 2015), equally became apparent over professional identity (i.e. in working as solely a researcher or EMDR clinician). I came to realise that complexity in the IAPT agenda itself is again debatable regarding NICE guidance in regulating approval of trauma treatment options, namely CBT vs. EMDR (NICE, 2018), and also in the lack of treatment choice offered to IAPT clients (NHS England, 2015; BACP, 2016). Henceforth, the greater need to voice client opinions and cater to their needs as although those involved with this project reported mainly moderate to good outcomes, there are many cases whereby the evidence-based climate may have caused barriers therefore, steering the discussion of epistemological stances and an ethical element which also questions, is a 'one-size-fits-all' approach really beneficial? For this to be answered, client choice is imperative to tailor therapy to client needs, rather than create a domineering climate with limited options (BPC and UKCP, 2015). Choice within a trauma-informed framework, such as the SAMHSA Trauma and Justice Strategic Initiative (2014) appeared highly relatable to the present study. As part of the six key principles, SAMHSA (2014, p.11) suggests "Safety" of physical settings and interactions throughout the organisation is an essential starting point, followed by "Trustworthiness and Transparency" of organisational decisions, ensuring transparency with staff and clients. "Peer Support" of individuals with lived experiences of trauma to promote trust and recovery is the third principle, which aligns with the fourth, "Collaboration and Mutuality" to ensure equity in power amid clients and staff. "Empowerment, Voice and Choice" as the fifth principle is paramount in understanding how previously, clients may have felt unheard and hence, the importance of their voice in decision making, goal setting and in the recognition of their resilience. The final principle is "Cultural, Historical, and Gender Issues" in which the organisation acknowledges and promotes equality and diversity through culturally, ethnically and racially informed policies and procedures. Mindful of historical trauma, stereotypes and biases (i.e. gender orientation, age, status etc); an extension of which would be appropriate training in dealing with such presentations and broader organisational workings.

Equally, to my surprise, recommendations in the current project were consistent with those of the annual IAPT staff survey results analysed by the GMMH IAPT research

associate (Verbist, presented 04/12/19) whereby '136' clinical staff participated, with a fairly equal distribution of participation across all localities; generic feedback was distributed amongst three key domains, as follows;

- 'Role Demands' indicating "Unrealistic targets compared to clients' complexity" and "Limited time on reflection of practice" – team and organisational recommendations included "peer support groups" and "flexibility in targets based on complexity"
- 'Leadership' indicated "Conflict between high complexity and duration of therapy" – organisational recommendations included "ethical consideration of limited therapy delivered to complex cases"
- 'Opportunities and Involvement' indicated "Limited time for research and upskilling" – organisational recommendations included "training related to complexity" was much required

Overall, in all areas more optimism was reported in 2019 (no report was produced for 2020 due to COVID-19) in comparison to feedback from 2018 (slide 28) suggesting improvements in these domains however interestingly, as highlighted within the current study, similar themes were reported in terms of both 'complexity' and 'time limitation' within both years. Therefore, the recommendations outlined in the above-mentioned staff survey results are consistent with 'unhelpful factors' fed back by participants (e.g. lack of time to complete work on complexity in presentation hence, utilisation of idiosyncratic techniques e.g. CBT/EMDR techniques to stabilise clients, which appear to help in the short-term, before discharge and re-referral, followed by lengthy wait times of over a year before core EMDR BLS can commence, by which time client presentations may regrettably have deteriorated, leaving therapists to work with yet more/similar levels of complexity; a vicious cycle). This revelation also made me reflect on why the partial research emphasis on 'CBT vs EMDR' as both seem to work well in conjunction with one another. Instead, in terms of practice-based progression, the IAPT model (in particular disparity amid lengthy client wait times due to the lack of criteria for staff taking cases within the stepped-care model), appeared to be the greatest barrier. Especially as many underlying factors may present during the course of treatment (e.g. complexity as demonstrated by 50% of

participants in this study), making it difficult for therapists to complete effective treatment within varied service timeframes and causing clients frustration in re-accessing services for EMDR phases 3-8, after a contract of solely EMDR phases 1-2.

It appears that the current research recommendation of a specific trauma pathway may not be resourced; though to my knowledge, for over three years, staff have at minimum requested clarity in the stepped care model (an 'approach, usually offering or referring for the least intrusive, most effective intervention first;' NICE, 2021), to date, no conclusive understanding of service criteria has been issued. Inevitably there will be some overlap between 'step-3' and '3+.' Currently two key issues persist, step-3 untrained/in-training/newly-trained staff are allocated complex cases or alternatively, experienced step-3 staff (comparable to 3+ in experience and qualifications) are allocated such 3+ complex trauma cases, though there is over a year waiting list between the two; meaning that some clients may wait much longer than others in receiving similar quality treatment, or that the treatment they do receive may be delivered by under-resourced staff. Such cases are generally allowed approximately 20 sessions and are seen 'off the IAPT pathway;' for various reasons figures are not generally counted towards the national target as per other allocated cases at step-3. However, 3+ practitioner caseloads are generally lower, whereas clinicians at step-3 are still required to maintain higher caseloads as a by-product of the target-driven IAPT model, sequentially causing burnout. Further, potentially affecting clinical work i.e. little continuity if the therapist is off sick, causing possible fear/anxiety around *lack of confidentiality* (if the client has been seen by multiple clinicians), attachment/trust issues may surface around the reported unhelpful factor regarding fear of '*Reliving Past Experiences*' (as reported by a third of participants) due to professional bureaucracy in caseload management and inadequate treatment time in emotional reprocessing.

Clarity in the stepped-care criteria will help clients (work with appropriately experienced therapists, with equal wait times) and also, staff (in allocation of presentations they are competent in working with and relevant acknowledgment/

appropriate training to further develop skills to avoid burnout/compassion fatigue), alike. Importantly however, a peer supervision group, complex-cases drop-in and some new training opportunities are now being offered to staff and equally, not all recommendations can be implemented on a local level without hierarchical guidance (e.g. adjustment of IAPT targets, IAPT dataset/‘*measures*’). This project has been an ‘eye-opener’ not only in the above-mentioned domains however especially when analysing qualitative data in understanding ways in which to improve my own practice and the importance of equilibrium between both evidence- and practice-based intervention (both of which imperative in their own right), when greatly considering service demands and client views.

5.8 SUMMARY

Though findings are consistent with much prior and more recent efficacy research (de Jongh et al, 2019; Schwarz et al, 2020; Wagenmans et al, 2018; Woudenberg et al, 2017; Hutchins and Mason, 2017) and also somewhat in accordance with IAPT staff surveys, the current research has built upon under-researched areas such as low self-esteem and hindering- as well as helpful- aspects of the therapy process. As defined in the initial results summary and subsequent sections of this chapter, numerous points of learning have been highlighted in evidence, practice and future research recommendations; all of which taking account of clinical, political, ethical and transient ideologies.

In sum, EMDR is substantiated in being an idiosyncratic modality which encourages change by uniting neuropsychological, emotional and behavioural interventions domains to cater for the clients’ clinical needs (in various facets including neuropsychology, anxiety, depression and low self-esteem), accounting for both process and preferences.

Participant perspectives of therapy have also added weight to the descriptive statistics in establishing the efficacy of EMDR and the client’s view of both positive and negative factors of their therapy experience in order to inform professional practice with client-based evidence. These results bring together evidence-based

practice and practice-based evidence in acknowledging what is effective from the very individual who experienced the event and remedy.

Chapter 6: Conclusion

As initially addressed, the IAPT service introduced to support the public's need for anxiety and depression treatment (Layard, 2006), both common comorbidities of PTSD (Flory and Yehuda, 2015; Spinhoven et al, 2014) as presented in a majority of CSA survivors, although admirable, has seen the supremacy of CBT, partly restricting the choice of psychological treatment offered to the public (NICE PTSD Guidance, 2018). Hence the growing need for valuable client perspectives in healthcare (Allen, 2000) in attaining clarity in the therapeutic change processes as without such assessment exploration of that said therapy, it is at a loss (Lambert, 2007), particularly for the delicate sample observed in this study.

The literature review highlighted gaps in research surrounding the client's view (rather than a mass of research around the therapist's opinion or researcher analysis) and equally, in assessing therapeutic change processes in comorbidities (e.g. lack of self-esteem, anxiety, depression) of Trauma. Though numerous variables were explored during the present study, further research is warranted to investigate broader connections between the individual trauma stress response and therapist style when delivering treatment (Paul, 1967) and possibly client perspectives of those opting for CBT over EMDR in order to identify whether any changes in EMDR can be implemented to make this more desirable for such clients.

In terms of methodology (incorporating descriptive statistics via outcome measures and follow-up semi-structured interviews via use of the TA approach (Braun and Clarke, 2006), with aim to maximize data whilst minimising any interference in the therapeutic relationship), a case series analysis design was implemented to investigate EMDR therapeutic change processes in routine practice with a naturally occurring sample of clients and therapists reflective of regular IAPT practice-settings since prior research into this subject has been plagued with the RCT design as gold standard, regardless of its unsuitable nature in addressing definitive elements of therapy, such as the subjective EMDR experience (Krause and Lutz, 2009; Storr, 2011; Stiles, 2013).

Aspects of the Hermeneutic Single-Case Efficacy Adjudicated Design (HSCED) (Elliott, 2001, 2002) was also employed to evaluate individual cases with two IRR's adjudicating each rich case-record to establish a rational outcome via analysis of substantial process factors (e.g. moderators and mediators). In accordance with the pragmatic and theory-building aspects of this design, cross-examination of all cases then took place, hence parallels and contradictions alike were exhausted in order to verify individual case outcomes.

6.1 RESEARCH AIMS ADDRESSED

In this project, one of the overall aims was to explore the client's experience of receiving EMDR via use of TA qualitative research methodology in understanding the client's perspective. Rich case-records were compiled outlining the clients positive and negative views of their therapy process (of which key emergent themes were highlighted as explored in the discussion section) in order to provide insight into recommendations for clinical practice and inform service policy.

A second aim of this research was to explore neuropsychological, behavioural, emotional and quality of life issues via utilisation of assured outcome measures. Though, sadly the absence of neuro-measures at post-treatment and changes in the delivery (face-to-face vs remote) of EMDR due to COVID-19 were demanding barriers in consolidation of results, overall clinical improvements were observed across domains with likeness exhibited amid quality of life issues, anxiety, depression and low self-esteem. Variance in neuropsychological domains was also detected however a high correlation between positive outcomes with those that had undertaken EMDR phases 1-8 as opposed to those having experienced solely EMDR phases 1-2.

6.2 PROJECT CONTRIBUTIONS TO EXISTING SUBJECT KNOWLEDGE

The current study highlights unique client perspectives of the un/helpful aspects of their EMDR experience; collaboration between client choice and therapist professional and interpersonal attributes in facilitating a supportive environment in conduction of EMDR, which as observed in the present project, has demonstrated

efficacy in working with the clients key emotional, behavioural, neuropsychological needs and fluctuations in quality of life stressors, allowing the client to gauge a sense of self-awareness.

Although the efficacy of EMDR has been widespread researched in relation to PTSD, emotional and behavioural functioning hence its implementation in services such as IAPT, it is significantly under-researched with particularly a young adult populace having experienced CSA (as seen in the literature review) as samples are often derived from a mixture of the child and adult populace making differentiation of results difficult to render (with the exclusion of a single case study which may have compromised generalisability in results; Aranda, Ronquillo, and Calvillo, 2015); specifically in terms of neuropsychological functioning due to the differences in traumatic stress response between the two groups (Altemus, Dhabhar, and Yang, 2006). Client perspectives are similarly two-fold in that there appears to be more emergence around positive aspects of EMDR however, little in the way of identifying unhelpful factors of therapy, a gap which this study has hoped to explore. The present research also defies the assertions of evidence-based research which dictate what treatment is most helpful for clients and instead, provides the counterbalance of both evidence- and practice-base from the perspectives of those who have experienced EMDR, bringing learning to attention for policy-makers.

Although this study was conducted in routine practice-based settings, with use of adherence measures and a naturalistic sample of clients and therapist styles adding transferability to results, deficits in design may be lack of controlled variables (aligning with the equilibrium of evidence-based RCT and practice-based case series analysis design theme of this thesis) and additionally, small sample posing restrictions on generalisability of findings. On the contrary, triangulation was employed through utilisation of both qualitative data and descriptive statistics to add convergence in results. Similarly, independent member-checking (Cresswell, 1994; Yanow and Peregrine, 2006) was administered, and data analysis was completed through use of independent researchers to increase credibility and trustworthiness in results and equally, to reduce therapist and researcher allegiance.

Regardless of the imperative role case studies have played in psychotherapy research, this methodology is often dismissed however in the present study it provided much-needed richness in data to assess case-by-case outcomes and client perspectives, as well as also accommodating the small expected sample, due to subject sensitivity (CSA) and inclusion criteria (e.g. namely age restrictions).

6.3 SUMMARY

The NHS IAPT landscape has somewhat evolved since the commencement of this research in 2018, as outlined in the discussion section and also generally, since the COVID-19 pandemic and worldwide publicity following the Apple TV series featuring Prince Harry (EMDR Association email, 25/05/21). Similarly, the BPS-PTM (Johnstone et al, 2018) Framework has increased strength in providing perspective in treating people in accordance with symptomology as oppose to stigmatizing them with mental health DSM labelling.

Outcomes of the present research have considered political, ethical and organisational barriers in moving forward with EMDR as a treatment for young adults' survivors of CSA within IAPT services. This study has touched upon numerous key areas:

- Treatment delivery e.g. issues with '*confidentiality*' particularly when remote working for which moving forward the service plans for clients to have a choice in conduction of sessions; unhelpful IAPT dataset/*'measures'* which remain the same based on government guidance; '*restricted service timeframe's'* and *extensive wait lists*, causing further issues in emotional reprocessing and whether these are consistent with guidelines/client choice (NHS England, 2015; BACP, 2016) are currently being discussed.
- Complexity in the clients level of functioning (e.g. neuropsychological, emotional and behavioural, when dealing with quality of life stressors), as during treatment clients may inform therapists of additional trauma, or underlying conditions may be identified and hence extended assessments and subsequent pathways/sign-posting is being explored.

- And importantly, whether such clients are within the correct service for treatment or would an independent trauma pathway be useful, and how can this be managed within multidisciplinary working. This is especially considered due to the lack of clarity between criteria at both IAPT 'Step-3' and '3+' often leading to unmet client needs (i.e. long wait times, causing possible deterioration in presentation/reversion to instability; similar clinical work offered with comparably qualified/experienced staff at both steps or alternatively, very complex cases being allocated to newly qualified/under-resourced staff; with very little difference in allocated timeframes off the IAPT pathway, yet higher caseload's for step-3 staff in comparison to 3+, all of which affects client care; especially as 50% of participants in this study were seen for a contract of only EMDR phases 1-2 and hence may be required to wait a significant length of time before being seen again for EMDR phases 3-8, with lack of criteria around at which step work will be carried out).

The results of this project illustrate generally positive EMDR therapy outcomes. EMDR efficacy has been highlighted for the treatment of young adult survivors of CSA due to its adaptability and idiosyncratic qualities, which consequently develop change mechanisms encompassing emotional, behavioural, neuropsychological functioning and quality of life issues. Further research is required to build upon the findings from this study.

References

- Achenbach, T. M. (1991). *Manual for the Youth Self-Report and 1991 Profile*. The University of Vermont.
- Addis, M. E., & Cardemil, E. V. (2006). Does manualisation improve therapy outcomes? In J. C. Norcross, L.E. Beutler & R.E. Levant (Eds.), *Evidence-based practices in mental health: debate and dialogue on the fundamental questions* (pp 131 -140). American Psychological Association.
- Adler, P. A., & Adler, P. (2012). In S.E. Baker & R. Edwards (Eds.). How many qualitative interviews is enough?: expert voices and early career reflections on sampling and cases in qualitative research, 5.
http://eprints.ncrm.ac.uk/2273/4/how_many_interviews.pdf
- Adler-Tapia, R., & Settle, C. (2008). *EMDR and the art of psychotherapy with children*. Springer Publishing.
- Ahn, H. N., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counselling and psychotherapy. *Journal of Counselling Psychology*, 48(3), 251–257. 10.1037//0022-0167.48.3.251
- Alix, S., Cossette, L., Hébert, M., Cyr, M., & Frappier, J. Y. (2017) Posttraumatic stress disorder and suicidal ideation among sexually abused adolescent girls: the mediating role of shame. *Journal of Childhood Sexual Abuse*. 26(2):158–174.
10.1080/10538712.2017.1280577
- Allen, D. (2000). "I'll tell you what suits me best if you don't mind me saying": "lay participation" in health care. *Nursing Inquiry*, 7, 182-190
<https://doi.org/10.1046/j.1440-1800.2000.00067.x>

- Allnock, D., Hynes, P., & Archibald, M. (2015) Self-reported experiences of therapy following child sexual abuse: messages from a retrospective survey of adult survivors. *Journal of Social Work*, 15(2), 115-137
- Altemus, M., Dhabhar, F. S., & Yang, R. (2006). Immune function in PTSD. *Annals of the New York Academy of Sciences*, 1071, 167-183. <https://doi.org/10.1196/annals.1364.013>
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed.,).
- American Psychiatric Association. (2004). Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. American Psychiatric Association Practice Guidelines.
- American Psychiatric Association. (2012). Adjustment disorders. <http://www.dsm5.org>.
- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).
- American Psychoanalytical Association. (2018). Psychoanalytic Psychotherapy
URL=<http://www.apsa.org/content/psychoanalytic-psychotherapy>
- Amir, M., Kaplan, Z., Neumann, L., Sharabani, R., Shani, N., & Buskila, D. J. (1997 Jun) Posttraumatic stress disorder, tenderness and fibromyalgia. *Journal of Psychosomatic Research*, 42(6), 607-13. 10.1016/s0022-3999(97)00009-3

- Antune-Alves, S., Vukovic, B., Kramer, U., Milyavskaya, M., Dobson, K., and Drapeau, M. (2018). Therapist interventions and patient outcome: addressing the common versus specific factor debate. *Archives of Psychiatry and Psychotherapy* 3, 7-35.
- Andersen, S. L., & Teicher, M. H. (2008). Stress, sensitive periods, and maturational events in adolescent depression. *Trends in Neuroscience*, 31(4), 183-191. [10.1016/j.tins.2008.01.004](https://doi.org/10.1016/j.tins.2008.01.004)
- Anderson, T., Patterson, C. L., & Song, X. (2013). Factorial and predictive validity of the expectations about counseling-brief (EAC-B) with clients seeking counseling. *Journal of Counseling Psychology*, 60 (4), 496–507. [10.1037/a0034222](https://doi.org/10.1037/a0034222)
- Andrade, J., Kavanagh, D., & Baddeley, A. (1997). Eye-movements and visual imagery: A working memory approach to the treatment of post-traumatic stress disorder. *British Journal of Clinical Psychology*, 36(2), 209-223. <http://dx.doi.org/10.1111/j.2044-8260.1997.tb01408.x>
- Andrews, B., Brewin, C. R., Rose, S., & Kirk, M. (2000). Predicting PTSD symptoms in victims of violent crime: The role of shame, anger, and childhood abuse. *Journal of Abnormal Psychology*, 109(1), 69-73. <https://doi.org/10.1037//0021-843X.109.1.69>.
- Anggleton, J. (2000). *The amygdala. A functional analysis* (2nd ed.) Oxford University Press
- Applegate, J. S., & Shapiro, J. R. (2005). *Neurobiology for clinical social work*. W. W. Norton & Company.
- Aranda, B. D. E., Ronquillo, N. M., & Calvillo, M. E. N. (2015). Neuropsychological and physiological outcomes pre- and post-EMDR therapy for a woman with PTSD: A case study. *Journal of EMDR Practice and Research*, 9(4), 174–187. <https://doi.org/10.1891/1933-3196.9.4.174>

- Archenholtz, B., Nordborg, E., & Bremell, T., (2001) Lower level of education in young adults with arthritis starting in the early adulthood. *Scandinavian Journal of Rheumatology*, 30(6), 353-5. 10.1080/030097401317148552
- Archer, M., Decoteau, C., Gorski, P., Little, D., Porpora, D., Rutzou, T., Smith, C., Steinmetz, G., and Vandenberghe, F. (2016). What is Critical Realism? Perspectives. [What is Critical Realism? - Theory Section \(asatheory.org\)](http://www.asatheory.org)
- Arnstein, M. (1996). Marital Therapy, EMDR, Herman's Model of Recovery from Trauma. The Journey of One Woman and Her Family. *Australian and New Zealand Journal of Family Therapy*. 17;4. <https://doi-org.salford.idm.oclc.org/10.1002/j.1467-8438.1996.tb01100.x>
- Atkinson, P., & Hammersley, M. (1995). *Ethnography: Principles in Practice*. Psychology Press. Social Sciences. Routledge
- Auckland University: Research Department. (April 2019). FAQ about Thematic Analysis. <https://cdn.auckland.ac.nz/assets/psych/about/our-research/documents/Answers%20to%20frequently%20asked%20questions%20about%20thematic%20analysis%20April%202019.pdf>
- Aupperle, R. L., Allard, C. B., Grimes, E. M., Simmons, A. N., Flagan, T., Behrooznia, M., & Stein, M. B. (2012). Dorsolateral prefrontal cortex activation during emotional anticipation and neuropsychological performance in posttraumatic stress disorder. *Archives of General Psychiatry*, 69(4), 360–371. <http://dx.doi.org/10.1001/archgenpsychiatry>.
- Aupperle, R. L., Melrose, A. J., Stein, M. B., & Paulus, M. P. (2012). Executive function and PTSD: Disengaging from trauma. *Neuropharmacology*, 62, 686-694.

- Avina, C., & O'Donohue, W. (2002). Sexual harassment and PTSD: Is sexual harassment diagnosable trauma? *Journal of Traumatic Stress*, 15, 69–75.
- Bachelor, A. (2011). Clients' and therapists' views of the therapeutic alliance: similarities, differences and relationship to therapy outcome. *Clinical Psychology and Psychotherapy*, 20(2), 118-135.
- Baddeley, A. D. (1998). Human memory: Theory and practice. Needham Heights, MA. Allyn & Bacon.
- Baddeley, A. D. (2003). Working memory: looking back and looking forward. *Nature Reviews Neuroscience*, 4, 829–839.
- Badenoch, B. (2008). Being a brain-wise therapist: A practical guide to interpersonal neurobiology. W. W. Norton & Co.
- Bae, H., Kim, D., & Park, Y. C. (2008). Eye movement desensitization and reprocessing for adolescent depression. *Psychiatry Investigation*, 5, 60–11. - PMC - PubMed. 10.4306/pi.2008.5.1.60
- Bagozzi, R. (1993). Assessing construct validity in personality research: applications to measures of self-esteem. *Journal of Environmental Psychology* 24(2), 227-236
10.1016/j.jenvp.2004.01.002
- Bak-Klimek, A., Karatzias, T., Elliott, L., Campbell, J., Pughs, R., & Laybourn, P. (2014). Nature of child sexual abuse and psychopathology in adult survivors: Results from a clinical sample in Scotland. *Journal of Psychiatric & Mental Health Nursing*, 21(6), 550-557. 10.1111/jpm.12127

Baker, C. (January 2020). Mental Health Statistics for England: Prevalence, Services and Funding Report. House of Commons Library. Number 6988.
www.parliament.uk/commons-library

Ballinger, L. (2013). Insecurity of tenure. *Therapy Today*, 24 (1).
<http://www.therapytoday.net/article/show/3547/>

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). Developing and delivering practice-based evidence: a guide for the psychological therapies. Wiley-Blackwell.

Barkham, M., & Mellor-Clark, J. (2003 Nov). Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*. 10(6), 319-27.

Barkham, M., Mullin, T., Leach, C., Stiles, W. B., & Lucock, M. (2007). Stability of the CORE-OM and the BDI-I prior to therapy: evidence from routine practice. *Psychology and Psychotherapy: Theory, Research and Practice*, 80(2), 269-278.
10.1348/147608306X148048

Barkham, M., Stiles, W. B., Miles, J. N. V., Margison, F., Evans, C., & Mellor-Clark, J. (2006). Dose–effect relations and responsive regulation of treatment duration: the good enough level. *Journal of Consulting and Clinical Psychology*, 74(1), 160-167.
10.1037/0022-006X.74.1.160

Barlow-Ogden, K., & Poynter, W. (2012). Mild traumatic brain injury and posttraumatic stress disorder: Investigation of visual attention in Operation Iraqi Freedom/Operation Enduring Freedom veterans. *The Journal of Rehabilitation Research and Development*, 49(7), 1101

Barnett, J. E., Wise, E. H., Johnson-Greene, D., & Bucky, S. F. (2007). Informed consent: too much of a good thing or not enough? *Professional Psychology: Research and Practice*, 38, 179–186.

- Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., Casiano, D. & Thompson, D. (2008). Early withdrawal from mental health treatment: implications for psychotherapy practice. *Psychotherapy Theory Research & Practice*, 45(2), 247–267.
- Barron, I., Bourgaize, C., Lempertz, D., Swinden, C., & Darker-Smith, S. (2019). Eye Movement Desensitization Reprocessing for Children and Adolescents With Posttraumatic Stress Disorder: A Systematic Narrative Review. *Journal of EMDR Practice and Research*. 13. 270-283. 10.1891/1933-3196.13.4.270.
- Barron, I. G. (November 2018). EMDR Therapy with Children and Adolescents. *Journal of EMDR Practice and Research*, 12(4), 10.1891/1933-3196.12.4.174
- Barrowcliff, A. L., Gray, N. S., Freeman, T. C. A., & Mac-Culloch, M. J. (2004). Eye-movements reduce the vividness, emotional valence and electrodermal arousal associated with negative autobiographical memories. *Journal of Forensic Psychiatry and Psychology*, 15, 325–345.
- Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth*, 17, 17–21.
- Beck, A. (1967). *Depression: Clinical, Experimental, and Theoretical Aspects*. University of Pennsylvania Press.
- Beck, A. (1976). *Cognitive therapy and emotional disorders*. International Universities Press.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). "Manual for the Beck Depression Inventory-II". Psychological Corporation
- Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4(6), 561-571

- Becker, H. S. (2012). In S.E. Baker & R. Edwards (Eds.). How many qualitative interviews is enough?: expert voices and early career reflections on sampling and cases in qualitative research, 15. http://eprints.ncrm.ac.uk/2273/4/how_many_interviews.pdf
- Bechara, A., Damasio, A. R., Damasio, H., & Anderson, S. W. (1994). Insensitivity to future consequences following damage to human prefrontal cortex. *Cognition*, 50, 7–15. 10.1016/0010-0277(94)90018-3
- Bechara, A., Damasio, A. R., Damasio, H., & Lee, G. P. (1999). Different contributions of the human amygdala and ventromedial prefrontal cortex to decision-making. *The Journal of Neuroscience*, 19(13), 5473–5481. 10.1523/JNEUROSCI.19-13-05473.1999
- Bechara, A., Damasio, H., Tranel, D., & Damasio, A. R. (1997). Deciding advantageously before knowing the advantageous strategy. *Science*, 275, 1293–1294.
- Bechara, A., Dolan, S., & Hinds, A. (2002). Decision-making and addiction (part II): Myopia for the future or hypersensitivity to reward?. *Neuropsychological*, 40, 1690–1705. 10.1016/S0028-3932(02)00016-7
- Bechara, A., Wardle, M., Gonzalez, R., & Martin-Thormeyer, E. (2010). Iowa Gambling Task performance and emotional distress interact to predict risky sexual behavior in individuals with dual substance and HIV diagnoses, *Journal of Clinical and Experimental Neuropsychology*, 32:10, 1110-1121
- Bedi, R. P. & Duff, C. T. (2014). Client as expert: A Delphi poll of clients' subjective experience of therapeutic alliance formation variables, *Counselling Psychology Quarterly*, 27(1), 1-18. 10.1080/09515070.2013.857295

- Beeber, L. B., Seeherunwong, A., Schwartz, T., Funk, S. G., & Vongsirimas, N. (2007). Validity of the Rosenberg Self-esteem Scale in Young Women from Thailand and the USA. *Thai Journal of Nursing Research*, 11(4), 240–250.
- Beer, R. (2018). Efficacy of EMDR Therapy for Children With PTSD: A Review of the Literature. *Journal of EMDR Practice and Research*, 12(4), 177-195.
- Beers, S. R., & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *American Journal of Psychiatry*, 159, 483-486.
- Bellg, A. J., Borrelli, B., Resnick, B., Hecht, J., Minicucci, D. S., Ory, M., et al. (2004) Enhancing treatment fidelity in health behavior change studies: best practices and recommendations from the NIH behavior change consortium. *Health Psychology*, 23(5), 443-51. 10.1037/0278-6133.23.5.443.
- Benish, S. G., Imel, Z. E., & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: a meta-analysis of direct comparisons. *Clinical Psychology Review*, 28(5): 766–775.
10.1016/j.cpr.2007.10.005
- Berch, D. B., Krikorian, R., Huha, E. M. (1998). The Corsi block-tapping task: Methodological and theoretical considerations. *Brain and Cognition*, 38(3), 17–338.
10.1006/brcg.1998.1039.
- Berg, C., Raminani, S., Greer, J., Harwood, M. & Safren, S. (2008). Participants' perspectives on cognitive-behavioural therapy for adherence and depression in HIV. *Psychotherapy Research*, 18 (3), 271-280. 10.1080/10503300701561537.

- Bergh, O. V., & Vrana, S. R. (1998). Repetition and boredom in a perceptual fluency/ attributional model of affective judgements. *Cognition and Emotions, 12*, 533-553. 10.1080/026999398379556
- Bergmann, U. (2008). The Neurobiology of EMDR: Exploring the Thalamus and Neural Integration. *Journal of EMDR Practice and Research, 2*(4), 300-31
- Bergman, U. (2012). *Neurobiological foundations for EMDR practice*. Springer Publishing Company LLC.
- Berne, E. (1961). *Transactional analysis in psychotherapy*. Grove Press.
- Bernstein, D. P., and Fink, L. (1997) Assess trauma history via retrospective self-report: Childhood Trauma Questionnaire. Pearson.
- Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174*: 727-735. Revised version www.sidran.org for Children/Adolescent use. Original Dissociative Experiences Scale (DES). The Serenity Programme™ - www.serene.me.uk www.hebpsy.net <https://www.hebpsy.net/files/ruZXkl5YGeKcvt6dBZpS.pdf>
- Beutler, L. E., & Forrester, B. (2014). What needs to change: Moving from "research informed" practice to "empirically effective" practice. *Journal of Psychotherapy Integration, 24* (3), 168-177.
- Bifulco, A., Moran, P. M., Baines, R., Bunn, R., & Stanford, K. (2002). Exploring psychological abuse in childhood: II. Association with other abuse and adult depression. *Bulletin of Menninger Clinic, 66*, 241-258. 10.1521/bumc.66.3.241.23366

- Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, 5(3), 214-224. 10.1080/14780880802314304
- Bishop, S. (2009). Trait anxiety and impoverished prefrontal control of attention. *Nature Neuroscience*, 12, 92–98.
- Bisson, J., Ehlers, A., Matthews, R. et al. (2007). Psychological treatments for chronic post-traumatic stress disorder. *British Journal of Psychiatry*, 190, 97–104.
- 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 System*. 13;(12), 10.1002/14651858.CD003388.pub4.
- Bjånes, T. K. (2011). Lokale bivirkninger ved parenteral administrering av legemidler. (Localized side effects caused by parenteral administration of drugs) *Tidsskr Nor Legeforen*, 131:472–474. PubMed.
- Blatt, S. J. (1995). The destructiveness of perfectionism. Implications for the treatment of depression. *American Psychologist*, 50, 1003–1020.
- Blatt, S. J., & Zuroff, D. (2005). Empirical evaluation of the assumptions in identifying evidence based treatments in mental health. *Clinical Psychology Review*, 25, 459–486.
- Block, R. S., King, P., Sripada, K. R., Weissman, H. D., Welsh, R., & Liberzon, I. (2016). Behavioral and neural correlates of disrupted orienting attention in posttraumatic stress disorder. *Cognitive, Affective, & Behavioral Neuroscience*, 17:422–436. 10.3758/s13415-016-0488-2

- Bohart, A. C. (2000). The Client Is the Most Important Common Factor: Clients' Self-Healing Capacities and Psychotherapy. *Journal of Psychotherapy Integration*, 10(2), 127-149.
- Bohart, A. C., Berry, M. & Wicks, C. (2011). Developing a systematic framework for utilizing discrete types of qualitative data as therapy research evidence. *Pragmatic Case Studies in Psychotherapy*, 7(1): 145-155.
- Bohart, A. C. & House, R. (2008). Empirically supported/validated treatments as modernist ideology, II: alternative perspectives on research and practice. In R. House and D. Loewenthal (eds.) *Against and For CBT*. (202-217) PCCS Books.
- Bohart, A. C., O'Hara, M. & Leitner, L. (1998). Empirically violated treatments: disenfranchisement of humanistic and other psychotherapies. *Psychotherapy Research*, 8(2), 141-157.
- Bohart, A. C. & Tallman, K. (2003). How clients make therapy work: the process of active self-healing. American Psychological Association.
- Bolton, D. (2013). Overdiagnosis problems in the DSM-IV and the new DSM-5: Can they be resolved by the distress-impairment criterion? *Canadian Journal of Psychiatry (The CJP)*. 58(11):612-617. 10.1177/070674371305801106
- Bond, T (2004). Ethical Guidelines for Researching Counselling and Psychotherapy. British Association for Counselling and Psychotherapy.
- Bond, T. & Mitchels, B. (2014). Breaches in confidentiality: Information sheet G2. BACP. http://www.bacp.co.uk/admin/structure/files/repos/592_g02_-breaches_in_confidentiality.pdf
- Bond, T. & Tyrrell, V. (2002). Knowledge beyond words: confusion and ethics. *Human Givens Journal*, 9(1). <http://www.hgi.org.uk/archive/Ethics-TimBond2.htm#.Uix8C8a1GK8>

Bongaerts, H., Van Minnen, A., & de Jongh, A. (2017 May). Intensive EMDR to treat patients with complex posttraumatic stress disorder: A case series. *Journal of EMDR Practice and Research*, 1;11(2):84-95.

Borges, M. C., Braga, D. T., Iêgo, S., D'Alcante, C. C., Sidrim, I., Machado, M. C., & Fontenelle, L. F. (2011). Cognitive dysfunction in post-traumatic obsessive–compulsive disorder. *Australian and New Zealand Journal of Psychiatry*, 45, 76-85

Born, J., Rasch, B., & Gais, S. (2006). Sleep to remember. *Neuroscientist* 12, 410–424.
10.1177/1073858406292647

Borrelli, B. (2011). The Assessment, Monitoring, and Enhancement of Treatment Fidelity in Public Health Clinical Trials. *Journal of Public Health Dentistry*, 71(s1), S52–S63.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074245/>

Boston University Medical Campus and Boston Medical Center (2021) Institutional Review Board; requirements of Systematic Case Series Investigation. Case Reports and Case Series | Institutional Review Board (bu.edu)

Bourne, A. H. & Robson, M. A. (2013). Participants' reflections on being interviewed about risk and sexual behaviour: implications for collection of qualitative data on sensitive topics. *International Journal of Social Research Methodology*, 18 (1), 105-116.
10.1080/13645579.2013.860747

Bowman, C. H., & Turnbull, O. H. (2003). Real versus facsimile reinforcers on the Iowa Gambling Task. *Brain and Cognition*, 53, 207–210.

Boyatzis, R. E. (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. Sage

- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, 162, 214–227. [10.1176/appi.ajp.162.2.214](https://doi.org/10.1176/appi.ajp.162.2.214)
- Braman, A. C. & Gomez, R. G. (2003). Patient personality predicts preference for relationships with doctors. *Personality and Individual Differences*, 37(4), 815-826. [DOI.org/10.1016/j.paid.2003.10.009](https://doi.org/10.1016/j.paid.2003.10.009)
- Brand, M., Labudda, K., Markowitsch, H. J. (2006). Neuropsychological correlates of decision-making in ambiguous and risky situations. *Neural Networks*. 19:1266–1276. [10.1016/j.neunet.2006.03.001](https://doi.org/10.1016/j.neunet.2006.03.001).
- Brannen, J. (2005). Mixed methods research: A discussion paper. National Centre for Research Methods. <http://eprints.ncrm.ac.uk/89/1/MethodsReviewPaperNCRM-005.pdf>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589-597. <https://doi.org/10.1080/2159676X.2019.1628806>
- Braun, V., Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*. <https://doi.org/10.1080/14780887.2020.1769238>
- Braun, V., Clarke, V., Hayfield, N., Terry, G. (2019). Answers to frequently asked questions about thematic analysis. <https://cdn.auckland.ac.nz/assets/psych/about/our-research/documents/Answers%20to%20frequently%20asked%20questions%20about%20thematic%20analysis%20April%202019.pdf>

- Bremner, J. D., Narayan, M., Staib, L. H., Southwick, S. M., McGlashan, T., & Charney, D. S. (1999). Neural correlates of memories of childhood sexual abuse in women with and without posttraumatic stress disorder. *The American Journal of Psychiatry*, 156: 1787–1795. [10.1176/ajp.156.11.1787](https://doi.org/10.1176/ajp.156.11.1787)
- Bremner, J. D., Randall, P., Scott, T. M., Bronen, R. A., Seibyl, J. P., Southwick, S. M., & Innis, R. B. (1995). MRI-based measurement of hippocampal volume in patients with combat-related posttraumatic stress disorder. *The American Journal of Psychiatry*, 152(7), 973–981. <http://dx.doi.org/10.1176/ajp.152.7.973>
- Brennstuhl, M. J. (2013). Utilisation de la thérapie EMDR dans le cadre de la douleur chronique : efficacité et perspectives cliniques. Thèse de troisième cycle, Université de Lorraine, document non publié.
- Breslau, N. (2001). The epidemiology of posttraumatic stress disorder: What is the extent of the problem? *Journal of Clinical Psychiatry*, 62 (Suppl. 17), 16–22.
- Brettle, A. & Grant, M. (2003). *Finding the evidence for practice: a workbook for health professionals*. Churchill Livingstone.
- Breuer, J., & Freud, S. (1893). On the psychological mechanism of hysterical phenomena: Studies on hysteria. Pelican Freud Library (Vol. 3). Penguin.
- Brewin, C. R., Andrews, B., & Rose, S. (2000). Fear, helplessness, and horror in posttraumatic stress disorder: Investigating DSM-IV criterion A2 in victims of violent crime. *Journal of Traumatic Stress*, 13, 499–509.
- Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., Humayun, A., Jones, L. M., Kagee, A., Rousseau, C., Somasundaram, D., Suzuki, Y., Wessely, S., van Ommeren, M., Reed, G. M. (2017). A review of current evidence regarding

the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clinical Psychology Review*. 2017; 58: 1–5.

British Association of Counselling and Psychotherapy: BACP. Perfect, D., Jackson, C., Pybis, J., & Hill, A. (2016). Choice of Therapies in IAPT: An overview of the availability and client profile of step 3 therapies. British Association for Counselling & Psychotherapy.

British Association of Counselling and Psychotherapy: BACP. (2014). Psychological therapies and parity of esteem: from commitment to reality, pp7.
http://www.bacp.co.uk/admin/structure/files/pdf/13801_bacp%20psychological%20therapies%20and%20parity%20of%20esteem.pdf

British Psychoanalytic Council and The United Kingdom Council for Psychotherapy: UKCP. (2015). Addressing the deterioration in public psychotherapy provision.
http://www.psychotherapy.org.uk/UKCP_Documents/Reports/PublicPsychotherapyProvision-FINAL-WEBsmall.pdf

British Psychological Society: BPS. (2007). Improving Access to Psychological Therapies.
http://dcp.bps.org.uk/iapt/iapt_home.cfm

British Psychological Society: BPS. (2014). Code of Human Research Ethics.
<https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014>

British Psychological Society: BPS. (09/05/19) 'Complex Trauma' Event. NW DCoP. University of Manchester, hosted by Christina Buxton; programme lead for MSc in Psychological Trauma at Chester University and also a Chair of the BPS' Crisis, Disaster and Trauma Section

- British Psychological Society: BPS. (2020). 'Power, Threat, Meaning' (PTM Framework) Summary. <https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/PTM%20Summary.pdf>
- British Psychological Society: BPS. (2020). 'Power, Threat, Meaning' (PTM Framework) Summary. <http://www.bps.org.uk/PTM-Main>
- British Psychological Society: BPS. (2006). Risk Assessment and Management Paper; Occasional Briefing Paper No 4. Division of Clinical Psychology Faculty of Forensic Clinical Psychology
- Broadbent, J. R. (2013). "The bereaved therapist speaks". An interpretive phenomenological analysis of humanistic therapists' experiences of a significant personal bereavement and its impact upon their therapeutic practice: an exploratory study. *Counselling and Psychotherapy Research*, 13 (4), 263-271.
- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health*, 21(1), 7-108. 10.1080/14768320500230185
- Brown, S. & Shapiro, F. (2006). EMDR in the treatment of borderline personality disorder. *Clinical Case Studies*, 5, 403–420.
- Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin*.99:66–77. 10.1037/0033-2909.99.1.66
- Brunyé, T. T., Mahoney, C. R., Augustyn, J. S., & Taylor, H. A. (2009). Horizontal saccadic eye movements enhance the retrieval of landmark shape and location information. *Brain Cognition*. 70, 279–288. 10.1016/j.bandc.2009.03.003
- Bryman, A. (2008). *Social research method*. (3rd ed.). Oxford University Press.

- Bukh, J. D., Bock, C., Vinberg, M. & Kessing, L. V. (2013). The effect of prolonged duration of untreated depression on antidepressant treatment outcome. *Journal of Affective Disorders*, 15,145(1), 42-48. 10.1016/j.jad.2012.07.008
- Burckhardt, C. S., & Anderson, K. L. (2003). The Quality of Life Scale (QOLS): Reliability, Validity and Utilization. *Health and Quality of Life Outcomes*, 1:60
<http://doi.org/10.1186/1477-7525-1-60>
- Burckhardt, C. S., Anderson, K. L., Archenholtz, B., & Hägg, O. (2003). The Flanagan Quality of Life Scale (QOLS): Further evidence of validity. *Health and Quality of Life Outcomes*, 1:59 (October 2018)
- Burckhardt, C. S., Wood, S, L., Schultz, A. A., & Ziebarth, D. M. (1989). Quality of life of adults with chronic illness: A psychometric study. *Research in Nursing and Health*, 12, 347-354.
- Butler, A. C., Chapman, J. E., Forman, E. M. & Beck, A. T. (2006). The empirical status of cognitive behavioural therapy: a review of meta-analyses. *Clinical Psychology Review*, 26, 17 – 31.
- Butts, J. B. & Rich, K. L. (Eds.). (2011). *Philosophies and theories for advanced nursing practice*. Jones & Bartlett
- Byrne, D. (2021). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality and Quantity*. <https://doi.org/10.1007/s11135-021-01182-y>
- Bzdok, D., Laird, A. R., Zilles, K., Fox, P. T., & Eickhoff, S. B. (2013). An investigation of the structural, connectional, and functional subspecialization in the human amygdala. *Human Brain Mapping*, 34(12), 3247–3266. <http://dx.doi.org/10.1002/hbm.22138>
- Calancie, O. G., Khalid-Khan, S., Booij, L., & Munoz, D. P. (2018). "Eye Movement Desensitization and Reprocessing as a Treatment for PTSD: Current Neurobiological Theories and a New Hypothesis." *Annals of the New York Academy of Sciences* 1426.1 127-45. Web.

- Callary, B., Rathwell, S. & Young, B.W. (2015). Insights on the process of using interpretative phenomenological analysis in a sport coaching research project. *The Qualitative Report*, 20(2), 63-75
- Camacho-Conde, J. A. (2020). Cognitive Function Assessment of a Patient With PTSD Before and After EMDR Treatment. *Journal of EMDR Practice and Research*.
- Campbell, D. T., & Stanley, J. C. (1963). *Experimental and quasi-experimental designs for research*. Rand McNally
- Campbell, K. A., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., Gehrke, P., Graham, L., & Jack, S. M. (2021). Reflexive Thematic Analysis for Applied Qualitative Health Research. *The Qualitative Report*, 26(6), 2011-2028. pp.5, <https://doi.org/10.46743/2160-3715/2021.5010>
(PDF) *Reflexive Thematic Analysis for Applied Qualitative Health Research*.
https://www.researchgate.net/publication/352791851_Reflexive_Thematic_Analysis_for_Applied_Qualitative_Health_Research
- Cape, J., Whittington, C., Buszewicz, M., Wallace, P. & Underwood, L. (2010). Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression. *Bio Med Central Medicine*, 8 (38), 1741-7015. 10.1186/1741-7015-8-38.
- Carey, M. E. (1991). Analysis of wounds incurred by U.S. army seventh corps personnel in Corps hospitals during operation desert storm, February 20 to March 10, 1991. *Journal of Trauma*, 40(3), S165–S169.
- Carey, M. E. (1996). Analysis of wounds incurred by U.S. army seventh corps personnel treated in Corps hospitals during operation desert storm, February 20 to March 10, 1991. *Journal of Trauma*, 40(3 Suppl), S165–169.

Carlson, E.B. & Putnam, F.W. (1993). An update on the Dissociative Experience Scale. *Dissociation* 6(1), 16-27. Dissociative Experiences Scale-II
<http://traumadissociation.com/des>

Carter, S., & Pasqualini, M. S. (2004). Stronger autonomic response accompanies better learning: A test of Damasio's somatic marker hypothesis. *Cognition & Emotion*. 18:901– 911. 10.1080/02699930341000338.

Carter, L. S., Weithorn, L. A., & Behrman, R. E. (1999). Domestic violence and children: analysis and recommendations, *The Future of Children*, 9 (3), 4-20.

Castonguay, L.G. (2011). Psychotherapy, psychopathology, research and practice: pathways of connections and integration. *Psychotherapy Research*, 21 (2), 125-140. 10.1080/10503307.2011.563250

Castonguay, L.G., Boswell, J.F., Zack, S.E., Baker, S., Boutselis, M.A., Chiswick, N. R., Damer, D. D., Hemmelstein, N. A., Jackson, J. S., Morford, M., Ragusea, S. A., Roper, J. G., Spayd, C., Weiszer, T., Borkovec, T. D., Holtforth, M. G. (2010). Helpful and hindering events in psychotherapy: a practice research network study. *Psychotherapy Theory, Research, Practice, Training*, 47, (3), 327-344.

Cawson, P., Wattam, C., Brooker, S., Kelly, G. (November 2000) NSPCC Research Findings: Child Maltreatment in the United Kingdom: A Study of the Prevalence of Abuse and Neglect. Executive Summary

Centre for Evidence-Based Medicine, University of Oxford,
UK. <http://www.cebm.net/index.aspx?o=1116>.

Centres for Disease Control and Prevention, National Centre for Injury Prevention and Control, Division of Violence Prevention. (May 2014) Adverse Childhood Experiences (ACE) Study. (2015) Archived from the original study. Adverse Childhood Experiences (ACEs) (cdc.gov)

- Cernich, A. N., Reeves, D., Sun, W., & Bleiberg, J. (2007). Automated Neuropsychological Assessment Metrics sports medicine battery. *Archives of Clinical Neuropsychology*, 22, S101-S114.
- Chamberlain, L. B. (2009). The amazing teen brain: What every child advocate needs to know. *Child Law Practice*, 28(2), 17-24. EBSCO Host: https://auth.lib.unc.edu/ezproxy_auth.php?url=http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=43748131&site=ehostlive&scope=site
- Chambless, D.L. & Hollon, S.D. (1998) Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66(1): 7-18.
- Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of affective disorders*. 82. 217-25.
<http://dx.doi.org/10.1016/j.jad.2003.12.013>
- Chen, L., Zhang, G., Hu, M., & Liang, X. (2015). Eye movement desensitization and reprocessing vs. cognitive-behavioral therapy for adult post-traumatic stress disorder: systematic review and meta-analysis. *Journal of Nervous & Mental Disease*. 203, 443–451. 10.1097/NMD.0000000000000306
- Chen, R. et al. (2018) 'The Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adults Who Have Experienced Complex Childhood Trauma: A Systematic Review of Randomized Controlled Trials', *Frontiers In Psychology*, 9, p. 534. 10.3389/fpsyg.2018.00534.
- Chen, R., Gillespie, A., Zhao, Y., Xi, Y., Ren, Y., & McLean, L. (2018). The efficacy of eye movement desensitization and reprocessing in children and adults who have experienced complex childhood trauma: A systematic review of randomized controlled trials. *Frontiers in Psychology*, 9(APR).
<https://doi.org/10.3389/fpsyg.2018.00534>

Chen, Y. R., Hung, K. W., Tsai, J. C., Chu, H., Chung, M. H., Chen, S. R., et al. (2014). Efficacy of eye-movement desensitization and reprocessing for patients with post-traumatic-stress disorder: a meta-analysis of randomized controlled trials. *PLoS ONE* 9:e103676. 10.1371/journal.pone.0103676

Child Welfare Information Gateway. (2004). Child abuse and neglect. National Clearinghouse on Child Abuse and Neglect Information, US Department of Health and Human Services.

Child Welfare Information Gateway. (August 2011). *Supporting brain development in traumatized children and youth*. www.childwelfare.gov.

Child Welfare Information Gateway. (November 2009). *Understanding the effects of maltreatment on brain development*. www.childwelfare.gov.

Children's Commissioner Reports (2017) Preventing Child Abuse: The Role of Schools. <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Preventing-CSA-The-Role-of-Schools-CCO-April-2017-1.2-1.pdf> Investigating Child Sexual Abuse: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Investigating-Child-Sexual-Abuse-CCO-April-2017-1.2-1.pdf> Making Noise: Children's voices for positive change after sexual abuse. In partnership with the NSPCC: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/UniBed_MakingNoise-20_4_17-1.pdf

Children Welfare Information Gateway (2015) Brain Development. https://www.childwelfare.gov/pubPDFs/brain_development.pdf

Christman, S. D., Garvey, K. J., Propper, R. E., & Phaneuf, K. A. (2003). Bilateral eye movements enhance the retrieval of episodic memories. *Neuropsychology* 17, 221–229. 10.1037/0894-4105.17.2.221

- Christman, S. D., Propper, R. E., & Brown, T. J. (2006). Increased interhemispheric interaction is associated with earlier offset of childhood amnesia. *Neuropsychology* 20, 336–345. 10.1037/0894-4105.20.3.336
- Cicchetti, D. (2007). Intervention and policy implications of research on neurobiological functioning in maltreated children. In J. Aber, S. Bishop-Josef, S. Jones, K. McLearn, & D. Phillips (Eds.), *Child development and social policy: Knowledge for action*. 167-184. American Psychological Association.
- Cicchetti, D., & Toth, S. L. (2005). Child maltreatment. *Annual Review of Clinical Psychology*, 1, 409–438.
- Clark, D. M., Layard, R., Smithies, R., Richards, D.A., Suckling, R. & Wright, B. (2009). Improving access to psychological therapy: initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, 47(11), 910-920.
- Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, 26(2), 120-123.
- Clarke, V. & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling Psychotherapy Research*, 18: 107-110. <https://doi.org/10.1002/capr.12165>
- Cloitre, M. (2020). ICD-11 complex post-traumatic stress disorder: Simplifying diagnosis in trauma populations. *The British Journal of Psychiatry*, 216(3), 129-131. 10.1192/bjp.2020.43
- Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of Traumatic Stress*, 24(6), 615-627.

- Cloitre, M., Courtois, C. A., Ford, J. D., Green, B. L., Alexander, P., Briere, J., & Van der Hart, O. (2012). The ISTSS expert consensus treatment guidelines for complex PTSD in adults.
- Cook-Cotton, C. (2004). Childhood Posttraumatic Stress Disorder: diagnosis, treatment, and school reintegration. *School Psychology Review*, 33, 127-139.
- Cohen, H., & Zohar, J. (2004). An animal model of posttraumatic stress disorder, the use of cut-off behavioral criteria. *Annals of the New York Academy of Sciences*, 1032, 167–178.
- Cohen, J. (2005). Treating traumatized children: Current status and future directions. *Journal of Trauma & Dissociation*, 6(2):109-21. 10.1300/J229v06n02_10.
- Cohen, L., Manion, L., and Morrison, K. (2000). Research methods in education. *British Journal of Educational Studies*. 48:446.
- Cohen, J.A., Perel, J. M., De Bellis, M. D., Friedman, M. J., & Putnam, F. W. (2002). Treating traumatized children, clinical implications of the psychobiology of posttraumatic stress disorder. *Trauma, Violence, and Abuse*, 3, 91-108.
- Colangelo, J., & Keefe-Cooperman, K. (2012). Understanding the impact of childhood sexual abuse on women's sexuality. *Journal of Mental Health Counseling*, 34(1), 14-37. www.amhcajournal.org
- Collishaw, S., Pickles, A., Messer, J., Rutter, M., Shearer, C., & Maughan, B. (2007). Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse & Neglect*. 31:211–229.

Committee on the Assessment of the Readjustment Needs of Military Personnel, Veterans, and Their Families, Board on the Health of Select Populations, Institute of Medicine. (2013) *Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*. National Academies Press. www.nap.edu/read/13499/chapter/1.

Constantino, M., Glass, C. R., Arnkoff, D. B., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed. 354-376). Oxford University Press.

Consumers in NHS Research. (2000). *"Who's learning?" Conference Report*. NHS Executive, Department of Health.

Cook, A., Spinazzola, P., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390-398.

Coombs, M. M., Coleman, D., & Jones, E. E. (2002). Working with feelings: the importance of emotion in both cognitive-behavioral and interpersonal therapy in the NIMH Treatment of Depression Collaborative Research Program. *Psychotherapy: Theory, Research, Practice, Training*, 39(3): 233–244.

Cooper, M. & McLeod, J. (2010). Pluralism: towards a new paradigm for therapy. *Therapy Today*, 21(9). <http://www.therapytoday.net/article/show/2142/>

Cornoldi, C., & Mammarella, I. C. (2008). A comparison of backward and forward spatial spans. *Quarterly Journal of Experimental Psychology*. 61, 674–682.
10.1080/17470210701774200

Corrigan, F. M., & Hull, A. M. (2015). Neglect of the complex: Why psychotherapy for post-traumatic clinical presentations is often ineffective. *Psychotherapy for complex PTSD. Neurological insults in complex trauma*. BPsych Bulletin, Corrigan & Hull. 39(2), 86-89. 10.1192/pb.bp.114.046995

- Corrigan P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7):614–625.
- Corsi, P. M. (1972). Human memory and the medial temporal region of the brain. *Dissertation Abstracts International*, 34, 819B.
- Cotter, D. D. (2011). Psychometric Evaluation of the Valued Living Questionnaire: Comparing Distress and Normative Samples. Western Michigan University
- Courtois, C., & Ford, J. D. & Cloitre, M. (2009). Best practices in psychotherapy for adults. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*. 82-103
- Courcy, D. M., & McCarthy, A. (2003). Psychotherapy and Cross-cultural Clients, Issue 40, Irish Association of Humanistic and Integrative Psychotherapy (IAHIP)
- Coyle, E., Karatzias, T., Summers, A., & Power, M. (2014). Emotions and emotion regulation in survivors of childhood sexual abuse: The importance of “disgust” in traumatic stress and psychopathology. *European Journal of Psychotraumatology*, 5, 1-9. 10.3402/ejpt.v5.23306
- Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain* (2nd ed.). W. W. Norton & Company
- Creswell, J. W. (1994). *Research Design Qualitative and Quantitative Approaches*. Sage. p.158
- Cresswell, J. W. (1998). *Qualitative inquiry and research design: choosing among five traditions*. Sage.
- Critical Appraisal Skills Programme (2018). CASP (Qualitative, Systematic-Review & Randomised Control Trial Checklists. <https://casp-uk.net/casp-tools-checklists/>

- Crone, E. A., & van der Molen, M. W. (2004). Developmental changes in real life decision making: Performance on a gambling task previously shown to depend on the ventomedial prefrontal cortex. *Developmental Neuropsychology*, 25(3), 250-279.
- Crone, E. A., Vendel, I., & van der Molen, M. W. (2003). Decision making in disinhibited adolescents and adults: Insensitivity to future consequences or driven by immediate reward? *Personality and Individual Differences*, 34, 1–17.
- Crooke, P. J. and Olswang, L. B. (2015). Practice-Based Research: Another Pathway for Closing the Research-Practice Gap. *Journal of Speech, Language, and Hearing Research*, American Speech-Language-Hearing Association (ASHA)
- Croschere, J., Dupey, L., Hilliard, M., Koehn, H., & Mayra, K. (2012). The effects of time of day and practice on cognitive abilities: Forward and backward Corsi block test and digit span. PEBL Technical Report Series.
<http://sites.google.com/site/pebltechnicalreports/home/2012/pebl-technical-report-2012-03>.
- Crotty, M. (1998). *The foundations of social research: meaning and perspective in the research process*. Sage.
- Cusak, K., Jonas, D. E., Forneris, C. A., Wilnes, C., Sonis, J., Middleton, J. C., ...& Aynes, B. N. G. (2016) Psychological treatments for adults with posttraumatic stress disorder: A systematic review and meta-analysis. *Clinical Psychology Review*, 43, 128-141, 10.1016/j.cpr.2015.10.003
- Cuthbert, B., Schupp, H., Bradley, M., Birbaumer, N., & Lang, P. (2000). Brain potentials in affective picture processing: Covariation with autonomic arousal and affective report. *Biological Psychology*, 52, 95–111.

Cvetek, R. (2008). EMDR Treatment of Distressful Experiences That Fail to Meet the Criteria for PTSD. *Journal of EMDR Practice and Research*, Volume 2, Number 1, 2008, 2-14(13). Springer Publishing Company
<https://doi.org/10.1891/1933-3196.2.1.2>

Dannowski, U., Stuhrmann, A., Beutelmann, V., Zwanzger, P., Lenzen, T., Grotegerd, D., ... Kugel, H. (2012) Limbic Scars: Long-Term Consequences of Childhood Maltreatment Revealed by Functional and Structural Magnetic Resonance Imaging. *Biological Psychiatry*, Volume 71, Issue 4, 286-293

Data Protection Act. (1998). UK Government Website:
<http://www.legislation.gov.uk/ukpga/1998/29/contents>

Dattilio, F. M. (2004). Extramarital affairs: The much over-looked PTSD. *The Behavior Therapist*, 27, 76–78.

Dattilio, F. M., Edwards, D. J. & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: toward a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy Theory, Research, Practice, Training*, 47 (4): 427–441.

Davidson, P. & Parker, K. (2001). Eye movement desensitization and reprocessing (EMDR): A meta-analysis. *Journal of Consulting and Clinical Psychology*, 69, 305–316.

Davidson, P. R., & Parker, K. C. H. (2005). Eye movement desensitization and reprocessing (EMDR): a meta-analysis. *Journal of Consulting and Clinical Psychology*. 69, 305–316. 10.1037/0022-006X.69.2.305

Davies, R. & Maguire, K. (2014). Becoming ‘them’ and remaining ‘us’ ... or the road to ruin? INVO Website: from <http://www.invo.org.uk/becoming-them-and-remaining-us-or-the-road-to-ruin/>

- De Bellis, M. D. (2005). The psychobiology of neglect. *Child Maltreatment*, 10, 150-172.
- De Bont, P. A., Van Den Berg, D. P., & Van Minnen, A. M. J. M., (2016). Prolonged exposure and EMDR for PTSD v. a PTSD waiting-list condition: Effects on symptoms of psychosis, depression and social functioning in patients with chronic psychotic disorders. *Psychological Medicine* 46, 2411–2421. 10.1017/S0033291716001094
- De Bont, P. A., Van Minnen, A., De Jongh, A., et al. (2013). Patients with psychosis: a within-group controlled feasibility study examining the efficacy and safety of evidence-based PE and EMDR protocols. *Journal of Behavior Therapy*. 2013; 44(4): 717–30. [Epub 2013 Jul 27].
- De Jongh, A. (2012). Treatment of a woman with emetophobia: a trauma focused approach". *Mental Illness*. 4(1): e3. 10.4081/mi.2012.e3
- De Jongh, A., Amann, B. L., Hoffman, A., & Lee, C. W. (2019) The Status of EMDR Therapy in the Treatment of Posttraumatic Stress Disorder 30 Years After Its Introduction. *Journal of EMDR Practice and Research*, 13 (4), 261-269, 10.1891/1933-3196.13.4.261
- De Jongh, A., Bicanic, I., Matthijssen, S., Amann, B. L., Hofmann, A., Farrell, D., Lee, C. W., Maxfield, L. (2019). The current status of EMDR therapy involving the treatment of complex posttraumatic stress disorder. *Journal of EMDR Practice and Research*, 13(4), 284-290.
- De Jongh, A., Ernst, R., Marques, L. & Hornsveld, H. (2013). The impact of eye movements and tones on disturbing memories of patients with PTSD and other mental disorders. *Journal of Behavior Therapy and Experimental Psychiatry*, 44, 447–483.

- De Jongh, A & Logie, R. (2014). The “Flashforward Procedure”: Confronting the Catastrophe. *Journal of EMDR Practice and Research*. 8. 25-32. 10.1891/1933-3196.8.1.25.
- De Jongh, A., ten Broeke, E. & Renssen, M. (1999). Treatment of specific phobias with EMDR. Protocol, empirical status and conceptual issues. *Journal of Anxiety Disorders*, 13 (1-2): 69–85.
- De Jongh, A., Ten Broeke, E., & Meijer, S. (2010). Two method approach: a case conceptualization model in the context of EMDR. *Journal of EMDR Practice and Research*. 4, 12–21. 10.1891/1933-3196.4.1.12
- De Jongh, A., Van den Oord, H, J, M., & Ten Broeke, E. (2002). Efficacy of EMDR in the treatment of specific phobias: four single- case studies on dental phobia. *Journal of Clinical Psychology*, 58 (12), 1489-1503.
- De Jongh, A., Holmshaw, M., Carswell, W., et al. (2002) “Usefulness of a trauma focused treatment approach for travel phobia”. *Clinical Psychology and Psychotherapy*. 18: 124-137.
- De Jongh, A. D., Resick, P. A., Zoellner, L. A., Van Minnen, A., Lee, C. W., Monson, C. M., Foa, E. B., Wheeler, K., ten Broeke, E., Feeny, N., Rauch, S. A. M., Chard, K. M., Mueser, K. T., Sloan, D. M., van der Gaag, M., Rothbaum, B. O., Neuner, F., de Roos, C., Hehenkamp, L. M. J., Rosner, R., and Bicanic, I. A. E. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and anxiety*, 33(5), 359-369.
- De Roos, C., Veenstra, A, C., de Jongh, A et al. (2010) Treatment of chronic phantom-limb pain using a trauma- focused psychological approach. *Pain Research and Management*. 15 (2): 65-71.

De Quervain, D. J. F. (2006). Glucocorticoid-induced inhibition of memory retrieval. *Annals of the New York Academy of Sciences*, 1071, 216-220

Dekkers, O. M., Egger, M., Altman, D. G., & Vandenbroucke, J. P. (2019) Distinguishing case series from cohort studies. *Ann Intern Med.* 156(1 Pt 1):37-40. 10.7326/0003-4819-156-1-201201030-00006. PMID: 22213493.

Delahanty, D. L., & Nugent, N. R. (2006). Predicting PTSD prospectively based on prior trauma history and immediate biological responses. *Annals of the New York Academy of Sciences*, 1071, 27–40.

Dennis, T. A., Chen, C. C., & McCandliss, B. D. (2008). Threat-related attentional biases: An analysis of three attention systems. *Depression and Anxiety*, 25, 1–10.

Denzin, N. K. & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Sage.

Department of Health. (2007). *Local Government and Public Involvement in Health Act*. Department of Health.

Department of Health and Social Care figures (2018) Accessed, 02/05/21. UK Government: Department of Health (publishing.service.gov.uk)

Department for Health and Social Security. (1983). *Inquiry into NHS management (The Griffiths Report)*. HMSO

DePoy, E., & Gitlin, L. (2005). Introduction to research: Multiple strategies for health and human services (3rd ed). Mosby.

Derogatis, L. R. (1994). Symptom Checklist-90-R: Administration, scoring & procedure manual for the revised version of the SCL-90. National Computer Systems.

DES-Taxon Critique (2018) Research Gate Website:

https://www.researchgate.net/publication/5408508_Is_There_Really_a_Dissociative_Taxon_on_the_Dissociative_Experiences_Scale

Deville, G. J., & Spence, S. H. (1999). The relative efficacy and treatment distress of EMDR and a cognitive behaviour trauma treatment protocol in the amelioration of posttraumatic stress disorder. *Journal of Anxiety Disorders*, 13 (1–2), 131–157.

Diamond, A (2013) Executive Functions Annual Review of Psychology, 64: 135-168.

Dingfelder, S. F. (2009). Stigma: Alive and well. *Monitor on Psychology*. 40(6), 52. APA: <http://www.apa.org/monitor/2009/06/stigma-war.aspx>

Doering, S., Ohlmeier, M. C., de Jongh, A., Hofmann, A., & Bisping, V. (2013). Efficacy of a trauma-focused treatment approach for dental phobia: a randomized clinical trial. *European Journal of Oral Sciences*. 121, 584–593. 10.1111/eos.12090

Domhardt, M., Manzer, A., Fegert, J. M., & Goldbeck, L. (2015) Resilience in survivors of child sexual abuse: A systematic review of the literature. *Trauma, Violence, & Abuse*, 16(4), 476-493

Dooley, L, M. (2002). Case study research and theory building. *Advances in Developing Human Resources*, 4(3):335-354.

Dorrepaal, E., Thomaes, K., Hoogendoorn, A. W., Veltman, D. J., Draijer, N., & van Balkom, A. J. (2014). Evidence-based treatment for adult women with child abuse-related complex PTSD: A quantitative review. *European Journal of Psychotraumatology*, 5, 1-9. 10.3402/ejpt.v5.23613

Double, D. B. (2019). Twenty years of the Critical Psychiatry Network. *British Journal of Psychiatry*, 214: 2, 61–62.

- Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *JAMA*. 286(24):3089-3096. 10.1001/jama.286.24.3089
- Duncan, B. (2010). *On becoming a better therapist*. APA Press.
10.1037/12080-000
- Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.). (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.) APA Press.
10.1037/12075-000
- Duncan, B. L., Miller S.D. & Sparks, J.A. (2004). *The Heroic Client: a revolutionary way to improve effectiveness through client-directed, outcome-informed therapy*. Jossey-Bass.
- Dunn, B. D., Dalgleish, T., & Lawrence, A. D. (2006). The somatic marker hypothesis: A critical evaluation. *Neuroscience & Biobehavioral Reviews*. 30:239–271.
10.1016/j.neubiorev.2005.07.001.
- Dyregrov, A., & Yule, W. (2006). A review of PTSD in children. *Child and Adolescent Mental Health*, 11(4), 176-184.
- Dziegielewska, S., & Wolfe, P. (2000). Eye Movement Desensitization and Reprocessing (EMDR) as a time limited treatment intervention for body image disturbance and self-esteem: a single subject case study design. *Journal of Psychotherapy in Independent Practice*, 1, 1–16. 10.1300/J288v01n03_01
- E-Prime Software (2018) <https://pstnet.com/products/e-prime/>
- Earl, J. F., Brooks-Gunn, J., Raudenbush, W. S., & Sampson J. R. (2000-02). Project on Human Development in Chicago Neighborhoods (PHDCN): Youth Self Report, Wave

3: ICPSR Study Number 13752. U.S. Department of Justice. Office of Justice Programs. *National Institute of Justice*. Adapted version.

<https://www.icpsr.umich.edu/icpsrweb/PHDCN/descriptions/ysr-w1-w2-w3.jsp>

Ecker, C., Suckling, J., Deoni, S. C., Lombardo, M. V., Bullmore, E. T., Baron Cohen, S., Catani, M., Jezzard, P., Barnes, A., Bailey, A. J. (2012). Brain Anatomy and Its Relationship to Behavior in Adults with Autism Spectrum Disorder: A Multicenter Magnetic Resonance Imaging Study. *Archives General Psychiatry*. 69:195–209

Economic and Social Research Council. (2005). Research Ethics Framework. Swindon. www.esrc.ac.uk

Edmond, T., & Rubin, A. (2004). Assessing the long-term effects of EMDR: Results from an 18-month follow-up study with adult female survivors of CSA. *Journal of Child Sexual Abuse*, 13:1. 69-86. Taylor & Francis

Edmond, T., Sloan, L., & McCarty, D. (2004). 'Sexual abuse survivors' perceptions of the effectiveness of EMDR and eclectic therapy,' *Research on Social Work Practice*, 14(4), 259–272.
<http://search.ebscohost.com.salford.idm.oclc.org/login.aspx?direct=true&db=cin20&AN=106775349&site=ehost-live>>.

Edmond, T., Rubin, A., & Wambach, K. G. (1999). 'The effectiveness of EMDR with adult female survivors of childhood sexual abuse...eye movement desensitization and reprocessing,' *Social Work Research*, 23(2), 103–116.
<http://search.ebscohost.com.salford.idm.oclc.org/login.aspx?direct=true&db=cin20&AN=107207757&site=ehost-live>

Ehlers, A., & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38, 319-345

Ehlers, A., Clark, D.M., Hackmann, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for PTSD: development and evaluation. *Behaviour Research and Therapy*,

43, 413-431. Ehlers, A. (unpublished) Cognitive Therapy for PTSD - treatment manual

Ehring, T., Welboren, R., Morina, N., Wicherts, J. M., Freitag, J., & Emmelkamp, P. M. G. (2014). Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse. *Clinical Psychology Review, 34*(8), 645–657. <https://doi.org/10.1016/j.cpr.2014.10.004>

Eifert, G. H., Schulte, D., Zvolensky, M. J., Lejuez, C.W. & Lau, A.W. (1997). Manualized behavior therapy: merits and challenges. *Behavior Therapy, 28*: 499-509.

El-Gilany, A. H. (2018) What is case series?ll, *Asp Biomed Clin Case Rep*, vol.1, no.1: 10-15. (PDF) What is case series? (researchgate.net)

Elkin, I. (1994). The NIMH Treatment of Depression Collaborative Research Program: where we began and where we are. In A.E. Bergin and S.L. Garfield (eds.) *The Handbook of Psychotherapy and Behavior Change*, 4th Ed., 114-139. John Wiley and Sons.

Elkin, I., Falconnier, L., Matrinovich, Z. & Mahoney, C. (2006). Therapist effects in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Psychotherapy Research, 16*(2): 144-160.

Elliott, R. (2001). Hermeneutic single case efficacy design: An Overview. In K.J. Schneider, J. Bugental and J.F. Pierson (eds.). *The handbook of humanistic psychology: learning edges in theory, research and practice*, 315-324. Sage.

Elliott, R. (2002). Hermeneutic single case efficacy design. *Psychotherapy Research, 12*: 1-20.

Elliott, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research, 18*(3), 239-242. [10.1080/10503300802074513](https://doi.org/10.1080/10503300802074513)

- Elliott, R. (2010). Psychotherapy change process research: realising the promise. *Psychotherapy Research*, 20(2): 123-135.
- Elliott, R., Bohart, A.C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed., 132-152). Oxford University Press.
- Elliott, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *The British Journal of Clinical Psychology*, 38: 215-229.
- Elliott, R., Greenberg, L. S., Watson, J., Timulak, L & Friere, E. (2013). Research on humanistic-experiential psychotherapies. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change (6th Edition)*. John Wiley and Sons
- Elliot, R. & James, E. (1989). Varieties of client experience in psychotherapy: an analysis of the literature. *Clinical Psychology Review*, 9 (4), 443-467.
- Elliott, R., Partyka, R., Alperin, R., Dobrenski, R., Wagner, J., Messer, S.B., Watson, J. C., and Castonguay, L.G. (2009). An adjudicated hermeneutic single-case efficacy design study of experiential therapy for panic/phobia. *Psychotherapy Research*, 19(4-5): 543-557.
- Elofsson, U. O., von Schèele, B., Theorell, T., & Söndergaard, H. P. (2008). Physiological correlates of eye movement desensitization and reprocessing. *J. Anxiety Disord.* 22, 622–634. 10.1016/j.janxdis.2007.05.012
- EMDR Europe. (2018). Research Studies. <https://emdr-europe.org/research/research-studies/>
- EMDR Europe. (2018). Code of Ethics. <http://www.emdr-europe.org/upload/editor/EMDR-Europe-Code-of-Ethics-2010.pdf>

EMDR UK Annual Conference. (Cardiff/Remote). Attended 12-13/06/2020

EMDR UK & Ireland (2018). Accreditation Guidelines.

<http://emdrassociation.org.uk/accreditation-faq/>

EMDRIA. (2018). Research. <https://emdria.site-ym.com/page/EMDRResearch?>

EMDRIA. (2018). EMDR-centered library. <https://emdria.omeka.net/>

EMDRIA (2019) EMDR Fidelity Rating Scale.

<https://emdrresearchfoundation.org/research-grants/emdr-fidelity-rating-scale/>

EMDRIA (2021) The Eight Phases of EMDR Therapy. The Eight Phases of EMDR Therapy
| EMDR International Association (emdria.org)

Emerson, J. D., Burdick, E., Hoaglin, D. C., Mosteller, F., & Chalmers, T. C. (1990). An empirical study of the possible relation of treatment differences to quality scores in controlled randomized clinical trials. *Controlled Clinical Trials*. 11: 339-352.

Engelhard, I. M., van den Hout, M. A., Janssen, W. C., & van der Beek, J. (2010). Eye movements reduce vividness and emotionality of images about “flashforwards”. *Behaviour Research and Therapy*, 48, 442-447.

<http://dx.doi.org/10.1016/j.brat.2010.01.003>

Engelhard, I. M., van den Hout, M. A., & Smeets, M. A. M. (2011). Taxing working memory reduces vividness and emotionality of images about the Queen’s Day tragedy. *Journal of Behavior Therapy and Experimental Psychiatry*, 42, 32-37.

<http://dx.doi.org/10.1016/j.jbtep.2010.09.004>

Engelhard, I. M., van Uijen, S. L., & van den Hout, M. A. (2010). The impact of taxing working memory on negative and positive memories. *European Journal of Psychotraumatology*, 1: 5623, 1-8. <http://dx.doi.org/10.3402/ejpt.v1i0.5623>

- Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. Allen & Unwin.
- Fairfax, H. (2008). CBT or not CBT, is that really the question? Re-considering the evidence base – the contribution of process research. *Counselling Psychology Review*, 23(4), 27-37.
- Fan, J., McCandliss, B. D., Sommer, T., Raz, M. & Posner, M. I. (2002). Testing the Efficiency and Independence of Attentional Networks. *Journal of Cognitive Neuroscience*, 14, 340-347.
- Farina, B., Imperatori, C., Quintiliani, M. I., Castelli Gattinara, P., Onofri, A., Lepore, M., Brunetti, R., Losurdo, A., Testani, E., and Della Marca, G. (2015). Neurophysiological correlates of eye movement desensitization and reprocessing sessions: Preliminary evidence for traumatic memories integration. *Clinical Physiology and Functional Imaging*, 35, 460–468. 10.1111/cpf.12184
- Farrell, D. (July 2018). Response to Draft Guideline Consultation from EMDR UK & Ireland Association as a Registered Stakeholder. EMDR UK & Ireland Association/EMDR Europe/Trauma Aid Europe
- Farruggia, S., Chen, C., Greenberger, E., Dmitrieva, J., & Macek, P. (2004). Adolescent self-esteem in cross-cultural perspective: testing measurement equivalence and a mediation model. *Journal of Cross-Cultural Psychology*, 35:719–733.
- Faulkner, A. & Thomas, P. (2002). User-led research and evidence-based medicine. *The British Journal of Psychiatry*, 180(1), 1-3.
- Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M. P., and Marks, J. (2019). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 56(6) 774-786. 10.1016/j.amepre.2019.04.001

- Feng, P., Zheng, Y., & Feng, T. (2016). Resting-state functional connectivity between amygdala and the ventromedial prefrontal cortex following fear reminder predicts fear extinction. *Social Cognitive and Affective Neuroscience*, 11(6), 991–1001. <http://dx.doi.org/10.1093/scan/nsw031>
- Fergusson, D. M., McLeod, G. F., & Horwood, L. J. (2013). Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand. *Child Abuse & Neglect*, 37(9), 664-674. doi.10.1016/j.chiabu.2013.03.013
- Feske, U., & Goldsteina, J. (1997). Eye movement desensitization and reprocessing treatment for panic disorder: a controlled outcome and partial dismantling study. *Journal of Consulting and Clinical Psychology*. 65, 1026–1035. 10.1037/0022-006X.65.6.1026
- Field, A. (2013). *Discovering Statistics Using IBM SPSS Statistics*. (4th Ed). Sage Publications
- Fishman, D. B. (1999). *The case for a pragmatic psychology*. New York University Press.
- Fishman, D. (2012). Editor's introduction: combining pragmatic case studies within a single case experimental design. *Pragmatic Case Studies in Psychotherapy*, 8(4): 245-54.
- Fitzpatrick, M. R., Janzen, J., Chamodraka, M., Gamberg, S. & Blake, E. (2009). Client relationship incidents in early therapy: Doorways to collaborative engagement. *Psychotherapy Research*, 19, 654–665. 10.1080/10503300902878235
- Flaks, M. K., Malta, S. M., Almeida, P. P., Bueno, O. F. A., Pupo, M. C., Andreoli, S. B., ... & Bressan, R. A. (2014). Attentional and executive functions are differentially affected by post-traumatic stress disorder and trauma. *Journal of Psychiatric Research. Res.* 48, 32–39. 10.1016/j.jpsychires.2013.10.009

- Flanagan, J. C. (1978). A research approach to improving our quality of life. *American Psychologist*, 33, 138-147.
- Flanagan, J. C. (1982). Measurement of quality of life: Current state of the art. *Archives of Physical Medicine and Rehabilitation*, 63, 56-59.
- Flatley, J. (2019) Crime Statistics and Analysis, Office for National Statistics.
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/abuse-during-childhood/findings-from-the-year-ending-march-2016-crime-survey-for-england-and-wales#statisticians-quote>
- Flory, J. D., & Yehuda, R. (2015). Comorbidity between post-traumatic stress disorder and major depressive disorder: alternative explanations and treatment considerations. *Dialogues in clinical neuroscience*, 17(2), 141-50.
- Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, 12(2):219-45.
- Foa, E. B., A., Ehlers, et al. (1999). "The posttraumatic cognitions inventory (PTCI): Development and validation." *Psychological Assessment* 11(3): 303-314
- Foa, E. B., & Meadows, E. A. (1997). Psychosocial treatments for post-traumatic stress disorder: A critical review. In J. Spence, J. M. Darley and D. J. Foss (Eds.), *Annual Review of Psychology*. Vol. 48, 449-480. Palo Alto, CA: Annual Reviews.
- Foa, E. D., Keane, T. M., Friedman, M. J., & Cohen, J. A. (2009). *Effective treatments for PTSD: Practice guidelines of the International Society for Traumatic Stress Studies*. Guilford Press.
- Falkenström, F., Solomonov, Nili., & Rubel, J. A. (2020) "Do Therapist Effects Really Impact Estimates of Within-patient Mechanisms of Change? A Monte Carlo Simulation Study." *Psychotherapy Research* 30.7 885-99. Web.

- Fogarty, S., & Wardle, J., (2015) Integrative medicine case series: A clinician's guide to publication, *Advances in Integrative Medicine*, 2(3), 147-151, <https://doi.org/10.1016/j.aimed.2015.11.001>.
- Folkestad, B. (2008). Analysing Interview Data: Possibilities and challenges, Eurosphere Working Paper Series. Online Working Paper, 13.
- Frank, E. (1991). Interpersonal psychotherapy as a maintenance treatment for patients with recurrent depression. *Psychotherapy*, 28: 259-266.
- Frankl, M., Philips, B. & Wennberg, P. (2014). Psychotherapy role expectations and experiences: Discrepancy and therapeutic alliance among patients with substance use disorders. *Psychology and Psychotherapy: Theory, Research and Practice*, 87(4), 411–424.
- Freud, S. (1901/1979). The case of Dora. *Pelican Freud library, Vol. 8: case histories. I.* Penguin.
- Freud, S. (1909/1979). Notes upon a case of obsessional neurosis (the 'Rat man'). *Pelican Freud library, Vol. 9: case histories II.* Penguin.
- Friedman, M. J. (1989). Toward rational pharmacotherapy for posttraumatic stress disorder: an interim report. *American Journal of Psychiatry*, 145: 281–285.
- Fromme, D. K. (2011). Systems of psychotherapy: dialectical tensions and integration. Springer-Verlag. 10.1007/978-1-4419-7308-5.
- Frueh, B. C., Grubaugh, A. L., Yeager, D. E., & Magruder, K. M. (2009). Delayed-onset post-traumatic stress disorder among war veterans in primary care clinics. *The British Journal of Psychiatry*, 194, 515–520.

FSSC-R (2018) Therapy Advisor:

<http://www.therapyadvisor.com/LocalContent/Child/FSSC-R.pdf>

Fuidge, C. (Europe EMDR Consultant and Trainer) & Pike, D. (EMDR West Midlands) (13/09/19). Workshop; EMDR and Anxiety/PANIC. Held at The Priory Rooms, Meeting and Conference Centre, 40 Bull Street, Birmingham, B4 6AF

Fullana, M. A., Albajes-Eizagirre, A., Soriano-Mas, C., Vervliet, B., Cardoner, N., Benet, O., & Harrison, B. J. (2018). Fear extinction in the human brain: A meta-analysis of fMRI studies in healthy participants. *Neuroscience and Biobehavioral Reviews*, 88, 16–25. <http://dx.doi.org/10.1016/j.neubiorev.2018.03.002>

Gabbay, V., Oatis, M. D., Silva, R. R., & Hirsch, G. S. (2004). Epidemiological aspects of PTSD in children and adolescents. In Silva, Raul R (Ed.), *Posttraumatic stress disorders in children and adolescents: Hand* Norton.

Gadamer, H. G. (1975). *Philosophical hermeneutics*. University of California Press.

Gainotti, G. (2012). Unconscious processing of emotions and the right hemisphere. *Neuropsychologia*, 50(2), 205–218. [10.1016/j.neuropsychologia.2011.12.005](https://doi.org/10.1016/j.neuropsychologia.2011.12.005)

Gallagher, M., Tracey, A., & Millar, R. (2005). Ex-clients' evaluation of bereavement counselling in a voluntary sector agency. *Psychology and Psychotherapy: Theory, Research and Practice*, 78(1), 59–76. [10.1348/147608304X21392](https://doi.org/10.1348/147608304X21392)

Galovski, T. E., Sobel, A. A., Phipps, K. A., & Resick, P. A. (2005). Trauma recovery: Beyond posttraumatic stress disorder and other Axis I symptom severity. In T. A. Corales (Ed.), *Trends in posttraumatic stress disorder*, 207–227. Nova Science Publishers.

Galovski, T. E., Blain, L. M., Mott, J. M., Elwood, L., & Houle, T. (2012). Manualized therapy for PTSD: flexing the structure of cognitive processing therapy. *Journal of consulting and clinical psychology*, 80(6), 968-81.

Gauvreau, P., & Bouchard, S. (2008). Preliminary evidence for the efficacy of EMDR in treating generalized anxiety disorder. *Journal of EMDR Practice and Research*, 2, 26–40.

General Data Protection Regulation 'GDPR' (2018, updated version of the Data Protection Act 1998). Information Commissioners Office.

<https://www.gov.uk/government/publications/guide-to-the-general-data-protection-regulation>

Geraghty, K. J. (2017). 'PACE-GATE': When clinical trial data meets open data access. *Journal of Health Psychology*, 22: 1106–1112.

Gerardi, M., Rothbaum, B. O., & Astin, M. C., et al. (2010) 'Cortisol Response Following Exposure Treatment for PTSD in Rape Victims', *Journal of Aggression, Maltreatment & Trauma*, 19(4), 349–356. Taylor & Francis (Routledge).

<https://search.proquest.com/docview/853218785?accountid=8058>

Gilbert, N., & Kerr, F. (Adult and Children EMDR Practitioners, EMDR UK & Ireland) (06/10/18). Workshop: Shame & EMDR in Adults and Children: A Developmental Approach

Ginzburg, K., Ein-Dor, T., & Solomon, Z. (2010). Comorbidity of posttraumatic stress disorder, anxiety and depression: a 20-year longitudinal study of war veterans. *Journal of affective disorders*, 123(1-3), 249-257.

Giorgi, A. (1997). The theory, practice and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology*, 28(2), 235-260.

Glass, C. R., & Arnkoff, D. B. (2000). Consumers' perspectives on helpful and hindering factors in mental health treatment. *Journal of Clinical Psychology*, 56 (11), 1467-1480.

GMMH IAPT Management email (25/03/20) Confirmation of transfer from 'in person' to 'online' therapy due to COVID-19. Outlook.

Goldman, S., Brettle, A. J., and McAndrew, S. L. (2016). A client focused perspective of the effectiveness of Counselling for Depression (CfD). The University of Salford. [Counselling for Depression.pdf \(salford.ac.uk\)](https://www.salford.ac.uk/research/cfd/counselling-for-depression.pdf)

Goldstein, A. J., de Beurs, E., Chambless, D. L., & Wilson, K. A. (2000). EMDR for panic disorder with agoraphobia: comparison with waiting list and credible attention-placebo control conditions. *Journal of Consulting Clinical Psychology*, 68, 947–956. 10.1037/0022-006X.68.6.947

Golub, S. A., Thompson, L. I., & Kowalczyk, W. J. (2016). Affective differences in Iowa Gambling Task performance associated with sexual risk taking and substance use among HIV-positive and HIV-negative men who have sex with men. *Journal of clinical and experimental neuropsychology*, 38(2), 141-57.

Gomez, A. M. (2012). *EMDR therapy and adjunct approaches with children: Complex trauma, attachment, and dissociation*. Springer Publishing Company.

Gómez, J. M., Kaehler, L. A., & Freyd, J. J. (2014). Are hallucinations related to betrayal trauma exposure? A three-study exploration. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6(6), 675-682. 10.1037/a0037084

Goodnight, J. R., Ragsdale, K. A., Rauch, S. A., & Rothbaum, B. O. (2019). Psychotherapy for PTSD: An evidence-based guide to a theranostic approach to treatment. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, 88, 418–426. <https://doi.org/10.1016/j.pnpbp.2018.05.006>

Gorilla Software (2018) www.gorilla.sc

- Gostas, M. W., Wiberg, B., Neander, K. & Kjekkin, L. (2012). 'Hard Work' in a new context: clients' experiences of psychotherapy. *Qualitative Social Work*, 0(00), 1-18.
10.1177/1473325011431649
- Gough, D. (1996). Defining the problem. *Child Abuse and Neglect* 20 (11) 993 – 1102
- Grafanaki, S. (1996). How research can change the researcher: the need for sensitivity, flexibility and ethical boundaries in conducting qualitative research in counselling/psychotherapy. *British Journal of Guidance and Counselling*, 24, 329-338.
- Green, J. (2000). Understanding social programs through evaluation. In Denzin, N., Lincoln, Y. (Eds.), *Handbook of qualitative research* (2nd ed., 981–999). Sage.
- Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*, 11: 255–274.
- Greenfield, T. (2002). *Research Methods for Postgraduates*. 2nd ed. Arnold
- Gresham, F. M., Gansle, K. A., & Noell, G. H. (1993). Treatment integrity in applied behavior analysis with children. *Journal of Applied Behavior Analysis*; 26:257e63.
- Grey, E. (2011). A pilot study of concentrated EMDR. *Journal of EMDR Practice and Research*, 5, 14–24.
- Greyber, L., Dulmus, C. & Cristalli, M. (2012). EMDR, PTSD, and trauma. *Child and Adolescent Social Work Journal* 29, 409–425.
- Griffioen, B. T., van der Vegt, A. A., de Groot, I. W., & de Jongh, A. (2017). The Effect of EMDR and CBT on Low Self-esteem in a General Psychiatric Population: A

Randomized Controlled Trial. *Frontiers in psychology*, 8, 1910.
10.3389/fpsyg.2017.01910

Grønli, O., & Wynn, R. (2012). Normocalcemic hyperparathyroidism and treatment resistant depression. *Psychosomatics*. 54:493–497. 10.1016/j.psym.10.008.

Gronwall, D. M. A. (1977). Paced auditory serial-addition task: A measure of recovery from concussion. *Perceptual and Motor Skills*, 44, 367-373.

Groves, S. J., Porter, R. J., Jordan, J., Knight, R., Carter, J. D., McIntosh, V. V., ... & Joyce, P. R. (2015). Changes in neuropsychological function after treatment with metacognitive therapy or cognitive behavior therapy for depression. *Depression Anxiety*, 32(6):437-44. 10.1002/da.22341.

Guajardo, J. M. F., & Anderson, T. (2007). An investigation of psychoeducational interventions about therapy. *Psychotherapy Research*, 17(1): 973-982.

Guba, E., & Lincoln, Y. S. (1994). Competing paradigm in qualitative research in Denzin N. K. & Lincoln Y. (Eds.). *Handbook of Qualitative Research*. Thousand Oaks: Sage

Gubrium, J. F., & Holstein, J. A. (2000). Analysing interpretive practice. In N.K. Denzin & Y.S. Lincoln (Eds.). *Handbook of Qualitative Research* (2nd Ed.). Thousand Oaks: Sage

Guest, G. (2006). How many interviews are enough?: an experiment with data saturation and variability. *Field methods*. 18:59–82. <https://doi.org/10.1177/1525822X05279903>.

Gunter, R., & Bodner, G. (2009). EMDR works... but how? *Journal of EMDR Practice and Research*, 3, 161–168. 10.1891/1933-3196.3.3.161

- Gyani, A., Shafran, R., Layard, R. & Clark, D.M. (2011). Enhancing recovery rates in IAPT services: lessons from analysis of the year one data.
<http://www.iapt.nhs.uk/silo/files/enhancing-recovery-rates--iapt-year-one-report.pdf>
- Haber, S. N., & Knutson, B. (2010). The reward circuit: linking primate anatomy and human imaging. *Neuropsychopharmacology: Official Publication of the American College of Neuropsychopharmacology*, 35(1), 4–26. <http://dx.doi.org/10.1038/npp.2009.129>
- Hackshaw, A. (2008). Small studies: strengths and limitations. *European Respiratory Journal*, 32: 1141–1143. 10.1183/09031936.00136408
- Hall, J. C. (2008). A practitioner's application and deconstruction of evidence-based practice. *Families in Society: The Journal of Contemporary Social Science*, 89(3), 385-393.
- Hampton, A. N., Adolphs, R., Tyszka, M. J., & O'Doherty, J. P. (2007). Contributions of the amygdala to reward expectancy and choice signals in human prefrontal cortex. *Neuron*, 55(4), 545–555. <http://dx.doi.org/10.1016/j.neuron.2007.07.022>
- Hancock, M. (Health Secretary) (24/03/20., The Daily No.10 COVID-19 Briefings. COVID-19 'Lockdown' rules explained
- Haour, F., Dobbelaere, E., & Beaurepaire, C. D. (2019). Scientific Evaluation of EMDR Psychotherapy for the Treatment of Psychological Trauma Summary: Scientific evaluation of EMDR psychotherapy. *Journal of Neurology and Neuromedicine*. 4(2): 5-14
- Harford, T. C., Yi, H. Y., & Grant, B. F. (2014). Associations between childhood abuse and interpersonal aggression and suicide attempt among US adults in a national study. *Child Abuse & Neglect*, 38(8), 1389–1398.
<https://doi.org/10.1016/j.chiabu.2014.02.011>

Hart, B. and Risley, T. (1995). *Meaningful Differences in the Everyday of Young American Children*. Brookes Publishing.

Harper, D., & Thompson, A.R. (2012). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp.83- 97). West Sussex, UK: John Wiley & Sons Ltd.

Harvey, B. H., Brand, L., Jeeva, Z., & Stein, D. J. (2006). Cortical/hippocampal monoamines, HPA-axis changes and aversive behavior following stress and restress in an animal model of post-traumatic stress disorder. *Physiology & Behavior*, 87, 881–890.

Hase, M., Balmaceda, U. M., Ostacoli, L., Liebermann, P., & Hofmann, A. (2017). The AIP Model of EMDR Therapy and Pathogenic Memories. *Frontiers in psychology*, 8, 1578. <https://doi.org/10.3389/fpsyg.2017.01578>

Hase, M., Balmaceda, U. M., Hase, A., et al. (2015 Jun) EMDR therapy in the treatment of depression: a matched pairs in an inpatient setting. *Brain Behavior*. 5(6): 10.1002/brb3.342. Epub 2015 Apr 30.

Haute Autorité de santé (HAS). (2007) *Troubles anxieux graves*. 93218Saint-Denis-la- Plaine. Saint-Denis La Plaine (France) [consulté le 2 avril 2019]

HAVOCA: Help for Adult Victims of Child Abuse (2021).

HAVOCA Survey Results - Help for Adult Victims Of Child Abuse - HAVOCA

Hawthorne, M. J., & Pierce, B. H. (2015). Disadvantageous Deck Selection in the Iowa Gambling Task: The Effect of Cognitive Load. *Europe's Journal of Psychology*, 11(2), 335–348. 10.5964/ejop.v11i2.931

Hayes, J., LaBar, K., Petty, C., McCarthy, G., & Morey, R. (2009). Alterations in the neural circuitry for emotion and attention associated with posttraumatic stress symptomatology. *Psychiatry Research: Neuroimaging*, 172, 7–15.

Hayes, J. P., Hayes, S. M., & Mikedis, A. M. (2012). Quantitative meta-analysis of neural activity in posttraumatic stress disorder. *Biology of Mood & Anxiety Disorders*, 2, 9. <http://dx.doi.org/10.1186/2045-5380-2-9>

Heale, R., & Forbes, D. (2013). Understanding triangulation in research. *Evidence Based Nursing*, 16:98. 10.1136/eb-2013-101494

Health and Social Care Information Centre (HSCIC). (2015) Improving Access to Psychological Therapies report. <http://www.hscic.gov.uk/catalogue/PUB17755>.

Health Quality Guidance (2017) Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder. Department of Affairs. <https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGClinicianSummaryFinal.pdf>

Hefez, A., Metz, L., & Lavie, P. (1987). Long-term effects of extreme situational stress on sleep and dreaming. *The American Journal of Psychiatry*. 144: 344–347. [d10.1176/ajp.144.3.344](https://doi.org/10.1176/ajp.144.3.344). PMID: 3826435.

Hefny, A. F., Eid, H. O., Al-Bashir, M., & Abu-Zidan, F. M. (2010). Blast injuries of large tyres: case series. *International Journal of Surgery and Medicine*; 8:151–154. <https://doi.org/10.1016/j.ijssu.2009.12.002>

Heidegger, M. (1927/2011). *Being and Time* (Macquarrie, J., Robinson, E., Trans.). New York, NY: Harper & Row.

Hennekens, C. H., Buring, J. E., & Mayrent, S. L., (1987) *Epidemiology in Medicine*. First edition. USA: Little, Brown and company Boston/Toronto

Herbert, J., Lilienfeld, S., Lohr, J. et al. (2000). Science and pseudoscience in the development of EMDR. *Clinical Psychology Review*, 20, 945–971.

Herman, J. (2012). CPTSD is a distinct entity: Comment on Resick et al. (2012). *Journal of Traumatic Stress*, 25(3), 256–257. 10.1002/jts.21697

Herman, J. L. (1992a). *Trauma and recovery*. Basic Books. p.196

Herman, J. L. (1992b). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*. 5(3), 377–391. 10.1002/(ISSN)1573-6598

Herman, J. L. (1998). Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences*, 52(S1), S98-S103.

Herrington, R., Phillips, M., Almeida, J., Insana, S., & Germain, A. (2012). Posttraumatic stress symptoms correlate with smaller subgenual cingulate, caudate, and insula volumes in unmedicated combat veterans. *Psychiatry Research*, 203(2–3), 139–145. <http://dx.doi.org/10.1016/j.psychresns.2012.02.005>

Hertlein, K. M., & Ricci, R. J. (2004 Jul). A systematic research synthesis of EMDR studies: implementation of the platinum standard. *Trauma Violence Abuse*. 5(3):285-300.

Hilsenroth, M. J. & Cromer, T.D. (2007). Clinician interventions related to alliance during the initial interview and psychological assessment. *Psychology*, 44 (2), 205-218. 10.1037/0033-3204.44.2.205.

Higgins, J, P, T., & Green, S [editors] (updated March 2011; Version 5.1.0) The Cochrane Handbook for Systematic Reviews of Interventions.

https://handbook-5-1.cochrane.org/front_page.htm

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: a review of qualitative studies. *Clinical Psychology & Psychotherapy* 14(3), 157-163.

Hofmann, A. (2012). EMDR and chronic depression. Paper presented at the EMDR Association UK & Ireland National Workshop and AGM, London.

Hofmann, A., Hilgers, A., Lehnung, M., Liebermann, P., Ostacoli, L., Wolfgang, S., & Hase, M. (2014) EMDR as adjunctive treatment in depression. *Journal for EMDR research and practice*. 8 (3) 103 -112. 10.1891/1933-3196.8.3.103

HM Government (2015) Child sexual exploitation: definition and guide for practitioners. Child sexual exploitation: definition and guide for practitioners - GOV.UK (www.gov.uk)

Hollon, S. D. (1999). Allegiance effects in treatment research: a commentary. *Clinical Psychology: Science and Practice*, 6(1): 107-12.

Hollon, S. D., Thase, M. E. & Markowitz, J. C. (2002) Treatment and prevention of depression. *Psychological Science in the Public Interest*, 3:1–39.

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research*, 3, 345–357. 10.1177/1468794103033004

Hollway, W., & Jefferson T. (2000). *Doing qualitative research differently: free association, narrative and the interview method*. Sage.

- Holton G, J. (1973). Thematic origins of scientific thought: Kepler to Einstein. Cambridge, MA: Harvard University Press.
- Hopper, J. W., Pitman, R. K., Su, Z., Heyman, G. M., Lasko, N. B., Macklin, M. L., & Elman, I. (2008). Probing reward function in posttraumatic stress disorder: expectancy and satisfaction with monetary gains and losses. *Journal of Psychiatric Research*, 42(10), 802–807. <http://dx.doi.org/10.1016/j.jpsychires.2007.10.008>
- Hornsveld, H. K., Houtveen, J., Vroomen, M., Aalbers, I., Kapteijn, I., Aalbers, D., & van den Hout, M.A. (2011). Evaluating the effect of eye movements on positive memories such as those used in Resource Development and Installation. *Journal of EMDR Practice and Research*, 5, 146-155. <http://dx.doi.org/10.1891/1933-3196.5.4.146>
- Horowitz, L.M., Rosenberg, S.E., Baer, B.A., Ureno, G., and Villasenor, V.S. (1988). Inventory of interpersonal problems: psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology*, 56: 885-892.
- Horowitz, M. Wilner, N. & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine*, 41, 209-218
- Horst, F., Den Oudsten, B., Zijlstra, W., & de Jongh, A. Lobbestael, J., & De Vries, J. (2017) Cognitive Behavioral Therapy vs Eye Movement Desensitization and Reprocessing for Treating Panic Disorder: A randomised controlled Trial. *Frontiers in Psychology* 8:1409. [10.3389/fpsyg.2017.01409](https://doi.org/10.3389/fpsyg.2017.01409)
- Horvath, A. O. (2013). You can't step into the same river twice, but you can stub your toes on the same rock: Psychotherapy outcome from a 50 year perspective. *Psychotherapy* 50 (1), 25-32.
- House, R. (1999). The culture of general practice and the therapeutic frame. In J. Lees, (Ed.) *Clinical counselling in primary care: clinical counselling in context*. (p19-42). Routledge.

- House, R. & Totton, N. (2011). *Implausible Professions: Arguments for Pluralism and Autonomy in Psychotherapy and Counselling*. PCCS Books.
- Hulley, S. B., Cummings, S. R., Browner, W. S., Grady, D. G., & Newman, T. B. (2007). *Designing clinical research*. 3. Lippincott Williams & Wilkins
- Hulme, P. A., & Agrawal, S. (2004). Patterns of childhood sexual abuse and their characteristics to other childhood abuse and adult health. *Journal of Interpersonal Violence*, 19, 389-405.
- Husserl, E. (1997). *Psychological and transcendental phenomenology and the confrontation with Heidegger (1927-1931)*. Translated and edited by T. Sheehan & R.E. Palmer. Kluwer Academic Publishers.
- Husserl, E. (1927). Phenomenology. *Encyclopaedia Britannica*. Translated by R. E. Palmer. <http://aleph0.clarku.edu/~achou/EncyBrit-DraftD.pdf>
- Hutchins, J., & Mason, C. (2017). Treating a Sexual Abuse Trauma with Eye Movement Desensitisation and Reprocessing Therapy in an Adult Community Mental Health Team Setting, A Case Series. *Psychology and Behavioral Science International Journal*; 6(1): 555676. 10.19080/PBSIJ.2017.06.555676
- Hutchison, I. C., & Rathore, S. (2015). The role of REM sleep theta activity in emotional memory. *Frontiers in Psychology*, 6, 1439.
- IAPT Toolkit, reproduced under the terms of the *Open Government Licence*. NHS. (2018). Improving Access to Psychological Therapies (IAPT) Programme. Work & Social Adjustment Scale (WSAS) and IAPT Phobia Scale (IPS). NHS England » The Improving Access to Psychological Therapies Manual
- Igloi, K., Doeller, C.F., Berthoz, A., Rondi-Reig, L., & Burgess, N., (2010). Lateralized human hippocampal activity predicts navigation based on sequence or place

memory. Proceedings of the National Academy of Sciences of the United States of America. 107 (32), 10.1073/pnas.1004243107

Imel, Z. E., Laska, K., Jakupcak, M., & Simpson, T. L. (2013 Jun). Meta-analysis of dropout in treatments for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 81(3):394.

Improving Access to Psychological Therapies. (2012). About Increased access to psychological therapies. <http://www.iapt.nhs.uk/about-iapt/>

Information Governance Policy (2017) NHS.

[http://intranet/integratedgovernance/policies/Lists/PoliciesList/Information Governance Policy.pdf](http://intranet/integratedgovernance/policies/Lists/PoliciesList/InformationGovernancePolicy.pdf)

Insel, T. R. (2013) Transforming diagnosis

[blog]. <http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml>

International Society for the Study of Trauma and Dissociation 'ISSTD' (2011). Guidelines for Treating Dissociative Identity Disorder In Adults, Third Revision: Summary Version. *Journal of Trauma & Dissociation*, 12(2), 188-212. DOI: 10.1080/15299732.2011.537248.

International Society for Traumatic Stress Studies 'ISTSS' (2018). Posttraumatic Stress Disorder Prevention and Treatment Guidelines Methodology and Recommendations and (2019) *Effective Treatments for PTSD* (3rd ed).

http://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_PreventionTreatmentGuidelines_FNL.pdf.aspx

Involve. (2012). Briefing notes for researchers: involving the public in NHS, public health and social care research. INVOLVE, Eastleigh.

Involve. (2014). Terms of reference. <http://www.invo.org.uk/about-involve/terms-of-reference/>

Irigaray, T. Q., Pacheco, J. B., Grassi-Oliveira, R., Fonseca, R. P., Leite, J. C. D. C., & Kristensen, C. H. (2013). Child maltreatment and later cognitive functioning: A systematic review. *Psicologia: Reflexão e Crítica*, 26(2), 376-387. 10.1590/S0102-79722013000200018

Ironson, G., Freund, B., Strauss, J. L., & Williams, J. (2002). Comparison of two treatments for traumatic stress: A community based study of EMDR and prolonged exposure. *Journal of Clinical Psychology*, 58, 113–128.

Ishak, N. & Bakar, A. (2012) Qualitative data management and analysis using NVivo: an approach used to examine leadership qualities among student leaders. *Education Research Journal*, 2(3), 94-103.

Iwakabe, S. & Gazzola, N. (2009). From single-case studies to practice-based knowledge: aggregating and synthesizing case studies. *Psychotherapy Research*, 19: 601-11.

Jaberghaderi, N., Greenwald, R., Rubin, A. et al (2004). A comparison of CBT and EMDR for sexually abused Iranian girls. *Clinical Psychology and Psychotherapy*, 11, 358–368.

Jamshidi, R., Rajabi, S., & Dehghani, Y. (2020) How to heal their psychological wounds? Effectiveness of EMDR therapy on post-traumatic stress symptoms, mind-wandering and suicidal ideation in Iranian child abuse victims.
<https://doi.org/10.1002/capr.12339>

Janet, P. (1924). Principles of psychotherapy. George Allen & Unwin.

- Jenicek, M. (1999). *Clinical case reporting in evidence-based medicine*. Butterworth Heinemann.
- Jones, E. E. & Pulos, S. M. (1993). Comparing the process in psychodynamic and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology*, 61(2): 306-316.
- Jones-Smith, A. (2018). Therapists' Perceptions of Eye Movement Desensitization & Reprocessing Treatment for Women Survivors of Child Sexual Abuse, p. 1.
<http://search.ebscohost.com.salford.idm.oclc.org/login.aspx?direct=true&db=cin20&AN=131792239&site=ehost-live>
- Johnson, B. (Prime Minister) (22/03/20). The Daily No.10 COVID-19 Briefings. COVID-19 Introduction of 'Lockdown'
- Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (30/07/18) Trauma Research Conference: The Complex Trauma & Resilience Research Unit: Towards Trauma Responsive Mental Health Care. Greater Manchester Mental Health (GMMH) NHS Trust.
- Johnson, R. B., & Onwuegbuzie A.J. (2007). Mixed methods research: a research paradigm whose time has come. *Educational Researcher*, 33(7): 14–26.
- Johnston, J. M., & Pennypacker, H. S. (1993). *Strategies and tactics of behavioral research* (2nd ed.). Lawrence Erlbaum.
- Johnstone, L., Boyle, M., with Cromby, J., Dillon, J., Harper, D., Kinderman, P., ... & Read, J. (2018). The Power Threat Meaning Framework: Overview. British Psychological Society. www.bps.org.uk/PTM-Overview

- Johnson, M., O'Hara, R., Hirst, E., Weyman, A., Turner, J., ...& Siriwardena, N, A. (2017). Multiple triangulation and collaborative research using qualitative methods to explore decision making in pre-hospital emergency care. *BMC Medical Research Methodology*, 17:11. 10.1186/s12874-017-0290-z
- Joppe, M. (2000). *The Research Process*.
<https://www.researchgate.net/publication/44286439> Reliability and Validity of Qualitative and Operational Research Paradigm.
- Jüni, P., Witschi, A., Bloch R., & Egger, M. (1999). The hazards of scoring the quality of clinical trials for meta-analysis. *JAMA*; 282: 1054-1060.
- Kaan, H., Karaya Murlu, A., & Soylu, N. (2019). Eye movement desensitization and reprocessing (EMDR) treatment for a patient diagnosed with post-traumatic stress disorder after sexual abuse. *Klinik Psikofarmakoloji Bulteni*, 29, 147-148.
<https://search.proquest.com/docview/2291463899?accountid=47770>
- Kadam, U.T., Croft, P., McLeod, J. & Hutchinson, M. (2001). A qualitative study of patients' views on anxiety and depression. *British Journal of General Practice*, 51(466), 375-380.
- Kamiya, Y., Timonen, V., and Kenny, R. A. (2016) The impact of childhood sexual abuse on the mental and physical health, and healthcare utilization of older adults. *International Psychogeriatrics*, 28(3), 415-422; Allnock et al. (2015), op. cit.; McCarthy-Jones and McCarthy-Jones (2014), op.
- Kaplow, J. B., & Widom, C. S. (2007). Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of Abnormal Psychology*, 116(1), 176-187.
 10.1037/0021- 843X.116.1.176
- Karadag, M., Gokcen, C., & Sarp, A. S. (2020) EMDR therapy in children and adolescents who have post-traumatic stress disorder: a six-week follow-up study. *International Journal of Psychiatry Clinical Practice*. 24(1):77-82.
 10.1080/13651501.2019.1682171. Epub 2019 Oct 30. PMID: 31663396.

- Kavanagh, D. J., Freese, S., Andrade, J., & May, J. (2001). Effects of visuospatial tasks on desensitization to emotive memories. *British Journal of Clinical Psychology, 40*, 267–280.
- Kazdin, A.E. (1981). Drawing valid inferences from case studies. *Journal of Consulting and Clinical Psychology, 49*: 183-92.
- Kazdin, A. E. (2003). *Research design in clinical psychology* (4th ed.). Allyn and Bacon. 290-299
- Keeble, C., Richard, G. L., Barber, S., & Baxter, P. D. (2015). Choosing a Method to Reduce Selection Bias: A Tool for Researchers. *Open Journal of Epidemiology, 5*, 155-162. <http://dx.doi.org/10.4236/ojepi.2015.53020>
- Keil, A., Bradley, M., Hauk, O., Rockstroh, B., Elbert, T., & Lang, P. (2002). Large-scale neural correlates of affective picture processing. *Psychophysiology, 39*, 641–649.
- Kelly, L., & Katsna, K. (2018). Measuring the scale and changing nature of child sexual abuse and child sexual exploitation: scoping report. Centre of expertise on child sexual abuse.
- Kemper, E. A., Stringfield, S., and Teddlie, C. (2003). Mixed methods sampling strategies in social science research. In: Tashakkori A, Teddlie C, editors. *Handbook of mixed methods in the social and behavioral sciences*. Sage. pp. 273–296.
- Kemps, E., & Tiggemann, M. (2007). Reducing the vividness and emotional impact of distressing autobiographical memories: The importance of modality specific interference. *Memory, 15*, 412-422. <http://dx.doi.org/10.1080/09658210701262017>

- Kenchel, J. M., Domagalski, K., Butler, B. J., & Loftus, E. F. (2020). The messy landscape of eye movements and false memories. *Memory*, 1-8. 10.1080/09658211.2020.1862234. Epub ahead of print. PMID: 33356911.
- Kendler, K. S., & Aggen, S. H. (2014) Clarifying the causal relationship in women between childhood sexual abuse and lifetime major depression. *Psychological Medicine*, 44(6), 1213-1221
- Kendler, K. S., Hettema, J. M., Butera, F., Gardner, C. O., & Prescott, C. A. (2003). Life event dimensions of loss, humiliation, entrapment, and danger in the prediction of onsets of major depression and generalized anxiety. *Archives of General Psychiatry*. 60(8):789-796. 10.1001/archpsyc.60.8.789
- Kendler, K. S., Kuhn, J. & Prescott, C. A. (2004). The interrelationship of neuroticism, sex, and stressful life interrelationship of neuroticism, sex, and stressful life events in the prediction of episodes of major depression. *American Journal of Psychiatry*, 161:631-636.
- Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: a review and synthesis of recent empirical studies. *Psychological Bulletin*, 113, 164-180.
- Kerr, A., Cunningham-Burley, S. & Tutton, R. (2007). Shifting subject positions: experts and lay people in public dialogue. *Social Studies of Science*, 37(3), 385-411.
- Kessels, R., Van den Berg, E., Carla, R., & Augustina, B. (2008). The backward span of the Corsi Block-Tapping Task and its association with the WAIS-III Digit Span. *Assessment*. 15. 426-34. 10.1177/1073191108315611.
- Kessels, R. P. C., van Zandvoort, M. J. E., Postma, A., Kappelle, L. J., & de Haan, E. H. F. (2000). The Corsi Block-Tapping Task: Standardization and Normative Data. *Applied Neuropsychology*, 7(4), 252-258.

- Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E. J., Cardoso, G., ... Koenen, K. C. (2017). Trauma and PTSD in the WHO World Mental Health Surveys. *European Journal of Psychotraumatology*, 8(sup5), 1353383. <https://doi.org/10.1080/20008198.2017.1353383>
- Khan, A. M., Dar, S., Ahmed, R., Bachu, R., Adnan, M., & Kotapati, V. P. (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):e3250. 10.7759/cureus.3250. PMID: 30416901; PMCID: PMC6217870.
- Kidder, L. H., and Fine, M. (1987). Qualitative and Quantitative Methods: When Stories Converge. *New Directions for Program Evaluation*, pp57-75
- Kiesler, D. J. (1983, October). *The paradigm shift in psychotherapy process research*. Summary discussant paper presented at the National Institute of Mental Health Workshop on Psychotherapy Process Research.
- King, A. P., Block, S. R., Sripada, R. K., Rauch, S., Giardino, N., Favorite, T., ... Liberzon, I. (2016). Altered default mode network (DMN) resting state functional connectivity following a mindfulness-based exposure therapy for post-traumatic stress disorder (PTSD) in combat veterans of Afghanistan and Iraq. *Depression and Anxiety*, 33(4), 289–299. <https://doi.org/10.1002/da.22481>
- King, N. (2004). Using templates in the thematic analysis of text. In C. Cassell & G. Symon (Eds.), *Essential guide to qualitative methods in organizational research*, p. 257–270. Sage.
- Kliethermes, M., Schacht., Drewry, K., (2014). Complex Trauma. *Child and Adolescent Psychiatric Clinics*, Volume 2, Issue 2 , 339 - 361
- Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*, 19, 976–986. 10.1111/j.1365-2648.1994.tb01177.x

- Kooistra, B., Dijkman, B., Einhorn, T. A., & Bhandari, M. (2009). How to design a good case series. 3:21–26.
- Korn, D. L., Maxfield, L., Smyth, N., & Stickgold, R. (2018). EMDR fidelity rating scale (EFRS): The manual.
- Korn, L. D. (2009). EMDR and the Treatment of Complex PTSD: A Review. *Journal of EMDR Practice and Research*. 3(4). EMDR International Association. 10.1891/1933-3196.3.4.264
- Kovacs, M. (1992). *Children's Depression Inventory*. Canada: Multi-Health Systems.
- Liberon, I., & Martis, B. (2006). Neuroimaging studies of emotional response in PTSD. *Annals of the New York Academy of Sciences*, 1071, 87-109.
- Kowal, J. A. (2005). QEEG analysis of treating PTSD and bulimia nervosa using EMDR. *Journal of Neurotherapy*, 9, 114–115.
- Kraft, S., Puschner, B. & Kordy, H. (2006). Treatment intensity and regularity in early outpatient psychotherapy and its relation to outcome. *Clinical Psychology and Psychotherapy*, 13(6): 397-404.
- Krause, M.S. & Lutz, W. (2009). Process transforms inputs to determine outcomes: therapists are responsible for managing process. *Clinical Psychology: Science and Practice*, 16(1), 73-81. 10.1111/j.1468-2850.2009.01146.x
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*. IAPT PHQ-9 is adapted from PRIME MD TODAY
- Kubany, E. S., Haynes, S. N., Abueg, F. R., Manke, F. P., Brennan, J. M., & Stahura, C. (1996). Development and Validation of the Trauma-Related Guilt Inventory (TRGI). *Psychological Assessment*. 8. 428-444. 10.1037/1040-3590.8.4.428.

Kuiken, D., Bears, M., Miall, D., & Smith, L. (2001–2002). Eye movement desensitization reprocessing facilitates attentional orienting. *Imagination, Cognition and Personality*, 21, 3–20.

Kuo, J. R., Kaloupek, D. G., & Woodward, S. H. (2012). Amygdala volume in combatexposed veterans with and without posttraumatic stress disorder: a cross-sectional study. *Archives of General Psychiatry*, 69(10), 1080–1086. <http://dx.doi.org/10.1001/archgenpsychiatry.2012.73>

Lambert, M. J. (2013). Outcome in psychotherapy: the past and important advances. *Psychotherapy*, 50 (1), 43.

Lambert, P. (2007). Client perspectives on counselling: before, during and after. *Counselling and Psychotherapy Research*, 7(2), 106-113.

Langdrige, D. (2007). Phenomenological psychology: Theory, research and method. Pearson Education.

Larkin, M., Eatough, V., & Osborn, M. (2011). Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory & Psychology*, 21(3), 318-337.

Layard R. (2012, 18 June). Ignoring mental illness is pure discrimination. *The Times*. p.20

Layard, R., Bell, S., Clark, D. M., Knapp, M., Meacher, M., Priebe, S., and Wright, B. (2006). London School of Economics and Political Science. Centre for Economic Performance. Mental Health Policy Group. The depression report: A new deal for depression and anxiety disorders. *Centre for Economic Performance Report*. http://cep.lse.ac.uk/textonly/research/mentalhealth/DEPRESSION_REPORT_LAYARD.pdf

Layard, R., & Clark, D. M. (2014). Thrive: The Power of Evidence-Based Psychological Therapies. Penguin Books.

Lazarus, R. S., & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality*, 1(3), 141-169.

10.1002/per.2410010304

Le Doux, J. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. Touchstone.

Leadham, C. S., Newland, C., & Blood, C. G. (1993). A descriptive analysis of wounds among U.S. Marines treated at second echelon facilities in the Kuwaiti theater of operation. *Military Medicine*, 158(8), 508–512.

Ledford, R. J., Gast, L. D. (2014). Measuring procedural fidelity in behavioural research, *Neuropsychological Rehabilitation*, 24:3-4, 332-348,
10.1080/09602011.2013.861352

Lee, C., Gavriel, H., Drummond, P., Richards, J. & Greenwald, R. (2002). Treatment of post-traumatic stress disorder: A comparison of stress inoculation training with prolonged exposure and eye movement desensitisation and reprocessing. *Journal of Clinical Psychology*, 58, 1071-1089.

Lee, C., Taylor, G., & Drummond, P. (2006). The active ingredient in EMDR: Is it traditional exposure or dual focus of attention? *Clinical Psychology and Psychotherapy*, 13, 97–107.

Lee, C. W. & Cuijpers, P. (2013). A metaanalysis of the contribution of eye movements in processing emotional memories. *Journal of Behavior Therapy and Experimental Psychiatry*, 44, 231–239.

Lee, C. W., & Drummond, P. D. (2008). Effects of eye movement versus therapist instructions on the processing of distressing memories. *Journal of Anxiety Disorders*, 22, 801–808.

- Lee, D. A., Scragg, P., & Turner, S. (2001). The role of shame and guilt in traumatic events: A clinical model of shame-based and guilt based PTSD. *British Journal of Medical Psychology*, 74, 451–466.
- Lee, N. J. (2009). *Achieving your professional doctorate: a handbook*. Maidenhead: Open University Press.
- Leedy, P., & Ormrod, E. J., (2005) *Practical Research: Planning and Design*, 8th Edition. Pearson
- Lenferink, L. I. M., Meyerbröker, K., & Boelen, P. A. (2020). PTSD treatment in times of COVID-19: A systematic review of the effects of online EMDR. *Psychiatry research*, 293, 113438.
- Leskin, L. P., & White, P. M. (2007). Attentional networks reveal executive function deficits in posttraumatic stress disorder. *Neuropsychology*, 21, 275–284. 10.1037/0894-4105.21.3.275
- Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P., Clarke, M., Devereaux, P. J., Kleijnen, J., & Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *PLoS medicine*, 6(7). <https://doi.org/10.1371/journal.pmed.1000100>
- Liberzon, I., & Martis, B. (2006). Neuroimaging studies of emotional response in PTSD. *Annals of the New York Academy of Sciences*, 1071, 87–109.
- Lilley, S.A., J. Andrade, G. Turpin, *et al.* (2009). Visuospatial working memory interference with recollections of trauma. *British Journal of Clinical Psychology*. 48: 309–321.

- Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin and Y. S. Lincoln (Eds.) *The handbook of qualitative research* (2nd ed., 163–188). Sage.
- Little, M., Remijn, M., Tinga, A. M., Engelhard, I. M., & Van Den Hout, M. (2017). Stress enhances the memory-degrading effects of eye movements on emotionally neutral memories. *Clinical Psychology Science*. 5, 316–324. 10.1177/2167702616687292
- Little, M., van den Hout, M. A., & Engelhard, I. M. (2016) Desensitizing Addiction: Using EMDR to reduce the intensity of substance-related mental imagery and craving. *Front Psychiatry*. 7: 14. 10.3389/fpsyt.2016.00014.
- Litz, B. T., & Gray, M. J. (2002). Emotional numbing in posttraumatic stress disorder: current and future research directions. *The Australian and New Zealand Journal of Psychiatry*, 36(2), 198–204. <http://dx.doi.org/10.1046/j.1440-1614.2002.01002.x>
- Llewelyn, S. P. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, 27(3), 223-237. Helpful Aspects of Therapy Form (HAT). wwwdata.unibg.it <http://wwwdata.unibg.it/dati/corsi/64031/65316-HAT%203.2reg.pdf>
- Lobregt-van Buuren, E., Mevissen, L., Sizoo, B., & de Jongh, A. (2018). EMDR therapy as a feasible and potentially effective treatment for adults with autism spectrum disorder (ASD) and a history of adverse events. *Journal of Autism and Developmental Disorders*. 10.1007/s10803-018-3687-6.
- Logie, R. (2014). EMDR—More than just a therapy for PTSD. *The Psychologist*, 27(7), 512-516. <http://emdrlebanon.org/home>
- Logie, R. (former President of the EMDR Association UK & Ireland) (14/09/19) Workshop: Using Stories for Trauma and Attachment Resolution (Based on the work of Joan Lovett, 1999: *Small Wonders: Healing Childhood Trauma with EMDR*. EMDR

Workshop 30 September 2017). EMDR Child and Adolescent. Held at "The Priory Rooms, Meeting and Conference Centre, 40 Bull Street, Birmingham, B4 6AF

Lohr, J., Tolin, D., & Lilienfeld, S. (1998). Efficacy of eye movement desensitization and reprocessing: Implications for behavior therapy. *Behavior Therapy*, 29(1), 123-156.

Long, T., Johnson, M. (2007). *Research Ethics in the Real World: Issues and Solutions for Health and Social Care*. Elsevier Health Sciences

Longwell, B. T., & Truax, P. (2015). The differential effects of weekly, monthly and bimonthly administrations of the Beck Depression Inventory II. Psychometric properties and clinical implications. *Behavior Therapy* 36: 265–275.

Looi, J. C. L., Maller, J. J., Pagani, M., Hö gberg, G., Lindberg, O., Liberg, B., & Wahlund, L.-O. (2009). Caudate volumes in public transportation workers exposed to trauma in the Stockholm train system. *Psychiatry Research*, 171(2), 138–143. <http://dx.doi.org/10.1016/j.psychresns.2008.03.011>

Lopez, K. A. & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: their contribution to nursing knowledge. *Qualitative Health Research*, 4(5), 726-735.

Low, Y. T. A., Kwok, S. Y., Tam, H. L. C., Yeung, W. K. J., & Lo, H. M. H. (2017). The relationship between childhood physical abuse and suicidal ideation among Chinese university students: Possible moderators. *Children and Youth Services Review*, 81, 94–100. <https://doi.org/10.1016/j.child.youth.2017.07.026>

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: a manual for supportive-expressive treatment*. Basic Books.

- Lupien, S., McEwen, B. S., Gunnar, M. R., & Heim, C. (2009). Effects of stress throughout the lifespan on the brain. *Nature*, *10*, 434-445.
- Luyten, P., Blatt, S.J., van Houdenhove, B. & Corveleyn, J. (2006). Depression research and treatment: are we skating to where the puck is going to be? *Clinical Psychology Review*, *26*: 985–999
- MacCulloch, M. (2006). Effects of EMDR on previously abused child molesters: Theoretical reviews and preliminary findings from Ricci, Clayton, and Shapiro. *Journal of Forensic Psychiatry & Psychology*, *17*, 531-537.
<http://dx.doi.org/10.1080/14789940601075760>
- Mackrill, T. (2009). Constructing client agency in psychotherapy research. *Journal of Humanistic Psychology*, *49*(2), 193-206.
- Maercker, A., Brewin, C. R., Bryant, R. A., Cloitre, M., Reed, G. M., van Ommeren, M., Humayun, A., Jones, L. M., Kagee, A., Llosa, A. E., Rousseau, C., Somasundaram, D. J., Souza, R., Suzuki, Y., Weissbecker, I., Wessely, S. C., First, M. B., and Saxena, S. (2013). Proposals for mental disorders specifically associated with stress in the International Classification of Diseases-11. *Lancet*, *381*: 1683–5.
- Majid, U. (2018). Research Fundamentals: Study Design, Population, and Sample Size. Undergraduate Research in Natural and Clinical Science and Technology (URN CST) Journal. *2*. [10.26685/urncst.16](https://doi.org/10.26685/urncst.16).
- Malarbi, S., Abu-Rayya, H. M., Muscara, F., & Stargatt, R. (2017) Neuropsychological functioning of childhood trauma and post-traumatic stress disorder: A meta-analysis, *Neuroscience & Biobehavioral Reviews*, Vol 72, pp 68-86,
<https://doi.org/10.1016/j.neubiorev.2016.11.004>.

- Mammarella, I. C., & Cornoldi, C. (2005). Sequence and space: the critical role of a backward spatial span in the working memory deficit of visuospatial learning disabled children. *Cognitive Neuropsychology*, 22, 1055–1068. 10.1080/02643290442000509
- Mander, H. (2014). The impact of additional initial face-to-face sessions on engagement within an Improving Access to Psychological Therapies service. *The Cognitive Behaviour Therapist*, 7, E1. doi:10.1017/S1754470X13000007
- Manly, J. T., Kim, J. E., Rogosch, F. A., & Cicchetti, D. (2001). Dimensions of child maltreatment and children's adjustment: Contributions of developmental timing and subtype. *Development and Psychopathology*, 13(4), 759-782.
- Manthei, R.J. (2007). Clients talk about their experiences of the process of counselling. *Counselling Psychology Quarterly*, 20 (1), 1-26.
- March, J. S., Parker, J. D. A., Sullivan, K., Stallings, P., & Conners, C. K. (1997). The multidimensional anxiety scale for children (MASC): Factor structure, reliability, and validity. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 554-565.
- Marcus, S., Marquis, P. & Sakai, C. (1997). Controlled study of treatment of PTSD using EMDR in an HMO setting. *Psychotherapy*, 34, 307-315.
- Marich, J., Dekker, D., Riley, M., & O'Brien, A. (2020). Qualitative Research in EMDR Therapy: Exploring the Individual Experience of the How and Why. *Journal of EMDR Practice and Research*.
- Marks, D. F. (2017). Special issue on the PACE Trial. *Journal of Health Psychology* 22: 1103–1105.

- Marsden, Z., Lovell, K., Blore, D., et al. (2017) A randomized controlled trial comparing EMDR and CBT for obsessive- compulsive disorder. *Journal of Clinical Psychology*. 25(1). 10.1002/cpp.2120. Epub 2017 Jul 28.
- Marsh, H., Grayson, D. (1994). Longitudinal stability of latent means and individual differences: a unified approach. *Structural Equation Modeling*, 1:317–359
- Marsh, H. W., Scalas, L. F., & Nagengast, B. (2010). Longitudinal tests of competing factor structures for the Rosenberg Self-Esteem Scale: traits, ephemeral artifacts, and stable response styles. *Psychological Assessment*, 22:366–381.
- Mason, J. (2002). *Qualitative Researching*. Sage.
- Maslow, A. H. (1943). "A theory of human motivation". *Psychological Review*. 50 (4): 370–96. 10.1037/h0054346
- Matthijssen, S. J., Lee, C. W., de Roos, C., Barron, I. G., Jarero, I., Shapiro, E., Hurley, E. C., Schubert, S. J., Baptist, J., Amaan, B. J., Moreno-Alcázar, A., Tesarz, J., de Jongh, A. (2020). The Current Status of EMDR Therapy, Specific Target Areas, and Goals for the Future. *Journal of EMDR Practice and Research*.
- Matulis, S., Resick, P. A., Rosner, R., & Steil, R. (2014). Developmentally adapted cognitive processing therapy for adolescents suffering from posttraumatic stress disorder after childhood sexual or physical abuse: A pilot study. *Clinical Child and Family Psychology Review*, 17(2), 173190.
- Maxfield, L., & Hyer, L. A. (2002). The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. *Journal of Clinical Psychology*, 58, 23–41.
- Maxfield, L., Melnyk, W. T., & Hayman, G. C. A. (2008). A working memory explanation for the effects of eye movements in EMDR. *Journal of EMDR Practice and Research*, 2: 247–261.

- Maxwell, P, J. (2003). The Imprint of Childhood Physical and Emotional Abuse: A Case Study on the Use of EMDR to Address Anxiety and a Lack of Self-Esteem. *Journal of Family Violence, Vol. 18, No. 5*
- Mavranezouli, I., Megnin-Viggars, O., Grey, N., Bhutani, G., Leach, J., Daly, C. & Pilling, S. (2020). Cost-effectiveness of psychological treatments for post-traumatic stress disorder in adults. *PLoS One. 15(4):e0232245. 10.1371/journal.pone.0232245. PMID: 32353011; PMCID: PMC7192458.*
- McAndrew, S., Chambers, M., Nolan, F., Thomas, B. & Watts, P. (2014). Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing, 23(3), 212-220. 10.1111/inm.12044.*
- MacGinley, M., Breckenridge, J., & Movll, J. (2019). A scoping review of adult survivors' experiences of shame following sexual abuse in childhood, 27(5), John Wiley & Sons Ltd
- McCarthy, S. (2008). Post-traumatic Stress Diagnostic Scale (PDS). *Occup Med (Lond). Aug;58(5):379. 10.1093/occmed/kqn062. PMID: 18676430.*
- McLean, L., Chen, R., Kwiet, J., Streimer, J., Vandervord, J., and Kornhaber, R. (2017). A clinical update on posttraumatic stress disorder in burn injury survivors. *Australas. Psychiatry 25, 348–350. 10.1177/1039856217700285*
- McLeod, J. (1999). *Practitioner research in counselling*. London: Sage.
- McLeod, J. (2010). *Case study research in counselling and psychotherapy*. Sage.
- McLeod, J. (2001). Introduction: research into the client's experience of therapy. *Counselling and psychotherapy research, 1 (1), 41.*

- McLeod, J. (2013). Qualitative research: methods and contributions. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change, 6th Edition*, 49-84. Wiley and Sons.
- McLeod, J. & Elliott, R. (2011). Systematic case study research: a practice-oriented introduction to building an evidence base for counselling and psychotherapy. *Counselling and Psychotherapy Research*, 11(1): 1-10.
- McManus, F., Peerbhoy, D., Larkin, M. & Clark, D. (2010). Learning to change a way of being: An interpretative phenomenological perspective on cognitive therapy for social phobia. *Journal of Anxiety Disorders*, 24(6), 581–589. 10.1016/j.janxdis.2010.03.018
- McMonagle, S. (GMMH Senior I.T. Project Manager, Clinical Lead) (26/03/20) email regarding migration of MS Teams for online working. Outlook.
- McMonagle, S. (GMMH Senior I.T. Project Manager, Clinical Lead) (30/03/20) email regarding webinar of MS Teams; instructions for online IAPT working. Outlook.
- Mearns, D. & Thorne, B. (2000). *Person centred therapy today: new frontiers*. Sage. 41
- Medic, G., Wille, M. & Hemels, M. E. H. (2017) Short- and long-term health consequences of sleep disruption. *Nature and Science of Sleep* 9, 151–161
- Mellman, T. A., Bustamante, V., Fins, A. I., Pigeon, W. R., & Nolan, B. (2002). REM sleep and the early development of posttraumatic stress disorder. *American Journal of Psychiatry*, 159: 1696–1701.
- Melton, H., Meader, N., Dale, H., Wright, K., Jones-Diette, J., Temple, M., Shah, I., Lovell, K., McMillan, D., Churchill, R., Barbui, C., Gilbody, S., & Coventry, P. (2020). Interventions for adults with a history of complex traumatic events: the INCiTE

mixed-methods systematic review. *Health technology assessment*. 24(43), 1–312.
<https://doi.org/10.3310/hta24430>

Mental Health Today. (2017) CBT vs counselling: what's next for the mental health of the UK? CBT vs counselling: what's next for mental health? | MHT
(mentalhealthtoday.co.uk)

Mickleborough, M. J. S., Daniels, J. K., Coupland, N. J., Kao, R., Williamson, P. C., Lanius, U. F., & Lanius, R. A. (2011). Effects of trauma-related cues on pain processing in posttraumatic stress disorder: an fMRI investigation. *Journal of Psychiatry & Neuroscience: JPN*, 36(1), 6–14. <http://dx.doi.org/10.1503/jpn.080188>

Milad, M. R., Pitman, R. K., Ellis, C. B., Gold, A. L., Shin, L. M., Lasko, N. B., & Rauch, S. L. (2009). Neurobiological basis of failure to recall extinction memory in posttraumatic stress disorder. *Biological Psychiatry*, 66(12), 1075–1082.
<http://dx.doi.org/10.1016/j.biopsych.2009.06.026>

Miller, W, P. (MD, MRCPsych, BCh, BAO, DMH, Medicine, Mental Health) (06/12/19)
Masterclass: EMDR with Psychoses. Marabilis Health

Miller, R. B. (2004). *Facing human suffering: psychology and psychotherapy as moral engagement*. Washington, DC: American Psychological Association Press.

Miller, R, W., & Rollnick, S. (2014) The effectiveness and ineffectiveness of complex behavioral interventions: Impact of treatment fidelity, *Contemporary Clinical Trials*. Vol 37, Issue 2. pgs 234-241. ISSN 1551-7144,
<https://doi.org/10.1016/j.cct.2014.01.005>.

Mills, R., Kisely, S., Alati, R., Strathearn, L., and Najman, J. (2016) Self-reported and agency-notified child sexual abuse in a population-based birth cohort. *Journal of Psychiatric Research*, 74, 87-93

- Minelli, A., Zampieri, E., Sacco, C., (2019) Clinical efficacy of trauma-focused psychotherapies in treatment-resistant depression (TRD) in-patients: A randomized, controlled pilot-study. *Psychiatry Research*. 273:567-574.
10.1016/j.psychres.2019.01.070
- Minnen, A. V., Voorendonk, E. M., Rozendaal, L., & Jongh, A. D. (2020). Sequence matters: Combining Prolonged Exposure and EMDR therapy for PTSD.
- Mitchell, M. L. & Jolley, J. M. (2013). *Research design explained*. (8th ed.). Cengage Learning.
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS medicine*, 6(7), 10.1371/journal.pmed.1000097
- Monaco, M., Costa, A., Caltagirone, C., & Carlesimo, A. G., (2013). Forward and backward span for verbal and visuo-spatial data: standardization and normative data from an Italian adult population. *Neurological Sciences*. 34(5): 749–754. 10.1007/s10072-012-1130-x
- Moncher, F. J., & Prinz, R. J. (1991). Treatment fidelity in outcome studies. *Clinical Psychology Review*; 11:247-266. [http://dx.doi.org/10.1016/0272-7358\(91\)90103-2](http://dx.doi.org/10.1016/0272-7358(91)90103-2)
- Moncrieff, J. (2013). The meaning in madness. *Therapy Today*, 24(5), 32-34.
- Moradi, A. R., Neshat Doost, H. T., Taghavi, M. R., Yule, W., & Dalgleish, T. (1999). Everyday memory deficits in children and adolescents with PTSD: performance on the Rivermead Behavioural Memory Test. *Journal of Child Psychology and Psychiatry*, 40, 357-361.
- Moran, D. (2002). *Introduction to phenomenology*. Routledge

- Moreno-Alcázar, A., Treen, D., Valiente-Gómez, A., Sio-Eroles, A., Pérez, V., & Amann, B. L. (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* 10;8:1750. 10.3389/fpsyg.2017.01750.
- Morey, R. A., Gold, A. L., LaBar, K. S., Beall, S. K., Brown, V. M., Haswell, C. C., & Mid-Atlantic MIRECC Workgroup (2012). Amygdala volume changes in posttraumatic stress disorder in a large case-controlled veterans group. *Archives of General Psychiatry*, 69(11), 1169–1178. <http://dx.doi.org/10.1001/archgenpsychiatry.2012.50>
- Morrow-Bradley, C., & Elliott, R. (1986). Utilization of psychotherapy research by practicing psychotherapists. *American Psychologist*, 48 (2): 188-197.
- Morrow, S. J. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52(2): 250–260.
- Morse, J. M. (1994). *Critical Issues in Qualitative Research Methods*. Sage.
- Morse, J. M. (2000) Determining sample size. *Qual Health Res.* 10:3–5. <https://doi.org/10.1177/104973200129118183>.
- Moustakas, C. (1994). *Phenomenological research methods*. Sage.
- Mueller, S. T. (2010). PEBL: The psychology experiment building language (Version 0.11) [Computer experiment programming language]. <http://pebl.sourceforge.net>.
- Mueller, S. T. (2010). The PEBL Manual, Version 0.11. Lulu Press. ISBN 978-0-557-65817-6.
- Mueller, S. T. (2010). A partial implementation of the BICA cognitive decathlon using the Psychology Experiment Building Language (PEBL). *International Journal of Machine Consciousness*, 2, 273-288.

Mueller, S. T., & Piper, B. J. (2014). The Psychology Experiment Building Language (PEBL) and PEBL Test Battery. *Journal of Neuroscience Methods*, (222), 250–259.

Mueller, S. T. (2012). The Psychology Experiment Building Language, Version 0.13.
<http://pebl.sourceforge.net>.

Murray, L. K., Nguyen, A., & Cohen, J. A. (2014). Child sexual abuse. *Child and Adolescent Psychiatric Clinics of North America*, 23(2), 321-337.
10.1016/j.chc.2014.01.003

Mutavi, T., Mathai, M., & Obondo, A. (2017). Post-Traumatic Stress Disorder (PTSD) in Sexually Abused Children and Educational Status in Kenya: A Longitudinal Study. *Journal of Child & Adolescent Behaviour*. 5(5):357. 10.4172/2375-4494.1000357.

Nanni, V., Uher, R. & Danese, A. (2012). Childhood maltreatment predicts unfavorable course of illness and treatment outcome in depression: A meta-analysis. *American Journal of Psychiatry*, 169, 141–151.

National Census (2011) Results for Greater Manchester. <https://www.gmcvo.org.uk/census-2011-ethnicity-greater-manchester>

National Center on Child Abuse and Neglect. (2007). *National Incidence Study of Child Abuse and Neglect*. US Department of Health and Human Services.

National Child Traumatic Stress Network. (2008, March). Child welfare trauma training toolkit: The essential elements of trauma-informed child welfare practice.
http://www.nctsn.org/nctsn_assets/pdfs/CWT3_CompGuide.pdf

National Collaborating Centre for Methods and Tools: NCCMT (2017) Video.
<http://www.nccmt.ca/capacity-development/videos>

National Crime Agency (2020).
<http://www.nationalcrimeagency.gov.uk/news/onlinesafetyathome>

National Health Service (NHS) England IAPT Manual, Appendix D, Online. (2018). NHS England. <https://www.england.nhs.uk/wp-content/uploads/2018/06/iapt-manual-resources-v2.pdf>

National Health Service (NHS) England IAPT Manual (2015) *2014 Adult IAPT Workforce Census Report*. Available at: <http://www.iapt.nhs.uk/silo/files/2014-adult-iapt-workforce-census-report.pdf>

National Health Service 'NHS' England and NHS Improvement Website (2021) [NHS England » Digital therapy selection](#)

National Health Service (NHS) Safeguarding Adults and Children Training (attended 02/08/18) Greater Manchester Mental Health Trust. Prestwich Mental Health Hospital

National Institute for Health and Care Excellence (NICE, 2021): 2.1 Stepped Care. <https://www.nice.org.uk/guidance/cg123/chapter/1-Guidance#stepped-care>

National Institute for Health and Care Excellence (NICE) Clinical guideline [CG26] (2005) Post-traumatic Stress Disorder: Management. <https://www.nice.org.uk/guidance/cg26>

National Institute for Health and Clinical Excellence. (2005). *Post-traumatic stress disorder (PTSD)*. London: Author.

National Institute for Health and Care Excellence (2009) Depression in adults. <http://www.nice.org.uk/guidance/index.jsp?action=download&o=45958>

National Institute for Health and Care Excellence (NICE), PTSD Guidance GID-NG10013 (June 2018). <https://www.nice.org.uk/guidance/indevelopment/gid-ng10013/documents>

National Institute for Health and Care Excellence (NICE), PTSD Guidance GID-NG116. (05 December 2018).

<https://www.nice.org.uk/guidance/ng116/chapter/Recommendations>

National Research Council and Institute of Medicine (NICIM) (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. National Academy Press.

Nemeroff, C. B., Weinberger, D., Rutter, M., MacMillan, L. H., Bryant, A. R., Wessely, S... et al. (2013). DSM-5: a collection of psychiatrist views on the changes, controversies, and future directions. *BMC Medicine*. 11:202. 10.1186/1741-7015-11-202

Nevid, J. S., Rathus, S. A., & Greene, B. (2008). *Abnormal psychology in a changing world* (7th ed.). Pearson Education.

NHS Digital. (2016) Psychological therapies: annual report on the use of IAPT services. <http://content.digital.nhs.uk/pubs/psycther1516>.

NHS Digital (2018-19). Improving access to psychological therapies data set reports - NHS Digital Access data from the IAPT data set - NHS Digital

Nieuwenhuis, S., Elzinga, B. M., Ras, P. H., Berends, F., Duijs, P., Samara, Z., Slagter, H. A. et al. (2013). Bilateral saccadic eye movements and tactile stimulation, but not auditory stimulation, enhance memory retrieval. *Brain Cognition*. 81, 52–56. 10.1016/j.bandc.2012.10.003

Nijdam, M.J., Gersons, B.P.R., Reitsma J.B., De Jongh, A. & Olf, M. (2012). Brief Eclectic Psychotherapy versus eye movement desensitization and reprocessing therapy in the treatment of posttraumatic stress disorder: randomized clinical trial. *British Journal of Psychiatry*, 200, 224–231.

Noel, S., Dogaru, C., & Ellis, F. (2015). *Hear Me. Believe Me. Respect Me. Focus on Survivors. Survivors in Transition.* University Campus Suffolk.

Noël, X., Bechara, A., Dan, B., Hanak, C., & Verbanck, P. (2007) Response inhibition deficit is involved in poor decision making under risk in nonamnesic individuals with alcoholism. *Neuropsychology*. 21:778. 10.1037/0894-4105.21.6.778.

Norcross, J.C. (2012). *Changeology: 5 Steps to Realizing Your Goals and Resolutions.* Simon & Schuster

Norcross, J.C. & Lambert, M.J. (2011). Evidence-based therapy relationships. In J.C. Norcross (Ed.), *Therapy relationships that work: evidence-based responsiveness.* (2nd. ed.). 3-24. Oxford University Press Inc.

Norcross, J. C. & Wampold, B.E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy*, 48(1):98-102.

Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The longterm health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLOS Medicine*, 9(11), 10.1371/journal.pmed.1001349

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*. <https://doi.org/10.1177/1609406917733847>

NSPCC. (2018). *The courage to talk: Childline annual review 2017/18.* NSPCC.

NSPCC Reading. (2019). *Statistics Briefing: Child Sexual Abuse.*
Statistics briefing: child sexual abuse ([nspcc.org.uk](https://www.nspcc.org.uk))

- O'Driscoll, G. A., Strakowski, S. M., Alpert, N. M., Matthysse, S. W., Rauch, S. L., Levy, D. L., et al. (1998). Differences in cerebral activation during smooth pursuit and saccadic eye movements using positron-emission tomography. *Biology. Psychiatry* 44, 685–689. 10.1016/S0006-3223(98)00047-X
- Øktedalen, T., Hagtvet, K.A., Hoffart, A. et al. (2014) *Journal of Psychopathology and Behavioral Assessment*. 36: 600. <https://doi.org/10.1007/s10862-014-9422-5>
- Oliveira, A., Sousa, D. & Pires, A.P. (2012). Significant events in existential psychotherapy: the client's perspective. *Existential Analysis* 23(2), 288-304.
- Ollendick, T. H. (1983). Reliability and validity of the Revised Fear Survey Schedule for Children (FSSC-R). *Behaviour Research and Therapy*, 21, 685-692.
- Ombok, C. A., Obondo, A., Kangethe, R., & Atwoli, L. (2013). The Prevalence of Post-traumatic Stress Disorder among Sexually Abused Children at Kenyatta National Hospital in airobi, Kenya. *East African Medical Journal*. 90(10):332-7.
- Omylinska -Thurston, J., & Cooper, M. (2014). Helpful processes in psychological therapy for patients with primary cancers: a qualitative interview study. *Counselling and Psychotherapy Research*, 14(2), 84-92.
- Onwuegbuzie, A. J., and Johnson, B. (2006). The validity issues in mixed research. *Research in Schools*, 13 (1), 48-63.
- Oren, E. & Solomon, R. (2012). EMDR therapy. *Revue européenne de psychologie appliquée; An overview of its development and mechanisms of action*. 62, 197–203. Buffalo Center for Trauma and Loss.
- Orr, S. P., Metzger, L. J., & Pitman, R. K. (2002). Psychophysiology of posttraumatic stress disorder. *The Psychiatric Clinics of North America*, 25(2), 271–293.

- Osborn, M. & Smith, J. A. (1998). The personal experience of chronic benign lower back pain: An interpretative phenomenological analysis. *British Journal of Health Psychology*, 3(1), 65-83.
- Ostacoli L., Carletto S., Cavallo M., Baldomir-Gago P., Di Lorenzo G., Fernandez I., Hofmann A. (2018). Comparison of eye movement desensitization reprocessing and cognitive behavioral therapy as adjunctive treatments for recurrent depression: The European Depression EMDR Network (EDEN) randomized controlled trial. *Frontiers in Psychology*, 9, 74.
- Otte, C., Lenoci, M., Metzler, T. Yehuda, R., Marmar, C. R., & Neylan, T. C. (2005). Hypothalamic-pituitary-adrenal axis activity and sleep in posttraumatic stress disorder. *Neuropsychopharmacology* 30: 1173–1180.
<https://doi.org/10.1038/sj.npp.1300676>
- Owen, J., Wong, J.Y. & Rodolfa, E. (2010). The relationship between clients' conformity to masculine norms and their perceptions of helpful therapist actions. *Journal of Counseling Psychology*, 57 (1), 68-78. 10.1037/a0017870
- Ozer, E. J., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin*, 129, 52–73.
- Page, M, J., Moher, D., Bossuyt, P, M., Boutron, I., Hoffmann, T, C., Mulrow, C, D., et al. (2020) PRISMA: Explanation and Elaboration: Updated Guidance and Exemplars for Reporting Systematic Reviews *BMJ* 2021; 372:n160 10.1136/bmj.n160
- Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., and Moher, D. (2021). Updating guidance for reporting

systematic reviews: development of the PRISMA 2020 statement. *Journal of Clinical Epidemiology*, 134, 103-112.

Pagel, F. (2000). Nightmares and disorders of dreaming. *American Family Physician*. 61: 2037–2042.

Panksepp, J. (2013) The Emotional Foundation of Mind. *The International Journal of Neuropsychotherapy (IJNPT)*. 1:2. *The Neuropsychotherapist*.

Panksepp, J., & Biven, L. (2012). *The archaeology of mind: Neuroevolutionary origins of human emotion*. W. W. Norton & Company.

Palmer, S. C., Kagee, A., Coyne, J. C., & DeMichele, A. (2004). Experience of trauma, distress, and posttraumatic stress disorder among breast cancer patients. *Psychosomatic Medicine*, 66, 258–264.

Paquola, C., Bennett, M., Hatton, S., Hermens, D., Groote, I., Lagopoulos, J. (2017) Hippocampal development in youth with a history of childhood maltreatment. *Journal of Psychiatric Research*, 91:149-155

Paquola, C., Bennett, M., & Lagopoulos, J. (2016). Understanding heterogeneity in grey matter research of adults with childhood maltreatment—A meta-analysis and review. *Neuroscience & Bio-behavioral Reviews*, 69:299-312

Parahoo, K. (1997). *Nursing Research: Principles, process and issues*. Macmillan.

Parnell, L. (2013). *Attachment-focused EMDR: Healing relational trauma*. W.W. Norton & Company.

Paterson, C, M. (OBE, PhD, DclinPsych, Cpsychol, AFBPsS, EMDR Europe Accredited Senior Trainer) (22/09/18) Masterclass; Healing Complex Trauma and Dissociation with Ego State Therapy and EMDR. TMR Health Professionals and Training Ltd.

Paterson, C, M. (OBE, PhD, DclinPsych, Cpsychol, AFBPsS, EMDR Europe Accredited Senior Trainer) (01/12/18) Masterclass; EMDR therapy in the treatment of chronic pain, depression and adults abused as children. TMR Health Professionals and Training Ltd.

Paterson, C, M. (OBE, PhD, DclinPsych, Cpsychol, AFBPsS, EMDR Europe Accredited Senior Trainer) (30/11/19) Masterclass; Enhance your EMDR Therapy Practice. TMR Health Professionals and Training Ltd.

Paul, G. L. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting Psychology*, 31:109–118.

Paulson, B.L., Everall, R.D. & Stuart, J. (2001). Client perceptions of hindering experiences in counselling. *Counselling and Psychotherapy Research*, 1 (1), 53-61.

Paylor, S, & Royal, C (2016) Assessing the Effectiveness of EMDR in the Treatment of Sexual Trauma. The Practitioner Scholar: *Journal of Counseling and Professional Psychology*. 5(1)

PCL5-C Scale (2013) In Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for *DSM-5* (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov.
<https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>)

Pearce, P., Sewell, R., Hill, A. & Coles, H. (2012). Counselling for depression. *Therapy Today*, 23(1), 20-23.

- Pearson: Clinical Psychology. (Original archived 13 May 2016) Symptom Checklist-90-Revised". Pearson Education, Inc.
- Perepletchikova, F., & Kazdin, A. E. (2005). Treatment integrity and therapeutic change: issues and research recommendations. *Clinical Psychology-Science and Practice*; 12(4). <https://doi.org/10.1093/clipsy.bpi045>
- Perren, S., & Robinson, L. (2010). Improving access, supporting choice. *Therapy Today*, 21(1), 24-27.
- Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. *Journal of Loss and Trauma*, 14(4), 240-255. 10.1080/15325020903004350
- Perry, B. D., Pollard, R., Blakely, T., Baker, W., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and 'use-dependent' development of the brain: how "states" become "traits". *Infant Mental Health Journal*, 16 (4): 271-291
- Piccinelli, M., & Wilkinson, G. (1994). Outcome of depression in psychiatric settings. *The British Journal of Psychiatry*, 164, 297-304.
- Pineles, S. L., Shipherd, J. C., Mostoufia, S. M., Abramovitz, S. M., & Yovelc, I. (2009). Attentional biases in PTSD: More evidence for interference. *Behaviour Research and Therapy*, 47, 1050–1057. 10.1016/j.brat.2009.08.001
- Pitman, R. K., Rasmusson, A. M., Koenen, K. C., Shin, L. M., Orr, S. P., Gilbertson, M. W., & Liberzon, I. (2012). Biological studies of posttraumatic stress disorder. *Nature Reviews. Neuroscience*, 13(11), 769–787. <http://dx.doi.org/10.1038/nrn3339>
- Platt, H. (2011). Fighting for professional survival. *The Psychotherapist*, 48, 29-32.

- Platt, M. (2012). Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists, by S. Boon, K. Steele, and O. van der Hart, *Journal of Trauma & Dissociation*, 13:3, 380-382, 10.1080/15299732.2011.641208
- Polak, A. R., Witteveen, A. B., Reitsma, J. B., & Olf, M. (2012). The role of executive function in posttraumatic stress disorder: A systematic review. *Journal of Affective Disorders*, 141, 11–21. 10.1016/j.jad.2012.01.001
- Polit, D. F., & Hungler, B. P. (1995). *Nursing research: principles and methods*. Lippincott.
- Polit, D. F., & Hungler, B. P. (2000). *Essentials of Nursing Research: Study Guide to Accompany Fifth Edition: Methods, Appraisal and Utilization*. Lippincott.
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: a primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126-136
- Pope, A. (2013). The depths of depression. *Therapy Today*, 24(6), 26-29.
- Rodenburg, R., Benjamin, A., de Roos, et al. (2009). Efficacy of EMDR in children: A meta-analysis. *Clinical Psychology Review*, 29, 599–606.
- Porges, S. W. (2001). The Polyvagal Theory: Phylogenetic substrates of a social nervous system. *International Journal of Psychophysiology*, 42, 123–146. 10.1016/S0167-8760(01)00162-3
- Porges, S. W. (2009). The polyvagal theory: New insights into adaptive reactions of the autonomic nervous system. *Cleveland Clinic Journal of Medicine*, 76(Suppl 2), S86–S90. 10.3949/ccjm.76.s2.17
- Porta, M. (2008). *A dictionary of epidemiology* / edited for the International Epidemiological Association. (5th ed.). Oxford University Press; p. 33.

- Porter, C., Lawson, J. S., & Bigler, E. D. (2005). Neurobehavioral sequelae of child sexual abuse. *Child Neuropsychology*, 11, 203-220.
- Posner, M. I., & Petersen, S. E. (1990). The attention system of the human brain. *Annual Review of Neuroscience*, 13, 25–42. 10.1146/annurev.ne.13.030190.000325
- Power, K., McGoldrick, T., Brown, K., Buchanan, R., Sharp, D., Swanson, V., et al. (2002). A controlled comparison of eye movement desensitization and reprocessing versus exposure plus cognitive restructuring versus waiting list in the treatment of post-traumatic stress disorder. *Clinical Psychology and Psychotherapy*, 9, 299–318.
- Power, R. (2001). Checklists for improving rigour in qualitative research: never mind the tail (checklist), check out the dog (research). British Medical Association; BJM Publishing Group, 323,514-515.
- PRISMA Guidance (2017) <http://www.prisma-statement.org/>
- Proctor, G. (2015). The NHS in 2015. *Therapy Today*, 26(9), 19-25.
- Propper, R. & Christman, S. (2008). Interhemispheric interaction and saccadic horizontal eye movements. Implications for episodic memory, EMDR, and PTSD. *Journal of EMDR Practice and Research*, 4, 269–281.
- Propper, R. E., Pierce, J., Geisler, M. W., Christman, S. D., and Bellorado, N. (2007). Effect of bilateral eye movements on frontal interhemispheric gamma EEG coherence: implications for EMDR therapy. *Journal of Nervous and Mental Disease*. 195, 785–788. 10.1097/NMD.0b013e318142cf73
- Putnam, F. W. (2003) Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry*. 42:269–278.

Raab, D. (Foreign Secretary) (16/04/20), The Daily No.10 COVID-19 Briefings. COVID-19 'Lockdown' rules extended

Raboni, M. R., Tufik, S. & Suchecki, D. (2006). Treatment of PTSD by Eye Movement Desensitization Reprocessing (EMDR) Improves Sleep Quality, Quality of life, and Perception of Stress. *Annals of the New York Academy of Sciences*, 1071: 508-513. 10.1196/annals.1364.054

Radford, L. Corral, S., Bradley, C., Fisher, H., B., Howat, N & Collishaw, S (2011) Child abuse and neglect in the UK today. NSPCC.

Rafiq, S., Campodonico, C., & Varese, F. (Dec 2018). The relationship between childhood adversities and dissociation in severe mental illness: a meta-analytic review. *Scandinavian Peer-reviewed Medical Journal*. 138(6):509-525. 10.1111/acps.12969. Epub

Raphael, K. (1987). Recall bias: a proposal for assessment and control. *International Journal of Epidemiology*, 16(2): 167- 170.

Ray, A., & Zbik, A. (2001). Cognitive behavioral therapies and beyond. In C. Tollison, J. Satterhwaite & J. Tollison (Eds.) *Practical pain management* (3rd edn) 189–208.

Reardon, M.L., Cukrowicz, K.C., Reeves, M.D. & Joiner, T.E. (2002). Duration and regularity of therapy attendance as predictors of treatment outcome in an adult outpatient population. *Psychotherapy Research*, 12(3): 273-285.

Reed, G. M. (2010) Toward ICD-11: improving the clinical utility of WHO's international classification of mental disorders. *Professional Psychological Res Practice*; 41: 457.

Reiners, G.M. (2012). Understanding the differences between Husserl's (Descriptive) and Heidegger's (Interpretive) phenomenological research. *Nursing & Care*, 1(5), 1-3. 10.4172/2167-1168.1000119

- Reis, B. F. & Brown, L. G. (2006). Preventing therapy dropout in the real world: the clinical utility of videotape preparation and client estimate of treatment duration. *Professional Psychology: Research and Practice*, 37:311–316.
- Reisman, M. (2016). PTSD Treatment for Veterans: What's Working, What's New, and What's Next. *P & T: a peer-reviewed journal for formulary management*, 41(10), 623–634.
- Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology*, 41(4), 427-437.
- Rennie, D. L. (2001) The client as a self-aware agent in counselling and psychotherapy. *Counselling and Psychotherapy Research: Linking research with practice*, 1(2), 82-89. 10.1080/14733140112331385118
- Resick, P. A. (2004, November). Beyond cognitive processing: A reconceptualization of posttrauma pathology. Presidential address presented at the annual meeting of the Association for Advancement of Behavior Therapy.
- Rethlefsen, M. L., Kirtley, S., Waffenschmidt, S., Ayala, A. P., Moher, D., Page, M. J., & Koffel, J. B. (2021). PRISMA-S: an extension to the PRISMA statement for reporting literature searches in systematic reviews. *Systematic reviews*, 10(1), 1-19.
- Reynolds, M., & Brewin, C. R. (1998). Intrusive cognitions, coping strategies and emotional responses in depression, post-traumatic stress disorder, and a nonclinical population. *Behaviour Research and Therapy*, 36, 135–147.
- Riach, K. (2009). Exploring participant-centred reflexivity in the research interview. *Sociology*, 43(2), 356–370. 10.1177/0038038508101170

- Ricoeur, P. (1976). *Interpretation theory: Discourse and the surplus of meaning*. Christian University Press.
- Ridgely, S.M., Lambert, D., Goodman, A., Chichester, C.S. & Ralph, R. (1998). Inter-agency collaboration in services for people with co-occurring mental illness and substance use disorder. *Psychiatric Services*, 49(2), 236–238.
- Riede, E. (2018) 'Therapists' Perceptions of Eye Movement Desensitization and Reprocessing Treatment for Women Survivors of Child Sexual Abuse.', *Therapists' Perceptions of Eye Movement Desensitization & Reprocessing Treatment for Women Survivors of Child Sexual Abuse*. Walden University.
- Ringel, S. (2014) 'An Intergartive Model in Trauma Treatment: Utilizing Eye Movement Desensitization and Reprocessing and a Relational Approach With Adult Survivors of Sexual Abuse.' *Psychoanalytic Psychology* by the American Psychological Association: University of Maryland, 31(1), 134–144. 10.1037/a0030044.
- Risch, N., Herrell, R., Lehner, T., Liang, K. Y., Eaves, L., Hoh, L., & Merikangas. K. R. (2009) Interaction between the serotonin transporter gene (5-HTTLPR), stressful life events, and risk of depression: a meta-analysis [published correction appears in JAMA. 302(5):492]. *JAMA*. 2009;301(23):2462-2471. 10.1001/jama.2009.878
- Roemer, L., Orsillo, S. M., Borkovec, T. D., & Litz, B. T. (1998). Emotional response at the time of a potentially traumatizing event and PTSD symptomatology: A preliminary retrospective analysis of the DSM-IV criterion A-2. *Journal of Behavior Therapy*, 29, 123–130.
- Rogers, C. (1942). *Counseling and Psychotherapy: Newer Concepts in Practice*. Boston; New York: Houghton Mifflin Company.
- Rogers, S., Silver, S., Goss, J., Obenchain, J., Willis, A., & Whitney, R. (1999). A single session, group study of exposure and eye movement desensitization and

reprocessing in treating posttraumatic stress disorder among Vietnam War Veterans: Preliminary data. *Journal of Anxiety Disorders*, 13, 119–130.

Rogers, S., & Silver, S. M. (2002). Is EMDR an exposure therapy? A review of trauma protocols. *Journal of Clinical Psychology*, 58, 43–59.

Rose, D. (2013) 'SI: Patient and Public Involvement in Health Research: Ethical Imperative and/or Radical Challenge?' *Journal of Health Psychology*, 1-10

Rose, S., Bisson, J., Churchill, R., & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*. (2) 10.1002/14651858.CD000560.

Rosen, G. M., & Lilienfeld, S. O. (2008). Posttraumatic stress disorder: An empirical evaluation of core assumptions. *Clinical Psychology Review*, 28, 837–868.

Rosen, G. M., Spitzer, R. L., & McHugh, P. R. (2008). Problems with the post-traumatic stress disorder diagnosis and its future in DSM-V. *British Journal of Psychiatry*, 192, 3–4.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press. Rosenberg Self-Esteem Scale.
http://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/Self_Measures_for_Self-Esteem_ROSENBERG_SELF-ESTEEM.pdf fetzer.org

Rosenthal, R. (1966). *Experimenter effects in behavioural research*. Appelton-Century-Crofts

Ross, J. (2004). *Ways of Approaching Research: Qualitative Designs*.
<http://www.fortunecity.com/greenfield/grizzly/432/rra3/htm>

Ross, R., Ball, W.A., Sullivan, K., & Caroff, S. (1989). Sleep disturbance as the hallmark of posttraumatic stress disorder. *The American Journal of Psychiatry*, 146 6, 697-707. 10.1176/AJP.146.6.697

Rothbaum, B. O. (1997). 'A controlled study of eye movement desensitization and reprocessing in the treatment of posttraumatic stress disorder sexual assault victims', *Bulletin of The Menninger Clinic*, 61(3), 317–334.
<http://search.ebscohost.com.salford.idm.oclc.org/login.aspx?direct=true&db=cmedm&AN=9260344&site=ehost-live>

Rothbaum, B. O., Astin, M. C., & Marsteller, F. (2005). Prolonged Exposure versus Eye Movement Desensitization and Reprocessing (EMDR) for PTSD rape victims. *Journal of Traumatic Stress*, 18(6), 614.

Rothschild, B. (2011) *Trauma Essentials; The go-to Guide*. WW Norton & Co Books. ISBN 978-0-393-70620-8

Rothschild, B. (2011) *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*. WW Norton & Co Books

Rousseau, P. F., El Khoury-Malhame, M., Reynaud, E., Zendjidjian, X., Samuelian, J. C., Khalfa, S (2019) Neurobiological correlates of EMDR therapy effect in PTSD. *European Journal of Trauma & Dissociation*, 3(2), 103-111

Royal College of Psychiatrists 'RCP' (2011). *National audit of psychological therapies for anxiety and depression, national report*.

Rushworth, M. F. S. (2008). Intention, choice, and the medial frontal cortex. *Annals of the New York Academy of Sciences*, 1124, 181–207. <http://dx.doi.org/10.1196/annals>.

Sack, M., Lempa, W., & Lamprecht, F. (2001). Metaanalyse de studien zur EMDR-behandlung von patienten mit posttraumatischen belastungsstörungen: Der einfluss der studienqualität auf die effekstärken [Metaanalyses of studies of EMDR

treatment of patients with posttraumatic stress disorder: The influence of study quality of effect sizes]. *Psychotherapie Psychosomatik Medizinische Psychologie*, 51, 350–355.

Sailer, U., Robinson, S., Fischmeister, F. P. S., König, D., Oppenauer, C., Lueger-Schuster, B., & Bauer, H. (2008). Altered reward processing in the nucleus accumbens and mesial prefrontal cortex of patients with posttraumatic stress disorder. *Neuropsychologia*, 46(11), 2836–2844.
<http://dx.doi.org/10.1016/j.neuropsychologia>.

Salkovskis, P. & Wolpert, L. (2012). Does psychoanalysis have a valuable place in modern mental health services? *British Medical Journal*, 344, e1188.
dx.doi.org/10.1136/bmj.e1188

SAMHSA Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)
Trauma and Justice Strategic Initiative.

[SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach](#)

Sanders, D., & Ten Broeke, E. (2011). EMDR bij de behandeling van een negatief zelfbeeld. *Psychopraktijk* 3, 19–22. 10.1007/s13170-011-0039-z

Sanders, P. & Hill, A. (2014). *Counselling for depression: a person-centred and experiential approach to practice*. Sage.

Sartori, J. (2011). IAPT and its limits. *Therapy Today*, 22(8), 35.

Sawyer, G. K., Futa, K. T., Hecht, D. B., & Hansen, D. J. (2004). *Manual for the Weekly Problems Scales: Parent and Child Versions*. Lincoln, NE: University of Nebraska-Lincoln Department of Psychology.

- Sawyer, G. K., Tsao, E. H., Hansen, D. J., & Flood, M. F. (2006) Weekly Problems Scales: Instruments for Sexually Abused Youth and Their Nonoffending Parents in Treatment. *Child Maltreatment*. 11(1):34-48. 10.1177/1077559505283550
- Schäfer, I., Chuey-Ferrer, L., Hofmann, A., Lieberman, P., Mainusch, G., & Lotzin, A. (2017). Effectiveness of EMDR in patients with substance use disorder and comorbid PTSD: study protocol for a randomized controlled trial. *BMC Psychiatry*. 17(1): 95. 10.1186/s12888-017-1255-9.
- Scher, C. D., Forde, D. R., McQuaid, J. R., & Stein, M. B. (2004). Prevalence and demographic correlates of childhood maltreatment in an adult community sample. *Child Abuse Neglect*. 28:167–180.
- Schmitt, W. A., Brinkley, C. A., & Newman, J. P. (1999). Testing Damasio's somatic marker hypothesis with psychopathic individuals: Risk takers or risk averse?. *Journal of Abnormal Psychology*, 3, 538–543.
- Schnyder, U., Ehlers, A., Elbert, T., Foa, E. B., Berthold, P. R., Resick, P. A, ... Cloitre, M. (2015) Psychotherapies for PTSD: what do they have in common. *European Journal of Psychotraumatology*, 6 (1), 28186, 10.3402/ejpt.v6.28186
- Schubert, S., & Lee, C. W. (2009). Adult PTSD and its treatment with EMDR: A review of controversies, evidence, and theoretical knowledge. *Journal of EMDR Practice and Research*, 3(3), 117-132.
- Schulz, K. F., Chalmers, I., Hayes, R. J., & Altman, D. G., (1995) Empirical evidence of bias. Dimensions of methodological quality associated with estimates of treatment effects in controlled trials. *JAMA*; 273: 408-412.
- Schupp, H., Cuthbert, B., Bradley, M., Hillman, C., Hamm, A., & Lang, P. (2004). Brain processes in emotional perception: Motivated attention. *Cognition & Emotion*, 18, 593–611.

- Schupp, H., Fleisch, T., Stockburger, J., & Junghofer, M. (2006). Emotion and attention: Event-related brain potential studies. *Understanding Emotions*, 156, 31–51.
- Schwabe, L., Nader, K., & Pruessner, J. C. (2014). Reconsolidation of human memory: brain mechanisms and clinical relevance. *Biological Psychiatry*, 76(4):274-80. 10.1016/j.biopsych.2014.03.008.
- Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: interpretivism, hermeneutics and social construction. In Denzin, N.K. & Lincoln, Y.S. (Eds.). *Handbook of qualitative research. (2nd ed.)*. (190-193). Sage.
- Schwarz, J. E., Baber, D., Barter, A., & Dorfman, K. (2020). A mixed methods evaluation of EMDR for treating female survivors of sexual and domestic violence. *Counseling Outcome Research and Evaluation*, 11(1), 4-18.
- Schwartz, E. D., & Perry, B. D. (1994) The post-traumatic stress response in children and adolescents. *Psychiatric Clinics of North America*, 17, 311-326.
- Scott, H. (2010). The medical model: the right approach to service provision? *Mental Health Practice*, 13(5), 27-30.
- Scott, J. C., Matt, G.E., Wrocklage, K.M., Crnich, C., Jordan, J., Southwick, S.M., Schweinsburg, B.C. (2015). A quantitative meta-analysis of neurocognitive functioning in posttraumatic stress disorder. *Psychology Bulletin*. 141 (1), 105–140, <http://dx.doi.org/10.1037/a0038039>.
- Scott, M. J. (2018). Improving Access to Psychological Therapies (IAPT) - The Need for Radical Reform. *Journal of Health Psychology*. 2018;23(9):1136-1147. 10.1177/1359105318755264

- Seidler, G. H., and Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study. *Psychological Medicine*, 36, 1515. [10.1017/S0033291706007963](https://doi.org/10.1017/S0033291706007963)
- Shadish, W.R., Cook T.D., and Campbell, D.T. (2002). *Experimental and quasi-experimental designs for generalised causal inference*.
- Shah, P. & Mountain. D. (2007). The medical model is dead - long live the medical model. *The British Journal of Psychiatry*, 191, 375- 377.
- Shahar, G., Noyman, G., Schnidel-Allon, I., & Gilboa-Schechtman, E. (2013). Do PTSD symptoms and trauma-related cognitions about the self constitute a vicious cycle? Evidence for both cognitive vulnerability and scarring models. *Psychiatry Research*, 205(1–2), 79–84. <http://dx.doi.org/10.1016/j.psychres.2012.07.053>
- Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, 2(2), 199-223., 2001
- Shapiro, F. (1989). Eye movement desensitization: a new treatment for posttraumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 20, 211–217.
- Shapiro, F. (1989). Eye movement desensitization. *Journal of Behavior Therapy and Experimental Psychiatry*, 20, 211–217.
- Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd edn). Guilford Press.
- Shapiro, F. (2001) EMDR protocol. <http://www.emdria.org/?120>

Shapiro, F. (2005). *Desensibilización y Reprocesamiento Por Movimiento Ocular*, 2nd Edn. Pax.

Shapiro, F. (2007). EMDR, adaptive information processing, and case conceptualization. *Journal of EMDR Practice and Research*, 1, 68–87.

Shapiro, F. (2009). *EMDR Solutions II*. Norton.

Shapiro F. (2012). *Getting past your past*. Rodale Inc.

Shapiro, F. (2013). The case: Treating Jared through eye movement desensitization and reprocessing therapy. *Journal of Clinical Psychology*, 69(5), 494-496.

10.1002/jclp.21986

Shapiro, F. (2014). The Role of Eye Movement Desensitization and Reprocessing (EMDR) Therapy in Medicine: Addressing the Psychological and Physical Symptoms Stemming from Adverse Life Experiences. *The Permanente Journal*. 18(1): 71–77.

10.7812/TPP/13-098

Shapiro, F. E. (2002). *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism*. American Psychological Association.

Shapiro, F., & Forrest, M. S. (1997). *Eye Movement Desensitization and Reprocessing: The breakthrough in "eye movement" therapy for overcoming anxiety, stress, and trauma*. Basic Books.

Shapiro, F., & Forrest, S, M. (2004). *EMDR: The Breakthrough Therapy for Anxiety, Stress and Trauma*. BasicBooks. <http://www.perseusbooksgroup.com/perseus-cgi-bin/display/0-465-04301-1>

- Shapiro, F., & Laliotis, D. (2011). EMDR and the Adaptive Information Processing Model: Integrative Treatment and Case Conceptualization. *Clinical Social Work Journal*. 39:191–200. Springer. 39: 191. <https://doi.org/10.1007/s10615-010-0300-7>
- Shapiro, F., & Laliotis, D. (January, 2017). Welcome to the weekend 2 training of the two-part EMDR therapy basic training. EMDR Institute.
- Shapiro, F., & Laliotis, D. (July, 2017). Weekend 1 training manual of the two-part EMDR therapy basic training. EMDR Institute.
- Shields, S. (2015). An Investigation Into EMDR and Imagery Rescripting for PTSD in Adult Survivors of Childhood Sexual Abuse: A Case Series. Murdoch University
- Shinebourne, P. (2011). The theoretical underpinnings of Interpretative Phenomenological Analysis. *Existential Analysis*, 22(1), 16-31.
- Shonkoff, J. P. et al (2008) The Timing and Quality of Early Experiences Combine to Shape Brain Architecture Working Paper 5. Center on the Developing Child, Harvard University.
- Shonkoff, J. P. et al (2014), Excessive Stress Disrupts the Architecture of the Developing Brain Working Paper 3. Center on the Developing Child, Harvard University.
- Shonkoff, J. P. et al (2015) Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience Working Paper 13. Center on the Developing Child, Harvard University.
- Shonkoff, J. P. & Phillips, D. (Eds.). (2000). From neurons to neighborhoods: The science of early childhood development. In National Research Council (U.S.). Committee on Integrating the Science of Early Childhood Development. National Academy Press.
- Sieck, B. C. (2012). Obtaining clinical writing informed consent versus using client disguise and recommendations for practice. *Psychotherapy*, 49(1): 3–11.

Siegel D. J. (1999) *The Developing Mind*. Guilford.

Siegel, D. J. (2007). *The mindful brain*. Norton.

Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: a longitudinal community study. *Child Abuse and Neglect*, 20, 709-723.

Silverstone, P. H., & Salsali M. (2003). Low self-esteem and psychiatric patients: part I- the relationship between low self-esteem and psychiatric diagnosis. *Annals of General Hospital Psychiatry* volume 2, Article number: 2. doi; 10.1186/1475-2832-2-2

Sinanan, A. N. (2015). Trauma and treatment of child sexual abuse. *Journal of Trauma & Treatment*, S4, 1-5. 10.4172/2167-1222.S4-024

Singer, B. & Luborsky, L. (1975). Comparative studies of psychotherapy: is it true that "everybody has won and all must have prizes"? *Archives of General Psychiatry*, 32: 995- 1008.

Simonsen, G. & Cooper, M. (2015). Helpful aspects of bereavement counselling: an interpretative phenomenological analysis. *Counselling and Psychotherapy Research*, 15(2), 119-127.

Smith, H. L., Summers, B. J., Dillon, K. H., & Cogle, J. R. (2016) Is worst-event trauma type related to PTSD symptom presentation and associated features?. *Journal of Anxiety Disorders*. 38:55-61. 10.1016/j.janxdis.2016.01.007

Smith, J. A., Flowers, P. & Larkin, M. (2009) *Interpretative phenomenological analysis: Theory, method and research*. Sage.

- Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J.A. Smith (Ed.). *Qualitative psychology: a practical guide to research methods*.(53-80). Sage.
- Smith, M. E. (2005). Bilateral hippocampal volume reduction in adults with posttraumatic stress disorder: a meta-analysis of structural MRI studies. *Hippocampus*, 15(6), 798–807. <http://dx.doi.org/10.1002/hipo.20102>
- Smith, S. W., Daunic, A. P., & Taylor, G. G. (2007). Treatment fidelity in applied educational research: expanding the adoption and application of measures to ensure evidence-based practice. *Education and Treatment of Children*, 30 (4), 121-134.
- Soberman, G., Greenwald, R. & Rule, D. (2002). A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problems. *Journal of Aggression, Maltreatment, and Trauma*, 6, 217–236.
- Sondergaard, H. P., and Elofsson, U. (2008). Psychophysiological studies of EMDR. *Journal of EMDR Practice and Research*. 2, 282–288. 10.1891/1933-3196.2.4.282
- Sotsky, S.M., Glass, D.R., Shea, M.T., Pilkonis, P.A., Collins, J.F., Elkin, I., Watkins, J.T., Imber, S.D., Leber, W.R., Moyer, J. and Oliveri, M.E. (1991). Patient predictors of response to psychotherapy and pharmacotherapy: findings in the NIMH Treatment of Depression Collaborative Research Program. *American Journal of Psychiatry*, 148, 997-1008.
- Sozda, C. N., Muir, J. J., Springer, U. S., Partovi, D., & Cole, M. A. (2014). Differential learning and memory performance in OEF / OIF veterans for verbal and visual material. *Neuropsychology* 28, 347–352. 10.1037/neu0000043

- Spinhoven, P., Penninx, W. B., van Hemert, M. A., Rooij, M., & Elzinga, M. B., (2014). Comorbidity of PTSD in anxiety and depressive disorders: Prevalence and shared risk factors. *Child Abuse & Neglect*, 38(8), pp 1320-1330
- Spitzer, R. L, et al. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder. 166(10) *Archive of International Medicine*, pp 1092-1097
- Sprang, G. (2001). The Use of Eye Movement Desensitization and Reprocessing (EMDR) in the Treatment of Traumatic Stress and Complicated Mourning: Psychological and Behavioral Outcomes. *Research on Social Work Practice*, 11(3), 300–320.
<https://doi.org/10.1177/104973150101100302>
- Sprenkle, D. & Blow, A. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy*, 30(2), 113–129.
- Stanbury, M. M., Drummond, D., & Lee, W. (2020). Efficiency of EMDR and Prolonged Exposure in Treating Posttraumatic Stress Disorder: A Randomized Trial. *Journal of EMDR Practice and Research*, 14(1), 3.
- Staring, A. B. P., van den Berg, D. P. G., Cath, D. C., Schoorl, M., Engelhard, I. M., and Korrelboom, C.W. (2016). Self-esteem treatment in anxiety: a randomized controlled crossover trial of Eye Movement Desensitization and Reprocessing (EMDR) vs. Competitive Memory Training (COMET) in patients with anxiety disorders. *Behavioural Research and Therapy*. 82, 11–20. 10.1016/j.brat.2016.04.002
- Stein, M. B., Koverola, C., Hanna, C., Torchia, M. G., & McClarty, B. (1997). Hippocampal volume in women victimized by childhood sexual abuse. *Psychological Medicine*, 27(4), 951–959.
- Steingroever H., Wetzels R., Horstmann A., Neumann J., Wagenmakers E.-J. (2013). Performance of healthy participants on the Iowa Gambling Task. *Psychological Assessment*, 25, 180–193. 10.1037/a0029929

- Stephen, S. and Elliott, R. (2011). Developing the adjudicated case study method. *Pragmatic Case Studies in Psychotherapy*, 7(1): 230-241.
- Stickgold, R. (2002). EMDR: A putative neurobiological mechanism of action. *Journal of Clinical Psychology*, 58, 61–75.
- Stickgold, R. (2008). Sleep-Dependent Memory Processing and EMDR Action. *Journal of EMDR Practice and Research*, 2 (4), p. 289 – 299. 10.1891/1933-3196.2.4.289
- Stickgold, R., and Wehrwein, P. (2009). Sleep now, remember later. *Newsweek* 153, 56–57.
- Stiles, W.B. (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research*, 7:122-7.
- Stiles, W.B. (2013). The variables problem and progress in psychotherapy research. *Psychotherapy*, 50 (1), 33-41.
- Stiles, W. B., Barkham, M., Mellor-Clark, J. & Connell, J. (2008). Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies in U.K. primary-care routine practice: replication in a larger sample. *Psychological Medicine*, 38(5), 677-688.
- Stocco, A., Fum, D., & Napoli, A. (2009). Dissociable processes underlying decisions in the Iowa Gambling Task: A new integrative framework. *Behavioral and Brain Functions*, 5, 10.1186/1744-9081-5-1
- Storr, M. (2011). Against RCT's. *Therapy Today*, 22(6).
<http://www.therapytoday.net/article/show/2646/>

- Strigo, I. A., Simmons, A. N., Matthews, S. C., Grimes, E. M., Allard, C. B., Reinhardt, L. E., & Stein, M. B. (2010). Neural correlates of altered pain response in women with posttraumatic stress disorder from intimate partner violence. *Biological Psychiatry*, 68(5), 442–450. <http://dx.doi.org/10.1016/j.biopsych.2010.03.034>
- Sugaya, L., Hasin, D. S., Olfson, M., Lin, K. H., Grant, B. F., & Blanco, C. (2012). Child physical abuse and adult mental health: A national study. *Journal of Traumatic Stress*, 25(4), 384-392. 10.1002/jts.21719
- Suleiman, S. R. (2008). Susan Suleiman responds to Judith Herman. *Women's Studies Quarterly* [H. W. Wilson - SSA], 36(1/2), pp285. 10.1353/wsq.0.0044
- Suzuki, A., Hirota, A., Takasawa, N., & Shigemasu, K. (in press 2003). Application of the somatic marker hypothesis to individual differences in decision making. *Biological Psychiatry*. *Biological Psychology* 65(1):81-8, 10.1016/S0301-0511(03)00093-0
- Swift, J. K., Callahan, J. L., and Vollmer, B. M., (2011). Preferences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (2nd ed. 301-315). Oxford University Press
- Swift, J. K., & Greenberg, R. P. (2014 Sept). A treatment by disorder meta-analysis of dropout from psychotherapy. *Journal of Psychotherapy Integration*. 24(3): pp193-207.
- Swinson, R, P. (2006). *The GAD-7 Scale was Accurate for Diagnosing Generalised Anxiety Disorder*. 11(6) *Evidence Based Medicine*. 11(6):184 10.1136/ebm.11.6.184
- Taber, K. H., Warden, D. L., & Hurley, R. A. (2006). Blast-related traumatic brain injury: what is known? *Journal of Neuropsychiatry and Clinical Neurosciences*, 18(2), 141–145.
- Tackling Child Sexual Abuse Strategy (2021). Tackling Child Sexual Abuse Strategy, pp5 (publishing.service.gov.uk)

- Tait, L., & Lester, H. (2005). Encouraging user involvement in mental health services. *Advances in Psychiatric Treatment*, 11, 168–175.
- Tashakkori, A., & Creswell, J. W. (2007). Editorial: exploring the nature of research questions in mixed methods research. *Journal of Mixed Methods Research*. 2007;1:207–11. 10.1177/1558689807302814
- Taylor, P., Richardson, J., Yeo, A., Marsh, I., Trobe, K. & Pilkington, A. (1995). *Sociology in Focus*. Causeway Press
- Taylor, S., Thordarson, D. S., Maxfield, L., Fedoroff, I. C., Lovell, K., & Ogradnicuk, J. (2003). Comparative efficacy, speed, and adverse affects of three PTSD treatments: Exposure therapy, EMDR, and relaxation training. *Journal of Consulting and Clinical Psychology*, 71, 330–338.
- Telford, R., Beverley, C.A., Cooper, C.L., & Boote, J.D. (2002). Consumer involvement in health research: fact or fiction? *British Journal of Clinical Governance*, 7(2), 92-103.
- Teicher, M. H., Andersen, S., L., Polcari, A., Andersen, C. M., & Navalta, C. P. (2002). Developmental neurobiology of childhood stress and trauma. (2002). *Psychiatric Clinics of North America*, 25, 397-426.
- Teicher, M. H., Samson, J. A., Polcari, A., & Andersen, S, L., (2009) Length of time between onset of childhood sexual abuse and emergence of depression in a young adult sample: a retrospective clinical report. *Journal of Clinical Psychiatry*. 70(5):684-691. 10.4088/jcp.08m04235
- The Improving Access to Psychological Therapies Manual. (June 2018: Updated, March 2019). The National Collaborating Centre for Mental Health. Version number: 2. Mental Health Policy Team, Operations and Information Directorate.

The NHS Long Term Plan (2019) NHS England – UK Government. NHS Long Term Plan »
The NHS Long Term Plan

The Office of National Statistics (2019). Child sexual abuse – Appendix tables - Office for
National Statistics (ons.gov.uk)

The Psychology Experiment Building Language 'PEBL' (2018) Homepage:

<http://pebl.sourceforge.net/>

Library of Tests:

http://pebl.sourceforge.net/wiki/index.php/Main_Page

Publications Citing PEBL: http://pebl.sourceforge.net/wiki/index.php/Publications_by_Year

The Psychological Corporation. (1999). *Wechsler abbreviated scale of intelligence manual*.
Harcourt Brace and Company.

The Royal College of Psychiatrists. (2015) PTSD.

<https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-traumatic-stress-disorder>

Thoits, P. A. (1995). Stress, coping, and social support processes: Where are we? What
next? *Journal of Health and Social Behavior*. 35, 53-79. 10.2307/2626957

Thomaes, K., Dorrepaal, E., Draijer, N. P. J., de Ruiter, M. B., Elzinga, B. M., van Balkom,
A. J., & Veltman, D. J. (2009). Increased activation of the left hippocampus region in
Complex PTSD during encoding and recognition of emotional words: a pilot study.
Psychiatry Research, 171(1), 44–53. <http://dx.doi.org/10.1016/j.psychres.2008.03.003>

Thomas, D. R. (2003). A general inductive approach for qualitative data analysis. School of
Population Health University of Auckland.

Thomas, E (1973) Bias and Therapist Influence in Behavioral Assessment: School of Social
Work and Department of Psychology, The University of Michigan. *Journal of
Behaviour Therapy and Experimental Psychiatry*. Vol. 4, 107-111. Pergamon Press.

- Thompson, J., Bissell, P., Cooper, C., Armitage, C.J. & Barber, R. (2012). Credibility and the 'professionalized' lay expert: reflections on the dilemmas and opportunities of public involvement in health research. *Health, 16*(6), 602–618. 10.1177/1363459312441008
- Tracy, N. (2016, February 26; Updated: 2019, June 5) PTSD Statistics and Facts, Healthy Place. <https://www.healthyplace.com/ptsd-and-stress-disorders/ptsd/ptsd-statistics-and-facts>
- Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry, 16*, 837–851. 10.1177/1077800410383121
- Triscari, M. T., Faraci, P., Catalisano, D., D'Angelo, V., & Urso, V. (2015). Effectiveness of cognitive behavioral therapy integrated with systematic desensitization, cognitive behavioral therapy combined with eye movement desensitization and reprocessing therapy, and cognitive behavioral therapy combined with virtual reality expo. *Neuropsychiatric Disease and Treatment, 11*, 2591–2598. 10.2147/NDT.S93401
- Tobin, G. A., Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*, 388–396. 10.1111/j.1365-2648.2004.03207.x
- Tomlinson, N. (2013). Payment by results: by what or whose measure? *Journal of Psychological Therapies in Primary Care, 2*(2), 212-222.
- Tompkins, K. A., Swift, J. K., & Callahan, J. L. (2013). Working with clients by incorporating their preferences. *Psychotherapy, 50*(3), 279.

- Tull, M. (2020) The Connection Between PTSD and Suicide. The Connection Between PTSD and Suicide (verywellmind.com)
- Thurmond, V. A. (2001). The point of triangulation. *Journal of Nursing Scholarship*, 33:253–8. 10.1111/j.1547-5069.2001.00253.x
- Ullman, S, E., Filipas, H, H., Townsend, S, M., & Starzynski, L, L., (October 2005) Trauma exposure, posttraumatic stress disorder and problem drinking in sexual assault survivors. *Journal of Studies on Alcohol*. 66(5):610-9. 10.15288/jsa.2005.66.610
- University of Washington. (2018, October 19). PTSD symptoms improve when patient chooses form of treatment. *Science Daily*.
www.sciencedaily.com/releases/2018/10/181019131515.htm
- Valentine, L., & Feinauer, L. L. (1993). Resilience factors associated with female survivors of childhood sexual abuse. *American Journal of Family Therapy*. 21:216–224.
- van den Berg D.P.G., de Bont P.A.J.M., van der Vleugel B.M., De Roos C., De Jongh A., van Minnen, A. van der Gaag M. (2015). Prolonged Exposure versus Eye Movement Desensitization and Reprocessing versus Waiting List for Posttraumatic Stress Disorder in Patients with a Psychotic Disorder: A randomized Clinical Trial. *JAMA Psychiatry*, 72(3):259-267.
- Van den Bulk, B. G., Somerville, L. H., van Hoof, M. J., van Lang, N. D., van der Wee, N. J., Crone, E. A., & Vermeiren, R. R. (2016). Amygdala habituation to emotional faces in adolescents with internalizing disorders, adolescents with childhood sexual abuse related PTSD and healthy adolescents. *Developmental Cognitive Neuroscience*, 21, 15–25. <https://doi.org/10.1016/j.dcn.2016.08.002>
- Van den Hout, M., & Engelhard, I., (2012). How does EMDR work? *Journal of Experimental Psychopathology*. Clinical and Health Psychology, Utrecht University. 3(5), 724–738
ISSN 2043-8087 / 10.5127/jep.028212

- Van den Hout, M.A., Engelhard, I.M., Beetsma, D., Slofstra, C., Hornsveld, H., Houtveen, J., & Leer, A. (2011). EMDR and mindfulness: Eye movements and attentional breathing tax working memory and reduce vividness and emotionality of aversive ideation. *Journal of Behavior Therapy and Experimental Psychiatry*, *42*, 423-431. <http://dx.doi.org/10.1016/j.jbtep.2011.03.004>
- Van den Hout, M., Engelhard, I., Rijkeboer, M. et al. (2011). EMDR: Eye movements superior to beeps in taxing working memory and reducing vividness of recollections. *Behaviour Research and Therapy*, *49*, 92–98.
- Van den Hout, M., Engelhard, I.M., Smeets, M.A.M., Hornsveld, H., Hoogeveen, E., Heer, E. de, ... Rijkeboer, M.M. (2010). Counting during recall: Taxing of working memory and reduced vividness and emotionality of negative memories. *Applied Cognitive Psychology*, *24*, 303-311. <http://dx.doi.org/10.1002/acp.1677>
- Van den Hout, M., Muris, P., Salemink, E., & Kindt, M. (2001). Autobiographical memories become less vivid and emotional after eye movements. *British Journal of Clinical Psychology*, *40*, 121-130. <http://dx.doi.org/10.1348/014466501163571>
- Van Der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Penguin Group.
- van der Kolk, B. A., & McFarlane, A. (1996). The black hole of trauma. In B. A. Van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society*, 3–23. Guilford Press.
- Van der Kolk, B., Spinazzola, J. Blaustein, M., Hopper, J. Hopper, E., Korn, D., & Simpson, W. (2007). A randomized clinical trial of EMDR, fluoxetine and pill placebo in the treatment of PTSD: Treatment effects and long-term maintenance. *Journal of Clinical Psychiatry*, *68*, 37-46.

- van Etten, M. L., & Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis. *Clinical Psychology and Psychotherapy*, 5(3), 126–144. 10.1002/(SICI)1099-0879(199809)
- van Toorenburg,, M.M., Sanches,, S.A., Linders,, B., Rozendaal, L., Voorendonk,, E.M., Van Minnen,A. & De Jongh, A. (24 Feb 2020, in press). Do emotion regulation difficulties affect outcome of intensive trauma-focused treatment of patients with severe PTSD? *European Journal of Psychotraumatology*. 11(1):1724417 10.1080/20008198.2020.1724417
- van Veen, S. C., Engelhard, I. M., & van den Hout, M. A. (2016). The effects of eye movements on emotional memories: using an objective measure of cognitive load. *European Journal of Psychotraumatology*. 7. <https://doi.org/10.3402/ejpt.v7.30122>. Article: 30122
- Van Veen, S. C., van Schie, K., Wijngaards-de Meij, L., Little, M., Engelhard, I., and van den Hout, M. (2015) Speed matters: relationship between speed of eye movements and modification of aversive autobiographical memories. *Frontiers in Psychiatry*. 10.3389/fpsy.2015.00045
- Vasterling, J. J., Proctor, S. P., Amoroso, P., Kane, R., Heeren, T., & White, R. F. (2006). Neuropsychological outcomes of my personnel following deployment to the Iraq war. *JAMA* 296, 519–529. 10.1001/jama.296.22.2679
- Verardo, A. R., & Cioccolanti, E. (2017). EMDR beyond PTSD. Traumatic experiences and EMDR in childhood and adolescence. A review of the scientific literature on efficacy studies. *Clinical Neuropsychiatry*, 14(5), 313-320
- Verbist, I. L. (Verbal Presentation and email 08/03/2019) Caseload Survey: Primary Care Psychological Therapies. Greater Manchester Mental Health Trust: Improving Access to Psychological Therapies Service (Central Manchester, Trafford, Salford, Bolton). Outlook.

- Verbist, I. L. (NHS IAPT Staff Away Day Presentation, 04/12/2019) Staff Survey Results, June 2019. Primary Care Psychological Therapies. Greater Manchester Mental Health Trust: Improving Access to Psychological Therapies Service (Central Manchester, Trafford, Salford, Bolton)
- Vink, M. (2017). PACE trial authors continue to ignore their own null effect. *Journal of Health Psychology*, 22: 1134–1140.
- Vogel, D. L., & Wade, N. G. (2009). Stigma and help-seeking. *The Psychologist*, 22(1), 20-23.
- von Below, C., & Werbart, A. (2012). Dissatisfied psychotherapy patients: A tentative conceptual model grounded in the participants' view. *Psychoanalytic Psychotherapy*, 26(3), 211-229.
- Wagenmans, A., Van Minnen, A., Sleijpen, M., & De Jongh, A. (2018). The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD . *European Journal of Psychotraumatology*, 9(1).
<https://doi.org/10.1080/20008198.2018.1430962>
- Walitzer, K. S., Dermen, K. H. & Connors, G. J. (1999). Strategies for preparing clients for treatment: a review. *Behavior Modification*, 23(1): 129-151.
- Waller, N. G., Putnam, F. W., & Carlson, E. B. (1996). Types of dissociation and dissociative types: A taxometric analysis of Dissociative Experiences. *Psychological Methods*, 1, 300–321.
- Waller, N. G., & Ross, C. A. (1997). The prevalence and biometric structure of pathological dissociation in the general population: Taxometric and behavior genetic findings. *Journal of Abnormal Psychology*, 106, 499–510. DES-T Scale. <http://www.isst-d.org/default.asp?contentID=66>

- Waltz, J., Addis, M., Koerner, K. & Jacobson, N.S. (1993) Testing the Integrity of a Psychotherapy Protocol: Assessment of Adherence and Competence. *Journal of Consulting and Clinical Psychology*, 61, 620-630.
<http://dx.doi.org/10.1037/0022-006X.61.4.620>
- Wampold, B. E. (2012). Humanism as a common factor in psychotherapy. *Psychotherapy*, 49 (4), 445-449. 10.1037/a0027113
- Warne, T. & McAndrew, S. (2010). Re-searching for therapy: the ethics of using what we are skilled in. *Journal of Psychiatric and Mental Health Nursing*, 17, 503–509.
10.1111/j.1365-2850.2009.01545.x
- Watts, B.V. et al. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 74, e541-550.
- Webster, C., Mercer, S., Schrage, J., Carrell, T. W., & Bowley, D. (2011). Indirect colonic injury after military wounding: a case series. *Journal of Trauma*; 71:147–157.
- Weems, C. F., Klabunde, M., Russell, J. D., Reiss, A. L., & Carrión, V. G. (2015). Post-traumatic stress and age variation in amygdala volumes among youth exposed to trauma. *Social Cognitive and Affective Neuroscience*. 1–7, <http://dx.doi.org/10.1093/scan/nsv053>
- Weiss, D. & Marmar, C. (1997). The Impact of Event Scale -Revised. In J. Wilson & T. Keane (Eds), *Assessing psychological trauma and PTSD*. Guildford. Impact of Events Scale-Revised (IES-R). www.aerztenetz-grafschaft.de
<https://www.aerztenetz-grafschaft.de/download/IES-R-englisch-5-stufig.pdf>
- Westen, D., Novotny, C.M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 130(4): 631–663.

- Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). "Predictors of Emotional Exhaustion, Disengagement and Burnout among Improving Access to Psychological Therapies (IAPT) Practitioners." *Journal of Mental Health*. 26.2: 172-79.
<https://files.acrobat.com/a/preview/30e2ba81-d409-438b-bf83-1ab66b813b0e>
- Whitehouse, J. (2019). What do clients say about their experiences of EMDR in the research literature? A systematic review and thematic synthesis of qualitative research papers. *European Journal of Trauma & Dissociation*,
<https://doi.org/10.1016/j.ejtd.2019.03.002>
- Whitty, C. (Chief Medical Officer, UK) (22/04/20). The Daily No.10 COVID-19 Briefings. COVID-19 'Lockdown' may last up to one year.
- Wiebren, M., de Weert-van, Oene, G. H., Woud, M. L., Becker, E. S., & De Jong, C. A. J. (2016). Are addiction-related memories malleable by working memory competition? Transient effects on memory vividness and nicotine craving in a randomized lab experiment. *Journal of Behaviour Therapy and Experimental Psychiatry*. 2016 Sep; 52: 83-91. [10.1016/j.jbtep.2016.03.007](https://doi.org/10.1016/j.jbtep.2016.03.007).
- Widdowson, M. (2013.) The Process and Outcome of Transactional Analysis Psychotherapy for the Treatment of Depression: An Adjudicated Case Series. PhD Counselling and Psychotherapy. University of Leicester
- Widiger, T. A., & Crego, C. (2015) Process and Content of DSM-5. Psychopathology Revision Notes. 2(1): 162-176. DOI 10.5127/PR.035314
- Wiedu, E. (17/06/19). Nvivo 12 Pro Software Workshop; University of Salford. Elizabeth Training: www.elizabethtraining.co.uk. QSR International Pty Ltd.
<https://www.qsrinternational.com/nvivo/nvivo-products/nvivo-12-pro>

- Wiedu, E. (01/05/19). SPSS Software Workshop; University of Salford. Elizabeth Training: www.elizabethtraining.co.uk. IBM SPSS. <https://www.ibm.com/analytics/spss-statistics-software>
- Wijma, K., Soderquist, J., Bjorklund, I., & Wijma, B. (September 2000). Prevalence of Posttraumatic Stress Disorder Among Gynecological Patients with a History of Sexual and Physical Abuse. *Journal of Interpersonal Violence*, 15 (9), 944-958
- Willig, C. (2001). *Introducing qualitative research in psychology: adventures in theory and method*. Maidenhead: Open University Press.
- Willig, C. (2008). *Introducing qualitative research in psychology*. (2nd ed.). Maidenhead: Open University Press
- Willig, C. (2013). *Introducing qualitative research in psychology*. (3rd ed.). Maidenhead: Open University Press
- Wilson, D. L., Silver, M., Covi, W. G., & Foster, S. (September 1996). Eye movement desensitization and reprocessing: effectiveness and autonomic correlates. *Journal of Behavior Therapy and Experimental Psychiatry*. 7(3). 219–229.
[https://doi.org/10.1016/S0005-7916\(96\)00026-2](https://doi.org/10.1016/S0005-7916(96)00026-2)
- Wilson, K. (2009). Neuropsychological Effects of the Traumatic Stress Response in Sexually Abused Adolescents throughout Treatment. *Univeristy of Nebraska, Department of Psychology*.
- Wilson, K., Hansen, J, D., & Li, M. (2011). The traumatic stress response in child maltreatment and resultant neuropsychological effects. *Aggression and Violent Behavior*. 16(2), pp 87-97, ISSN 1359-1789.
<https://doi.org/10.1016/j.avb.2010.12.007>.
<http://www.sciencedirect.com/science/article/pii/S135917891100005X>

- Wilson, K. G., & Groom, J. (2002). *The Valued Living Questionnaire*. Available from Kelly Wilson. Valued Living Questionnaire (VLQ, revised date 4 October 2006)
<https://www.div12.org/wp-content/uploads/2015/06/Valued-Living-Questionnaire.pdf>
www.div12.org
- Wilson, K. G., & Murrell, A. R. (2004). Values work in acceptance and commitment therapy: Setting a course for behavioral treatment. In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive behavioral tradition*, 120-151. Guilford Press.
- Wilson, K. G., Sandoz, E. K., & Kitchens, J. (2010). The Valued Living Questionnaire: Defining and Measuring Valued Action within a Behavioral Framework. University of Mississippi and Miguel Roberts, VA Maryland Healthcare System. *The Psychological Record*. Springer
- Wisdom, J., & Creswell, J. W. (2013). Mixed methods: integrating quantitative and qualitative data collection and analysis while studying patient-centered medical home models. BMJ Publishing Group
- Wisdom, J. P., Cavaleri, M. C., Onwuegbuzie, A. T., Green, C. A. (2011). Methodological reporting in qualitative, quantitative, and mixed methods health services research articles. *Health Services Research*. 47:721–745.
- Wolfe, V. V., Gentile, C., Michienzi, T., Sas, L., & Wolfe, D. A. (1991). The Children's Impact of Traumatic Events Scale: A measure of post-sexual abuse PTSD symptoms. *Behavioral Assessment*, 13, 359-383.
- Wolpe, (1958). *Psychotherapy by reciprocal inhibition*. California: Stanford University Press.
- Wongpakaran, T., & Wongpakaran, N. (2012). A comparison of reliability and construct validity between the original and revised versions of the Rosenberg Self-Esteem Scale. *Psychiatry investigation*, 9(1), 54-8.

Wood, E., Ricketts, T., Parry, G., (2018). EMDR as a treatment for long-term depression: A feasibility study. *Psychology and Psychotherapy: Theory, Research and Practice* 91, 63–78. 10.1111/papt.12145

Woon, F. L., Sood, S., & Hedges, D. W. (2010). Hippocampal volume deficits associated with exposure to psychological trauma and posttraumatic stress disorder in adults: a meta-analysis. *Progress in Neuro-Psychopharmacology & Biological Psychiatry*, 34(7), 1181–1188. <http://dx.doi.org/10.1016/j.pnpbp.2010.06.016>

World Health Organisation 'WHO' Consultation on Child Abuse Prevention (1999) Guidelines for Medico-Legal Care for Victims of Sexual Violence. p.75
https://www.who.int/violence_injury_prevention/resources/publications/en/guidelines_chap7.pdf

World Health Organization (2013). *Guidelines for the management of conditions that are specifically related to stress*. WHO.

World Health Organisation (2016, September 30) Child Maltreatment.
<https://www.who.int/news-room/fact-sheets/detail/child-maltreatment>

World Health Organization (2017). WHO clinical guidelines. *Child maltreatment (child abuse)*. Licence: CC BY-NC-SA 3.0 IGO, World Health Organization.
<http://www.who.int/media-centre/factsheets/fs150/en/>

World Health Organization (2018). *International Statistical Classification of Diseases and Related Health Problems (11th Revision)*.

World Health Organisation, Europe Office (2019) Child Maltreatment.
<http://www.euro.who.int/en/health-topics/disease-prevention/violence-and-injuries/areas-of-work/violence/child-maltreatment>

Woudenberg, C. V., Voorendonk, E. M. Bongaerts, H. A. Zoet, M., Verhagen, C. W., Lee, A., ... De Jongh, A. (2017). Effectiveness of an intensive treatment programme combining prolonged exposure and eye movement desensitization and reprocessing for severe post-traumatic stress disorder, *European Journal of Psychotraumatology*, 9:1, 1487225, 10.1080/20008198.2018.1487225

Wright, L., & Warner, A. (2020). EMDR treatment of childhood sexual abuse for a child molester: self-reported changes in sexual arousal. *Journal of EMDR practice and research*. 14(2). 10.1891/EMDR-D-19-00060

Wurtz, H., El-Khoury-Malhame, M., Wilhelm, F. H., Michael, T., Beetz, E. M., Roques, J., & Herry, C. (2016). Preventing long-lasting fear recovery using bilateral alternating sensory stimulation: A translational study. *Neuroscience*, 321, 222–235. <http://dx.doi.org/10.1016/j.neuroscience.2015.06.012>

Yan, X., Brown, A. D., Lazar, M., Cressman, V. L., Henn-Haase, C., Neylan, T. C., & Marmar, C. R. (2013). Spontaneous brain activity in combat related PTSD. *Neuroscience Letters*, 547, 1–5. <http://dx.doi.org/10.1016/j.neulet.2013.04.032>

Yanow, D., Schwartz-Shea, P. (2006). Interpretation and Method: Empirical Research Methods and the Interpretive Turn.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215-228.

Yehuda, R., Hoge, C.W., McFarlane, A.C., Vermetten, E., Lanius, R.A., Nievergelt, C.M., Hyman, S.E., 2015. Post-traumatic stress disorder. *Nature Reviews Disease Primers*. 1 (10), 1–22, <http://dx.doi.org/10.1038/nrdp.2015.57>

Zaleski, K. L., Johnson, D. K., and Klein, J. T. (2016). Grounding Judith Herman's Trauma Theory within Interpersonal Neuroscience and Evidence-Based Practice Modalities

for Trauma Treatment, *Smith College Studies in Social Work*, 86:4, pp391, 10.1080/00377317.2016.1222110

Zeglin, R. J., DeRaedt, M. R., & Lanthier, R. P. (2015) Does having children moderate the effect of child sexual abuse on depression? *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, 24 (6), 607-626

Zoet, H.A., Wagenmans, A., Van Minnen, A., Sleijpen, M., & De Jongh, A. (2018). Presence of the Dissociative Subtype of PTSD does not moderate the Outcome of Intensive Trauma-Focused Treatment for PTSD. *European Journal of Psychotraumatology*, 9:1, 1468707

Zuroff, D. C., Blatt, S. J., Sotsky, S. M., Krupnick, J. L., Martin, D. J., and Simmens, S. (2000). Relation of therapeutic alliance and perfectionism to outcome in brief outpatient treatment of depression. *Journal of Consulting and Clinical Psychology*, 68: 114–124.

Appendix 1: Database (figure 1) and Snowball (figure 2) Literature Search Results

Figure 1: Database Literature Search Results

	Line 1: EMDR or "Eye Movement Desensitization and Reprocessing" or "Eye Movement Desensitization and Reprocessing"	Line 2 (when searched with line 1): "posttraumatic stress disorder*" or "post- traumatic stress disorder*" or PTSD or "post- traumatic stress" or "posttraumat ic stress" or "posttraumat ic distress" or "post- traumatic distress" or "complex PTSD" or cPTSD or "complex posttraumat ic*" or psychotraum a or trauma	Line 3 (when searched with line 1): "sexual assault" or "sexual trauma" or "sexual violence" or "sexual attack" or "sexual molestat ion" or "sexual violation" or "sex abuse*" or "sexual abuse" or "child abuse" or "childhood abuse" or "childhood sexual abuse" or "sexual harassme nt" or rape or "sexual traumatic* "	Search results include all three lines (and derivative s), published within 10 years
Box of Broadcasts (Date undertaken: 09/10/18)	22	6	0	0
CINAHL (with corresponding search headings)	99	46	5	1

(Date undertaken: 04/10/18)				
Communication & Mass Media Complete	2	0	0	0
(Date undertaken: 07/10/18)				
COPAC	211	50	20	3
(Date undertaken: 07/10/18)				
DawsonEra	49	33	9	3
(Date undertaken: 07/10/18)				
EMBASE (via work library)	87	63	0	0
(Date undertaken: 14/08/18)				
Ebook Central	14	3	0	0
(Date undertaken: 07/10/18)				
EBSCO eBook Collection	14	4	0	0
(Date undertaken: 07/10/18)				
Google Scholar	1729	320	45	14
(Date undertaken: 10/10/18)				
Hathi Trust Digital Library	3	2	0	0
(Date undertaken: 07/10/18)				
Health and Wellness Centre (Gale)	8	4	0	0
(Date undertaken: 07/10/18)				
Highwire Press (via Evidence-Based Mental Health Articles/Journals)	5	4	0	0
(Date undertaken: 07/10/18)				
JSTOR	47	21	3	1
(Date undertaken: 07/10/18)				

<p>MEDLINE (Ovid, with use of MeSH terms) 8 Resources selected as follows; SalfordUniversityJournals@Ovid Journals@Ovid Full Text PsycARTICLES Full Text Books@Ovid AMED (Allied and Complementary Medicine) PsycEXTRA PsycINFO Ovid MEDLINE® and Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Daily and Versions® (Date undertaken: 04/10/18)</p>	1857	586	32	4
<p>Ovid Online 8 Resources selected as follows; SalfordUniversityJournals@Ovid Journals@Ovid Full Text PsycARTICLES Full Text Books@Ovid AMED (Allied and Complementary Medicine) Ovid MEDLINE® and In-Process and Other Non-Indexed Citations Ovid MEDLINE® without Revisions (1946-Sept 2018) Ovid MEDLINE® without Revisions (1996-Oct 2018) Ovid MEDLINE® PsycEXTRA PsycINFO (1906-Oct 2018) PsycINFO (1806-Oct 2018) PsycINFO (2002-Oct 2018) Ovid MEDLINE® and Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Daily and Versions® (1946-Oct 2018) Ovid MEDLINE® and Epub Ahead of Print, In-Process</p>	1922	586	32	4

& Other Non-Indexed Citations and Daily (1946-Oct 2018) Ovid MEDLINE® and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily (2014-Oct 2018) Ovid MEDLINE® and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily without Versions® (2014-Oct 2018) Ovid MEDLINE® and Epub Ahead of Print (Oct 2018) Ovid MEDLINE® (Sept 2018) (Date undertaken: 08/10/18)				
Oxford Reference Online (Date undertaken: 08/10/18)	13	8	4	2
PILOTS Published International Literature On Traumatic Stress (Date undertaken: 08/10/18)	1407	942	140	50
ProQuest Central All 13 databases searched; <u>Art and Architecture Archive</u> Art and Humanities Database Asian and European Business Collection British Nursing Index British Periodicals Early European Books Performing Arts Periodicals Database Periodicals Archive Online ProQuest Central ProQuest Dissertations & Thesis A&I Social Science Premium Collection The Vogue Archive The Vogue Italia Archive	1407	942	14	50

PsycARTICLES full text (abstract search) (Date undertaken: 08/10/18)	59	21	1	1
PsycINFO (abstract search) (Date undertaken: 08/10/18)	1102	288	23	3
SCOPUS (Date undertaken: 13/10/18)	1173	723	110	48
SciELO Citation Index (Date undertaken: 08/10/18)	6	4	0	0
ScienceDirect (Date undertaken: 08/10/18)	71	43	3	0
TRIP Database (Date undertaken: 08/10/18)	124	48	4	3
UK National Statistics (Date undertaken: 08/10/18)	0	0	0	0
University of Salford Institutional Repository (USIR) (Date undertaken: 09/10/18)	4	4	0	0
Web of Science: Core Collection (Date undertaken: 08/10/18)	483	347	25	25
Wiley Online Library (Date undertaken: 09/10/18)	44	31	4	3

Figure 2: Snowball Literature Search Results

Databases	Number of Relevant Extracted Papers (terms searched within all fields, published within 10 years)
Google Scholar (Date undertaken: 14/10/18)	4
SCOPUS (Date undertaken: 13/10/18)	6
Web of Science (Date undertaken: 14/10/18)	12

Appendix 2: Database Search Results of Included Literature

Of 100 studies identified - nine papers met the present reviews inclusion and exclusion criteria as below.

Nine Included Studies
Aranda, B. D. E., Ronquillo, N. M., & Calvillo, M. E. N. (2015). Neuropsychological and physiological outcomes pre- and post-EMDR therapy for a woman with PTSD: A case study. <i>Journal of EMDR Practice and Research</i> , 9(4), 174–187. https://doi.org/10.1891/1933-3196.9.4.174
Edmond, Tonya; Rubin, Allen (2004) Assessing the long-term effects of EMDR: Results from an 18-month follow-up study with adult female survivors of CSA. <i>Journal of Child Sexual Abuse</i> . Vol 13:1. Page 69-86. Taylor & Francis
Gerardi, M. <i>et al.</i> (2010) 'Cortisol Response Following Exposure Treatment for PTSD in Rape Victims', <i>Journal of Aggression, Maltreatment & Trauma</i> , 19(4), pp. 349–356. Available at: https://search.proquest.com/docview/853218785?accountid=8058
Hutchins J and Mason C. (2017) Treating a Sexual Abuse Trauma with Eye Movement Desensitisation and Reprocessing Therapy in an Adult Community Mental Health Team Setting, A Case Series. <i>Psychol Behav Sci Int J</i> ; 6(1): 555676. 10.19080/PBSIJ.2017.06.555676
Ringel, S. (2014) 'AN INTEGRATIVE MODEL IN TRAUMA TREATMENT: Utilizing Eye Movement Desensitization and Reprocessing and a Relational Approach With Adult Survivors of Sexual Abuse.', <i>PSYCHOANAL. PSYCHOL.</i> (C) 2014 by the American Psychological Association: (1)University of Maryland, 31(1), pp. 134–144. 10.1037/a0030044.
Rothbaum, B. O., Astin, M. C., & Marsteller, F. (2005). Prolonged Exposure versus Eye Movement Desensitization and Reprocessing (EMDR) for PTSD rape victims. <i>Journal of Traumatic Stress</i> , 18(6), 607–616. http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med5&NEWS=N&AN=16382428
Shields, S (2015) An Investigation Into EMDR and Imagery Rescripting for PTSD in Adult Survivors of Childhood Sexual Abuse: A Case Series. Murdoch University
Wagenmans, A., Van Minnen, A., Sleijpen, M., & De Jongh, A. (2018). The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD . <i>European Journal of Psychotraumatology</i> , 9(1). https://doi.org/10.1080/20008198.2018.1430962
Woudenberg, C. V., Voorendonk, E. M.; Bongaerts, H. et al. (2017) Effectiveness of an intensive treatment programme combining prolonged exposure and <u>eye movement desensitization and reprocessing</u> for severe <u>post-traumatic stress disorder</u> . <i>EUROPEAN JOURNAL OF PSYCHOTRAUMATOLOGY</i>

Appendix 3: Database Search Results of Excluded Literature

Of 100 studies identified - the following eighty-seven studies were fully excluded in this thesis for the reasons listed below. An additional four papers were identified which were relevant but did not meet the inclusion criteria as they were review/meta-analysis. They were not included in the results section of this review though included in the introduction. Details of all papers can be found below.

Study	Reason for Exclusion
<p>Adler-Tapia, R., Settle, C. and Shapiro, F. (2012) 'Eye Movement Desensitization and Reprocessing (EMDR) psychotherapy with children who have experienced sexual abuse and trauma.', <i>Handbook of child sexual abuse: Identification, assessment, and treatment</i>. Edited by A.-T. Adler-Tapia Bisson, Felitti, Greenwald, Hansen, Jaberghaderi, Jarero, Lovett, Scheck, Shapiro, Shapiro, Shapiro, Tinker. Hoboken, NJ, US: John Wiley & Sons Inc, pp. 229–250. Available at: http://ovidsp.ovid.com/ovidweb.cgi?T=J&PAGE=reference&D=psyc9&NEWS=N&AN=2011-22926-010.</p>	<p>Ebook Chapter examining advice of the 8-phase EMDR protocol, 'Adaptive Information Processing (AIP) Theory,' when working with sexually abused children, not adults</p>
<p>Adler-Tapia, R. & Settle, C. (2017) <i>EMDR and the art of psychotherapy with children: infants to adolescents</i>. 2nd ed. New York. Springer Publishing Company. Held by: British Library: Cardiff Metropolitan University</p>	<p>Ebook treatment guide for when working with 'infants and toddlers, children with intellectual and developmental disabilities, and children in the welfare system,' detailing changes to the 8-phase EMDR protocol alongside alterations to case conceptualization for target identification and organization</p>
<p>Allon, M (2015) <i>EMDR Group Therapy With Women Who Were Sexually Assaulted in the Congo</i>. JOURNAL OF EMDR PRACTICE AND RESEARCH. Volume: 9 Issue: 1 Pages: 28-34</p>	<p>Adult female sample derived from Democratic Republic of the Congo to assist in developing and evaluating a brief psychotherapeutic approach that could be used to effectively treat sexually assaulted women suffering from posttraumatic stress</p>
<p>Anonymous (2010) 'Sayre Elks To Hold Drug Awareness Night', <i>Daily Review</i>, 16 November. Available at: https://search.proquest.com/docview/792974362?accountid=8058.</p>	<p>News article outlining drug awareness</p>
<p>Bains, M. <i>et al.</i> (2018) 'Identifying post-traumatic stress disorder in forced migrants', <i>BMJ: British Medical Journal (Online)</i>. London, United Kingdom</p>	<p>EMDR with a forced migrant</p>

<p>London, London: BMJ Publishing Group LTD, 361. http://dx.doi.org/10.1136/bmj.k1608</p>	
<p>Balbo, M., Zaccagnino, M., Cussino, M et al. (Oct 2017) <u>EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR) AND EATING DISORDERS: A systematic review</u>. <i>Clinical Neuropsychiatry</i>. Vol 14 pgs 321-329</p>	<p>The aim of this study was the use of the Eye Movement Desensitization and Reprocessing therapy (EMDR) in the treatment of eating disorders (EDs)</p>
<p>Barbosa, J. (2013) 'THE EFFECTIVENESS OF EMDR THERAPY IN THE TREATMENT OF PSYCHOLOGICAL TRAUMA AS A RESULT OF INTRAFAMILIAL SEXUAL ABUSE.', <i>J Sex Med.</i> (C) 1999?2012 John Wiley & Sons, Inc, 10, p. 349. Available at: http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=ovfto&NEWS=N&AN=01222926-201309005-00308.</p>	<p>This abstract of an address given at a conference (namely the 21st Congress of the World Association for Sexual Health) is all that has been published about this study. However also excluded as the outcomes in this article differ to that of the current DProf project as authors examine the psychological consequences caused by intrafamilial sexual abuse, leading to the outcome of living a sexually satisfactory life</p>
<p><i>Biotech Week</i> (2013) 'Clinical Research; New Clinical Trials and Studies Findings from D. Gillies and Co-Authors Described', 6 November, p. 588. Available at: https://search.proquest.com/docview/1446950353?accountid=8058.</p>	<p>News reporter quote from review regarding trauma treatments in children or adolescents exposed to a traumatic event or diagnosed with PTSD due to sexual abuse, civil violence, natural disaster, domestic violence and motor vehicle accidents</p>
<p>Bira, L. M. (2014) <i>Brief psychological intervention for acute posttraumatic stress: Individual and trauma factors affecting recovery in low SES minorities</i>, ProQuest Dissertations and Theses. University of Miami. Available at: https://search.proquest.com/docview/1614127079?accountid=8058</p>	<p>This study focused on working in a deprived area; outcome measures included 'PTSD, depressive and physical symptoms' and individual factors included substance abuse and borderline personality disorder</p>
<p>Black, P. J. et al. (2012) 'A Review of Trauma-Informed Treatment for Adolescents', <i>Canadian Psychology</i>. Ottawa: Canadian Psychological Association, 53(3), pp. 192–203. Available at: https://search.proquest.com/docview/1034977537?accountid=8058</p>	<p>This review provides 'a summary of the main trauma-informed therapies that are currently available for treating adolescents with PTSD or trauma-related symptoms, as well as the therapeutic techniques that are common to all of these main treatments'</p>
<p>Bongaerts, H., Van, A, M; de Jongh, A, M (2017) Intensive <u>EMDR to Treat Patients With Complex Posttraumatic Stress Disorder: A Case Series</u>. <i>JOURNAL OF EMDR PRACTICE AND</i></p>	<p>This paper included participants suffering from complex PTSD however large levels of multiple comorbidities averse to the current DProf research</p>

RESEARCH. Volume: 11 Issue: 2 Pages: 84-95	
Boukezzi, S., El Khoury-Malhame, M., Auzias, G et al. (2017) Grey matter density changes of structures involved in <u>Posttraumatic Stress Disorder (PTSD)</u> after recovery following <u>Eye Movement Desensitization and Reprocessing (EMDR)</u> therapy. PSYCHIATRY RESEARCH-NEUROIMAGING. Pages: 146-152	This investigation 'aimed to determine whether symptoms improvement is associated with grey matter (GM) density changes of brain structures involved in PTSD.' CSA was not specifically addressed, nor participant age group outlined - rather trauma explored in a general sense
Cameron, V, L (2013) EMDR: Promising Treatment for Co-Occurring Eating Disorders and Childhood Sexual Abuse	Focus of outcome differed to that of current project - EMDR in exploring particularly disordered eating and CSA via qualitative interviewing with EMDR clinicians
Cavalcanti, A, L., Zampieiri, A, M, F (2013) Transgenerational Sexual Abuse Treated With Emdr: A Case Report. The Journal of Sexual Medicine. Vol 10. Page 354	Unpublished work
Chen, L., Zhang, G., Hu, M et al. (2015) <u>Eye Movement Desensitization and Reprocessing Versus Cognitive-Behavioral Therapy for Adult Posttraumatic Stress Disorder Systematic Review and Meta-Analysis.</u> JOURNAL OF NERVOUS AND MENTAL DISEASE. Volume: 203 Issue: 6 Pages: 443-451	Meta-analysis to compare Eye movement desensitization and reprocessing (EMDR) and cognitive-behavioral therapy (CBT) to confirm the most effective psychotherapy for PTSD
Clayton, D (2011) Eye movement desensitization and reprocessing for sexual assault. Surviving Sexual Violence: A Guide to Recovery and Empowerment. Page 129-141. United Kingdom: Rowman & Littlefield Publishers	Adult sample working with sexual assault, namely military settings
Colman, A. (2015). post-traumatic stress disorder. In (Ed.), A Dictionary of Psychology. : Oxford University Press,. Retrieved 8 Oct. 2018, from http://www.oxfordreference.com.salford.idm.oclc.org/view/10.1093/acref/9780199657681.001.0001/acref-9780199657681-e-6509	Overview of trauma-focused treatment for PTSD
de Bont, P., van den Berg, D., van der Vleugel, B et al. (2013) <u>A multi-site single blind clinical study to compare the effects of prolonged exposure, eye movement desensitization and</u>	This paper examined 'the efficacy and safety of prolonged exposure and eye movement desensitization and reprocessing (EMDR) for PTSD in patients with both psychotic disorders

<p><u>reprocessing and waiting list on patients with a current diagnosis of psychosis and co morbid post traumatic stress disorder: study protocol for the randomized controlled trial Treating Trauma in Psychosis Trails.</u> Volume: 14 Article Number: 151</p>	<p>and PTSD, as compared to a waiting list'</p>
<p>de Haan, K. L. B., Lee, C. W., Fassbinder, E., Voncken, M. J., Meewisse, M., Van Es, S. M., ... Arntz, A. (2017). Imagery rescripting and eye movement desensitisation and reprocessing for treatment of adults with childhood trauma-related post-traumatic stress disorder: IREM study design. <i>BMC Psychiatry</i>, 17(1). https://doi.org/10.1186/s12888-017-1330-2</p>	<p>Incomplete - solely study protocol/proposal presented, ethics sought however investigation not carried out hence no outcome/results nor follow-up found</p>
<p>Diehle, J., Opmeer, B. C., Boer, F., Mannarino, A. P., & Lindauer, R. J. L. (2015). Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: what works in children with posttraumatic stress symptoms? A randomized controlled trial. <i>European Child & Adolescent Psychiatry</i>, 24(2), 227. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=24965797</p>	<p>Child sample aged between 8-18 years were randomly assigned to eight sessions of TF-CBT or EMDR, comparative study, sample age not reflective of current DProf project</p>
<p>Dunleavy, K. and Slowik, A. K. (2012) 'Emergence of Delayed Posttraumatic Stress Disorder Symptoms Related to Sexual Trauma: Patient-Centered and Trauma-Cognizant Management by Physical Therapists', <i>Physical Therapy</i>. Washington: Oxford University Press, 92(2), pp. 339–351. Available at: https://search.proquest.com/docview/921018985?accountid=8058</p>	<p>Case report describing 'the emergence of delayed PTSD symptoms, disclosure of history of sexual trauma, and the influence of re-experiencing, avoidance, and hyperarousal symptoms on physical therapy treatment' - not EMDR</p>
<p>Edmond, T., Lawrence, K, A., Schrag, R, V (2016) <u>Perceptions and Use of EMDR Therapy in Rape Crisis Centers</u> JOURNAL OF EMDR PRACTICE AND RESEARCH. Volume: 10 Issue: 1 Pages: 23-32</p>	<p>Therapist perspectives explored via web-based survey 'to determine the extent to which rape crisis centers use EMDR therapy, practitioners' perceptions of EMDR, and the provider characteristics that might support or hinder implementation of EMDR in this setting' – not client perspectives</p>
<p>Edmond, T. E. and Schrag, R. V. (2017) 'Assessing Receptivity to Empirically</p>	<p>'This research project sought to determine counselors' attitudes toward</p>

<p>Supported Treatments in Rape Crisis Centers', <i>Advances in Social Work</i>. Washington University in St. Louis ; University of Texas at Arlington ; Washington University in St. Louis: Indiana University, School of Social Work, 18(2), p. 611. Available at: https://search.proquest.com/docview/2039155231?accountid=8058.</p>	<p>evidence-based practices (EBPs)' (including EMDR) however no client perspectives sought</p>
<p>Englebrecht, K. M. (2012) <i>Healing the invisible wounds: A grant proposal for female veterans suffering from PTSD</i>, ProQuest Dissertations and Theses. California State University, Long Beach. Available at: https://search.proquest.com/docview/1033833000?accountid=8058</p>	<p>Development of project for female veterans suffering from Posttraumatic Stress Disorder (PTSD)</p>
<p>Farkas, L. (2009) <i>The effects of Motivation-Adaptive Skills-Trauma Resolution (MASTR) - Eye Movement Desensitization and Reprocessing (EMDR) on traumatized adolescents with conduct problems</i>, ProQuest Dissertations and Theses. Universite de Montreal (Canada). Available at: https://search.proquest.com/docview/305129159?accountid=8058</p>	<p>This study explored 'the effectiveness of a treatment package, Motivation-Adaptive Skills-Trauma Resolution (MASTR) in combination with Eye Movement Desensitization and Reprocessing (EMDR),' with a sample of traumatized adolescents (aged 13-17) 'manifesting conduct problems (CPs)' – not reflective of current DProf project sample age range</p>
<p>Fernandez, B. R. (2010) <i>Through the eyes of a child: A symbolic, narrative journey through complex childhood trauma</i>, Masters Abstracts International. Available at: https://search.proquest.com/docview/1018354354?accountid=8058</p>	<p>Research investigating 'how symbolic expression in the form of written autobiographical stories, dream images, and original art can heal the survivor of complex childhood trauma'</p>
<p>Field, A., & Cottrell, D. (2011) <u>Eye movement desensitization and reprocessing as a therapeutic intervention for traumatized children and adolescents: a systematic review of the evidence for family therapists</u>. <i>Journal of Family Therapy</i>. Volume 33, Issue 4</p>	<p>Literature review inclusion criteria were analysis of participants up to age 18 and not 18-25 who had experienced a traumatic event and not specifically CSA related, as follows; "1. they examine the effects of EMDR on children or adolescents (0–18years) 2. the children had suffered a traumatic event of some kind as their primary 'problem' but, in recognition of the difficulties of defining and diagnosing PTSD in children, formal diagnosis was not necessary. No restriction on the basis of severity of difficulties, comorbidity or type of traumatic event was imposed. 3. the study examined</p>

	the use of EMDR on individuals only (no group work).”
Gillies, D. <i>et al.</i> (2013) ‘Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents (Review)’, <i>Evidence-Based Child Health</i> . United Kingdom, United Kingdom: Wiley-Blackwell Publishing Ltd., 8(3), pp. 1004–1116. Available at: https://search.proquest.com/docview/1937395913?accountid=8058	A review to focus on ‘the effectiveness of psychological therapies in treating children and adolescents who have been diagnosed with PTSD’
Gillies, D., Maiocchi, L., Bhandari, A. P., Taylor, F., Gray, C., & O’Brien, L. (2016). Psychological therapies for children and adolescents exposed to trauma. <i>Cochrane Database of Systematic Reviews</i> , 2016(10). https://doi.org/10.1002/14651858.CD012371	This study assessed ‘the effects of psychological therapies in preventing PTSD and associated negative emotional, behavioural and mental health outcomes in children and adolescents who have undergone a traumatic event’
Goldberg, Daniel B (2016) Impact of Childhood Sexual Abuse on College Student Development: A Seven-Vectors. <i>Journal of College Counseling</i> . Vol 19:2. Page 168-179. Wiley Online Library	This paper ‘expanded on Chickering and Reisser’s (1993) 7-vectors framework by considering the effects of childhood sexual abuse (CSA) on the normal experience of student development in higher education’
Gomez, M, A. (2013) EMDR therapy and adjunct approaches with children: complex trauma, attachment, and dissociation. New York, NY Springer Pub. Held by: King’s College London Library	Ebook providing ‘step-by-step strategies for clinicians using EMDR therapy and adjunct approaches with children with severe dysregulation of the affective system’
Harford, M, P (2010) The Integrative Use of EMDR and Clinical Hypnosis in the treatment of Adults Abused as Children. <i>Journal of EMDR Practice and Research</i> . Volume 4, Number 2. EMDR International Association 10.1891/1933-3196.4.2.60	Integration of unused intervention in primary care settings (Hypnosis) with EMDR via x3 CSA vignettes
Hegarty, K. <i>et al.</i> (2016) ‘Interventions to support recovery after domestic and sexual violence in primary care’, <i>International Review of Psychiatry</i> . Abingdon: Taylor & Francis Ltd., 28(5), p. 519. http://dx.doi.org/10.1080/09540261.2016.1210103 .	Paper discussing experiences of domestic and sexual violence amongst patients attending primary care settings
Helen (2011) Child abuse and voice hearing: Finding healing through EMDR. <i>Psychosis</i> . Vol 3. No 1. Page 90-95. Taylor & Francis Press	EMDR and Psychosis explored

<p>Hensel, Thomas (2009) EMDR with children and adolescents after single-incident trauma an intervention study. <i>Journal of EMDR Practice and Research</i>. Vol 3:1. Springer Publishing Company</p>	<p>Investigation into the effectiveness of eye movement desensitization and reprocessing (EMDR) with children and adolescents (aged 1 year 9 months to 18 years 1 month) who were exposed to single-incident trauma, not exclusively CSA</p>
<p>Ho, M., Lee, C (2012) <u>Cognitive behaviour therapy versus eye movement desensitization and reprocessing for post-traumatic disorder - is it all in the homework then? EUROPEAN VIEW OF APPLIED PSYCHOLOGY</u>. Volume: 62 Issue: 4 Pages: 253-260 Published: OCT 2012</p>	<p>Meta-analysis determining whether there are any differences between eye movement desensitization and reprocessing (EMDR) or trauma-focused cognitive behaviour therapy (TFCBT) in the treatment of post-traumatic stress disorder (PTSD)</p>
<p>Hurd, D. A. (2015) <i>A narrative analysis of women’s adaptation following a sexual assault</i>, <i>ProQuest Dissertations and Theses</i>. The University of Texas at Arlington. Available at: https://search.proquest.com/docview/1700216616?accountid=8058.</p>	<p>The purpose of this study was to describe the narratives and coping strategies of adult female sexual assault victims</p>
<p>Hurley, E. C. (2016) ‘Treating military sexual trauma with EMDR therapy.’, <i>Treating military sexual trauma</i>. Edited by B. Bisson Carlson, Chemtob, Davidson, Edmond, Foa, Ironson, Lee, Marcus, Marcus, Maxfield, Rothbaum, Rothbaum, Seidler, Shapiro, Shapiro, Shapiro, Stickgold. New York, NY, US: Springer Publishing Co, pp. 155–173. Available at: http://ovidsp.ovid.com/ovidweb.cgi?T=J&PAGE=reference&D=psyc13a&NEWS=N&AN=2015-19558-009.</p>	<p>Book chapter providing an overview of the application of eye movement desensitization and reprocessing (EMDR) therapy in the treatment of military sexual trauma (MST)</p>
<p>Jaberghaderi, N., Greenwald, R., Rubin, A., Zand, SO., Dolatabadi, S. (2004) A comparison of CBT and EMDR for sexually-abused Iranian girls. <i>CLINICAL PSYCHOLOGY & PSYCHOTHERAPY</i>. Volume: 11 Issue: 5 Pages: 358-368. Clarivate Analytics Web of Science</p>	<p>Comparative study (CBT and EMDR) of post-traumatic stress symptoms in 14 randomly assigned Iranian girls aged between 12–13 years who had been sexually abused – sample not reflective of current DProf research</p>
<p>Jarero, I., Roque-López, S., Gomez, J (2013) The Provision of an EMDR-Based Multicomponent Trauma Treatment With Child Victims of Severe Interpersonal Trauma. <i>Journal of EMDR Practice and Research</i>. Volume 7. Number 1. <i>Latin American & Caribbean</i></p>	<p>Study works with child victims as oppose to adults</p>

<p>Foundation for Psychological Trauma Research, Mexico City, Mexico, <i>Innocence in Danger Colombia</i>. EMDR International Association http://dx.doi.org/10.1891/1933-3196.7.1.17</p>	
<p>Jones-Smith, A. (2018) <i>Therapists' Perceptions of Eye Movement Desensitization and Reprocessing Treatment for Women Survivors of Child Sexual Abuse</i>, ProQuest Dissertations and Theses. Walden University. Available at: https://search.proquest.com/docview/2055375593?accountid=8058</p>	<p>'The purpose of this phenomenological qualitative study was to explore the perceptions of therapists about EMDR as a tool to assist adult women survivors of child sexual abuse' - not client perspectives</p>
<p>Leiner, A. S. et al. (2012) 'Avoidant coping and treatment outcome in rape-related posttraumatic stress disorder', <i>Journal of Consulting and Clinical Psychology</i>. Arlington: American Psychological Association, 80(2), p. 317. http://dx.doi.org/10.1037/a0026814</p>	<p>Study investigating the impact of avoidant coping on treatment outcome in adult rape-related posttraumatic stress disorder (PTSD)</p>
<p>Maddoux, J. (2016) <i>An investigation of the efficacy of empirically supported treatments (ESTS) for posttraumatic stress disorder (PTSD): A meta-analytic review</i>, ProQuest Dissertations and Theses. Texas Woman's University. Available at: https://search.proquest.com/docview/1833993174?accountid=8058.</p>	<p>Comparison study of seven trauma-treatments for PTSD – 'natural disasters, rape or sexual assault, and combat'</p>
<p>Malchiodi, A. C. & Perry, D., B. (2014) <i>Creative Interventions with Traumatized Children</i>, Second Edition. Guilford Publications Inc. M.U.A.</p>	<p>Book outlining various innovative ways of working with children and adolescents, based on evidence and multiple experienced practitioners</p>
<p>Martin, E. (2015). post-traumatic stress disorder. In (Ed.), <i>Concise Medical Dictionary</i>. : Oxford University Press,. Retrieved 8 Oct. 2018, from http://www.oxfordreference.com.salford.idm.oclc.org/view/10.1093/acref/978019687817.001.0001/acref-9780199687817-e-8102</p>	<p>Overview of PTSD treatment</p>
<p>Mevisen, L., Didden, R., Korzilius, H., & Jongh, A. de. (2017). Eye movement desensitisation and reprocessing therapy for posttraumatic stress disorder in a child and an adolescent with mild to borderline intellectual disability: A multiple baseline across subjects study.</p>	<p>EMDR for PTSD with borderline intellectual disability explored</p>

<p><i>Journal of Applied Research in Intellectual Disabilities : JARID</i>, 30 Suppl 1, 34. https://doi.org/10.1111/jar.12335</p>	
<p>Midyette, D. A. (2015) <i>Applied therapeutic interventions for children diagnosed with traumatic brain injury and/or posttraumatic stress disorder</i>, ProQuest Dissertations and Theses. Saybrook University. Available at: https://search.proquest.com/docview/1765427037?accountid=8058.</p>	<p>Trauma treatment when working with brain injury examined</p>
<p>Mosquera, D., Gonzalez-Vazquez, A (2012) <u>Borderline Personality Disorder, trauma and EMDR</u>. RIVISTA DI PSICHIATRIA. Volume: 47 Issue: 2 Supplement: S Pages: 26-32</p>	<p>EMDR when working with symptomology of Borderline Personality Disorder investigated</p>
<p>Mosquera, D., Leeds, A, M., Gonzalez, A (2015) <u>Application of EMDR Therapy to Borderline Personality Disorder</u>. JOURNAL OF EMDR PRACTICE AND RESEARCH. Volume: 9 Issue: 4 Pages: E123-E141</p>	<p>Authors exploration of the diagnostic criteria for Borderline Personality Disorder, from the Adaptive Information Processing (AIP) perspective, when working with traumatic interpersonal events connected to attachment story in an EMDR capacity</p>
<p>Mosquera, D., Leeds, A, M., Gonzalez, A (2016) <u>Understanding and treating narcissism with EMDR therapy</u>. JOURNAL OF EMDR PRACTICE AND RESEARCH. Volume: 10 Issue: 3</p>	<p>EMDR therapy when working with narcissistic traits explored</p>
<p>Napitupulu, A. (2017). Play Therapy in Indonesia. In Siu A. & Pon A. (Eds.), <i>Play Therapy in Asia</i> (pp. 101-116). Sha Tin, N.T., Hong Kong: Chinese University Press. http://www.jstor.org/salford.idm.oclc.org/stable/j.ctv2t4cxn.13</p>	<p>Aim of study is to investigate the development of play therapy in Indonesia, EMDR only briefly described</p>
<p>Ni, T, Ohta., Matsuo, K., Kasai, K et al. (2009) Hemodynamic responses of <u>eye movement desensitization and reprocessing in posttraumatic stress disorder</u>. NEUROSCIENCE RESEARCH. Volume: 65 Issue: 4 Pages: 375-383 Published: DEC 2009</p>	<p>General PTSD investigated to determine neural mechanisms underlying the process of EMDR</p>
<p>Nijdam, M. J. <i>et al.</i> (2013) 'Treatment of sexual trauma dissolves contamination fear: case report', <i>European Journal of Psychotraumatology</i>. Abingdon: Taylor & Francis Ltd., 4.</p>	<p>Case report of patient with co-morbid obsessive-compulsive disorder (OCD) and posttraumatic stress disorder (PTSD)</p>

<p>http://dx.doi.org/10.3402/ejpt.v3i0.19157</p>	
<p>Nogg, O. (2014) 'Caring: Teresa Drelicharz', <i>The Jewish Press</i>, 28 March, pp. 1–2. Available at: https://search.proquest.com/docview/1561975015?accountid=8058</p>	<p>News advert about parenting classes</p>
<p>Olf, M. (2014) 'Complete abstract book', <i>European Journal of Psychotraumatology</i>. Abingdon: Taylor & Francis Ltd., 5. http://dx.doi.org/10.3402/ejpt.v5.26477.</p>	<p>Exploration of social support systems for sufferers of PTSD</p>
<p>Ong, J. I. (2016) <i>Trauma-sensitive yoga: A collective case study of the trauma recovery of women impacted by Intimate Partner Violence (IPV)</i>, ProQuest Dissertations and Theses. The University of North Carolina at Greensboro. Available at: https://search.proquest.com/docview/1836100213?accountid=8058.</p>	<p>PTSD explored in terms of <i>Trauma-sensitive yoga</i></p>
<p>Panko, T. R. and George, B. P. (2012) 'Child Sex Tourism: Exploring the Issues', <i>Criminal Justice Studies</i>, 25(1), pp. 67–81. Available at: https://search.proquest.com/docview/1240203636?accountid=8058</p>	<p>This paper explores the trauma experienced by child victims of commercial sexual abuse in tourist settings</p>
<p>Papanikolopoulos, P. and Prattos-Spongialides, T.-A. (2017) 'E.M.D.R therapy and the theory of structural dissociation of the personality in severe interpersonal trauma of young adolescents', <i>European Journal of Psychotraumatology</i>. pennypapanikolopoulos@gmail.com TACT HELLAS, Psychological Services, Athens, Greece ; pennypapanikolopoulos@gmail.com TACT HELLAS, Psychological Services, Athens, Greece: Taylor & Francis Ltd., 8, pp. 1–2. http://dx.doi.org/10.1080/20008198.2017.1351207.</p>	<p>This presentation illustrates 'the effects of combining eye movement desensitization and reprocessing (E.M.D.R) therapy and theory of structural dissociation of the personality (T.S.D.P) on dissociative and post-traumatic stress disorder (P.T.S.D) symptoms; young severely traumatized adolescents with PTSD who have been early victims of emotional, physical and sexual abuse within an interpersonal relationship and have exhibited dissociative symptoms" – sample not reflective of current adult age range and dissociation ruled out as exclusion criteria in the current DProf study</p>
<p>Peterson, R. (2009) A study of the traumatic effects of rape and its treatment through the use of EMDR (Eye-Movement Desensitization Reprocessing), ProQuest Dissertations and Theses. Prescott College. Available at:</p>	<p>The focus of this study was to determine the effects of adult rape through EMDR</p>

<p>https://search.proquest.com/docview/305148317?accountid=8058.</p>	
<p>Potter, A. E., Davidson, M. M. and Wesselmann, D. (2015) 'UTILIZING DIALECTICAL BEHAVIOR THERAPY AND EYE MOVEMENT DESENSITIZATION AND REPROCESSING AS PHASE-BASED TRAUMA TREATMENT: A CASE STUDY SERIES', <i>International Journal of Medical and Biological Frontiers</i>. Hauppauge: Nova Science Publishers, Inc., 21(2), pp. 189–205. Available at: https://search.proquest.com/docview/1705546213?accountid=8058</p>	<p>Book chapter to 'describe, provide rationale for, and illustrate a phase-based trauma treatment program that integrates Linehan's Dialectical Behavior Therapy (DBT) and Shapiro's Eye Movement Desensitization and Reprocessing (EMDR), when assisting clients to regulate emotions and behavior, decrease psychiatric symptomatology, improve relationships, resolve past traumatic events, move toward a healthier and more secure attachment status, and cope more effectively with significant present-day stressors'</p>
<p><i>Psychology & Psychiatry Journal</i> (2015) 'Post-Traumatic Stress Disorders; Reports Summarize Post-Traumatic Stress Disorders Study Results from King Abdul-Aziz University (Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse)', 24 January, p. 264. Available at: https://search.proquest.com/docview/1645699567?accountid=8058.</p>	<p>Sample consists of adult victims of sexual violence and rape, not CSA</p>
<p>Regehr, C. <i>et al.</i> (2013) 'Interventions to Reduce Distress in Adult Victims of Sexual Violence and Rape: A Systematic Review', p. 134. Available at: https://search.proquest.com/docview/1471983917?accountid=8058</p>	<p>Sample includes adult victims of rape / sexual trauma</p>
<p>Riede, E. (2018) 'Therapists' Perceptions of Eye Movement Desensitization and Reprocessing Treatment for Women Survivors of Child Sexual Abuse.', <i>Therapists' Perceptions of Eye Movement Desensitization & Reprocessing Treatment for Women Survivors of Child Sexual Abuse</i>. Walden University: Walden University, p. 1. Available at: http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=131792239&site=ehost-live.</p>	<p>Therapist perceptions of treatment process examined - not client</p>
<p>Roman, J. V. (2017) <i>The Impact of Childhood Trauma: Cognitive</i></p>	<p>No access - contacted awarding institution (California State University)</p>

<p><i>Development, Mental Health, and Trauma Informed Treatment</i>, ProQuest Dissertations and Theses. California State University, Los Angeles. Available at: https://search.proquest.com/docview/1914677926?accountid=8058</p>	<p>however they are unable to supply this thesis as it is not held in their collection nor is it available for purchase. Additionally, this has been awarded at Masters and not Doctoral level</p>
<p>Ronald, R, J., Clayton, C, A. (2016) <u>EMDR</u> With Sex Offenders: Using Offense Drivers to Guide Conceptualization and Treatment. JOURNAL OF EMDR PRACTICE AND RESEARCH. Volume: 10 Issue: 2 Pages: 104-118</p>	<p>A model designed to guide and inform EMDR therapists with sex offenders, having experienced adverse childhood experiences (ACE)</p>
<p><u>Rubin</u>, A. (2011) Programs and Interventions for Maltreated Children and Families at Risk: Clinician`s Guide to Evidence-Based Practice. <u>John Wiley & Sons Inc</u></p>	<p>Compendium of short, ‘how-to’ chapters focuses on ‘programs and interventions to prevent child maltreatment that have the best scientific evidence supporting their effectiveness. Interventions and programs discussed include Cognitive Behavioral Therapy, EMDR, Multisystemic Therapy, Coping Cat, and many more’</p>
<p><u>Rubin</u>, A. & Springer, D. (2011) Treatment of Traumatized Adults and Children Clinician`s Guide to Evidence-Based Practice. <u>John Wiley & Sons Inc</u></p>	<p>Treatment guide, step-by-step guidance for implementing clinical interventions that are supported by the latest scientific evidence</p>
<p>Samardzic, D. (2010) <i>Trauma and the Body: The Somatic Experience in Psychotherapy</i>, ProQuest Dissertations and Theses. John F. Kennedy University. Available at: https://search.proquest.com/docview/907105580?accountid=8058.</p>	<p>‘This qualitative study aimed to explore the experience of 5 participants who underwent ongoing somatic therapy in the treatment of symptoms associated with Posttraumatic Stress Disorder (PTSD)’</p>
<p>Saniti, Ni Made Apriliani (2013) Diagnosis And Management Post Traumatic Stress Disorder In Sexual Abuse. E-Jurnal Medika Udayana. Vol 2:6. 954-971. Directory of Open Access Journals</p>	<p>Comparison study between TFCBT and EMDR, discussion around trauma-treatments available for PTSD in Sexual Abuse, not specifically CSA</p>
<p><i>Senate Armed Services Subcommittee on Personnel Hearing</i> (2016) <i>Congressional Documents and Publications</i>. Washington: Federal Information & News Dispatch, Inc. Available at: https://search.proquest.com/docview/1785762856?accountid=8058</p>	<p>Focuses on rape as a traumatic experience within the armed forces hence the use of EMDR and alternative treatments for PTSD symptomology</p>
<p>Siegel-Itzkovich, J. (2009) ‘Wounded young psyches’, <i>Jerusalem Post</i>, 12</p>	<p>EMDR with war victims discussed</p>

July, p. 6. Available at: https://search.proquest.com/docview/319700314?accountid=8058 .	
Sinanan, A (2015) Trauma and Treatment of Child Sexual Abuse. <i>Department of Social Work, Stockton University, NJ, USA</i> . http://dx.doi.org/10.4172/2167-1222.S4-024	Various trauma-treatments reviewed, when working with children, only brief EMDR overview provided
Stevens, S. (2015) Integrative Team Treatment for Attachment Trauma in Children: Family Therapy and EMDR. <i>JOURNAL OF EMDR PRACTICE AND RESEARCH</i> Volume: 9 Issue: 3 Pages: 163-164. Clarivate Analytics Web of Science	The book is broken into two parts: 'Case Conceptualization and Foundation Work,' and 'EMDR Strategies.' It presents a model in which an EMDR therapist and a family therapist work in tandem providing attachment trauma therapy
Sugimoto, A. <i>et al.</i> (2015) 'Efficacy of Atomoxetine for Symptoms of Attention-Deficit/Hyperactivity Disorder in Children with a History of Child Abuse', <i>Journal of Child and Adolescent Psychopharmacology</i> . New Rochelle: Mary Ann Liebert, Inc., 25(3), pp. 269–271. http://dx.doi.org/10.1089/cap.2014.0119	Child sample working with severity and/or drug response of attention-deficit/hyperactivity disorder (ADHD) – 'A retrospective study to assess the efficacy of atomoxetine in children with a history of child abuse'
Taylor. F. (2014) Trauma-Attachment Tangle: Modifying EMDR to Help Children Resolve Trauma and Develop Loving Relationships http://ebookcentral.proquest.com/lib/rcn/detail.action?docID=1883830 . Held by: Royal College of Nursing	Summary of symptoms, case histories, and treatment methods, in which an explanation of how to write a narrative and integrate this into EMDR when working with children
ten Hoor, N (2013) Treating Cognitive Distortions with EMDR: A Case Study of a Sex Offender, <i>International Journal of Forensic Mental Health</i> , 12:2, 139-148, 10.1080/14999013.2013.791350	This single-case study illustrates how eye movement desensitization and reprocessing (EMDR) can be of use in the treatment of cognitive distortions in a sex offender who himself has been sexually victimized in his childhood – focus differs from that in the current DProf research due to examination of forensic-related cognitive distortions
<i>The Observer</i> (2017) 'Doctor is vital FIFO worker', 9 March, p. 7. Available at: https://search.proquest.com/docview/1875027641?accountid=8058 .	Newspaper article informing public that 'founder of the Institute for Chronically Traumatized Children, will be in Boyne Island this month offering mental health treatments'
<i>Times News</i> (2011) 'Abuse doesn't have to ruin victim's life', 30 November. Available at:	Newspaper article providing general overview of EMDR as trauma-treatment for survivors of CSA

https://search.proquest.com/docview/906738466?accountid=8058.	
<p>Torun, F. (2010) 'Treatment of Vaginismus with EMDR: A Report of 2 Cases', <i>Turk Psikiyatri Dergisi</i>. Ankara: Turkiye Sinir ve Ruh Sagligi Dernegi (Turkish Association of Nervous and Mental Health), 21(3), pp. 1–8. Available at: https://search.proquest.com/docview/759961047?accountid=8058</p>	<p>A two-case EMDR study when working with patients presenting with vaginismus that developed secondary to childhood sexual trauma, however outcome analysis is different to that of the current DProf study; 'reduction in the credibility of dysfunctional beliefs concerning sexual intercourse'</p>
<p>Pagani, M., Castelnuovo, G., Daverio, A et al. (2018) Metabolic and Electrophysiological Changes Associated to Clinical Improvement in Two Severely Traumatized Subjects Treated With EMDR. A Pilot Study. <i>FRONTIERS IN PSYCHOLOGY</i>. Vol 9, article 475</p>	<p>'The aim of this study was to assess by electroencephalography (EEG) and for the first time by positron emission tomography (PET) the changes occurring after EMDR therapy in two cases of psychological trauma following brain concussion and comatose state due to traffic accident.'</p>
<p>Trauma-focused therapies (trauma-focused CBT and EMDR) for adults with PTSD: a meta-analysis and meta-regression. (2018). <i>PROSPERO</i>. http://www.crd.york.ac.uk/prospero/display_record.asp?src=trip&ID=CRD42018100169</p>	<p>Unpublished work, focus of study was with PTSD, not specifically CSA</p>
<p>van Vliet, N. I., Huntjens, R. J. C., Van Dijk, M. K., & de Jongh, A. (2018). Phase-based treatment versus immediate trauma-focused treatment in patients with childhood trauma-related posttraumatic stress disorder: Study protocol for a randomized controlled trial. <i>Trials</i>, 19(1). https://doi.org/10.1186/s13063-018-2508-8</p>	<p>Incomplete - solely study protocol/proposal. Trial status - the second protocol version was finished in May 2016. Trial enrolment started on 5 September 2017 and recruitment is ongoing as of 31 December 2018</p>
<p>Waltermire, L. (2015) <i>Childhood sexual abuse, exposure to community and domestic violence, and posttraumatic stress disorder symptomology and diagnosis</i>, ProQuest Dissertations and Theses. California State University, Los Angeles. Available at: https://search.proquest.com/docview/1726892948?accountid=8058.</p>	<p>Combined outcome study working with a child sample, investigating CSA alongside exposures to community and domestic violence</p>
<p>Wizansky, B (2011) EMDR and the Challenge of Treating Childhood Trauma: A Theoretical and Clinical Discussion with Case Examples. <i>Post-Traumatic Syndromes in Childhood and</i></p>	<p>Treatment guide for EMDR therapist when working with children and adolescents</p>

Adolescence: A Handbook of Research and Practice. Page 297-321. John Wiley & Sons, Ltd Chichester, UK	
Yasar, A. B., Altunbas, F. D., Abamor, A. E et al. (2017) Treatment refractory or <u>trauma</u> overlooked? A case of <u>EMDR</u> responsive late onset <u>PTSD</u> . <u>TURKISH CLINICAL PSYCHOLOGY</u> . Vol 20, pgs66-69	Only abstract available in English, Salford University unable to obtain full-text copy in English language
Young, C. and Skorga, P. (2011) 'Acute traumatic stress treatment', <i>Nursing Times</i> . London, United Kingdom London, London: Emap Limited, 107(44), p. 17. Available at: https://search.proquest.com/docview/1146476827?accountid=8058	Newspaper article discussing nursing implications of the psychological impact of a traumatic events, 'such as physical or sexual assault, military combat, violent crime, severe accidents, and natural and man-made disasters'
Zaccagnino, M., Cussino, M., Callerame, C et al. (2017) <u>Anorexia Nervosa and EMDR: A Clinical Case</u> . <u>JOURNAL OF EMDR PRACTICE AND RESEARCH</u> . Volume: 11 Issue: 1 Pages: 43-53	This paper 'illustrates a clinical case by describing the positive results of the EMDR therapy in the recovery of unremitting anorexia nervosa in a 17-year-old inpatient'

Four Identified Systematic Reviews and Meta-Analysis (relevant however excluded from main Literature Review)

Chen, R., Gillespie, A., Zhao, Y., Xi, Y., Ren, Y., & McLean, L. (2018). The efficacy of eye movement desensitization and reprocessing in children and adults who have experienced complex childhood trauma: A systematic review of randomized controlled trials. *Frontiers in Psychology*, 9(APR). <https://doi.org/10.3389/fpsyg.2018.00534>

Ehring, T., Welboren, R., Morina, N., Wicherts, J. M., Freitag, J., & Emmelkamp, P. M. G. (2014). Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse. *Clinical Psychology Review*, 34(8), 645–657. <https://doi.org/10.1016/j.cpr.2014.10.004>

Korn, L, D (2009) EMDR and the Treatment of Complex PTSD: A Review. Journal of EMDR Practice and Research. Volume 3, Number 4. EMDR International Association. 10.1891/1933-3196.3.4.264

Paylor, S, & Royal, C (2016) Assessing the Effectiveness of EMDR in the Treatment of Sexual Trauma. The Practitioner Scholar: Journal of Counseling and Professional Psychology. Vol 5. No 1

Appendix 4: Characteristics of the Single Case Studies and Series Identified in the Present Review.

Paper (Country of Study)	Aim of Study	Study Design	Intervention	Comorbidities	Sample	Outcome (Measures) / Methodology	Findings
Aranda et al, 2015 (Mexico)	Study investigated whether EMDR therapy would change neuropsychological and physiological responses of participant	Case study	EMDR	Comorbid PTSD, Major Depressive Disorder	18-year-old female CSA survivor	<p>Psychological evaluation.</p> <p><i>Posttraumatic Stress Global Scale.</i> The Posttraumatic Stress Global Scale (PSGS; Crespo & Gómez, 2011) - Diagnostic and characterization of PTSD in adults</p> <p><i>Beck Depression Inventory-II.</i> The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) - Self-report instrument for intensity of depressive symptomatology</p>	<p>Neuropsychological evaluations of attention, memory, and brain executive functions showed pre-treatment impairments in attentional processes, information processing speed, and working memory and post-treatment improvement of these cognitive functions, with significant differences on the Paced Auditory Serial Addition Test. Substantial post-treatment decrease in mean scores on the Beck Depression Inventory-II and the Dissociative Experiences Scale were found.</p> <p>Furthermore, the patient showed no signs of PTSD after the intervention, based on the</p>

						<p><i>Dissociative Experiences Scale.</i> The Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) - Self-administered questionnaire, screening instrument evaluating different types of dissociative symptomatology and their frequency</p> <p>Neuropsychological evaluation.</p> <p><i>Rey Osterrieth Complex Figure Test.</i> The Rey Osterrieth Complex Figure Test (Rey, 2003) evaluates visual memory, visuospatial</p>	<p>Posttraumatic Stress Global Scale.</p>
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					<p>organization, and brain executive functions</p> <p><i>Paced Auditory Serial Addition Test.</i> The <i>Paced Auditory Serial Addition Test</i> (Gronwall, 1977) assesses working memory, sustained attention, divided attention, estimate, and speed of information processing.</p> <p><i>Trail Making Test, Part B.</i> The <i>Trail Making Test, Part B</i> (Reitan, 1958) assesses visual search, processing speed, mental flexibility, and working memory</p> <p><i>Physiological Recordings.</i></p>	
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					<p>Biofeedback device named ProComp5 Infiniti System recorded changes, these were then sent to a computer to be analyzed with the Multimedia Biofeedback Software.</p> <p>To record heart rate, <i>EKG sensors</i> (P/N: SA9306M) were placed in the triangular area over the heart for coracoid and xiphoidal processes to reduce artifacts: The measurement unit is millivolts (mV). Heart rate reflects blood volume, which increases with anxiety, thus showing the activity of the sympathetic nervous system (S. B. Miller & Ditto, 1989).</p>	
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						<p>To register skin conductance, the SC-Flex/Pro (SA309M) sensor was used, and sensors were placed on the index and ring fingers, measurement units were microsiemens (mS). Skin conductance has been shown to increase in stressful situations (Fowles et al., 1981).</p>	
<p>Hutchins and Mason, 2017 (United Kingdom)</p>	<p>This study focused on three case studies treating sexual trauma using EMDR.</p>	<p>A case series</p>	<p>EMDR</p>	<p>PTSD, Anxiety, Depression</p>	<p>Client #1 60- year-old man, sexually abused by his uncle from the age of 7 to 11</p>	<p>These measures were assessed pre- and post-treatment and at 3 months follow-up; Beck Depression Inventory (BDI) Beck Anxiety Inventory (BAI) Outcome Questionnaire 45- item version</p>	<p>The results of these three case studies suggest that EMDR is a highly effective and efficient treatment for sexual trauma, both in terms of childhood sexual abuse and adult rape. Reliable change is highlighted across all outcome measures, to the point where all three clients no longer met the</p>

					<p>Client #2 22-year-old woman, complex sexual trauma history which included being sexually abused by her next door neighbour from the age of 10 to 15. She also reported several experiences of being raped at her workplace between the ages</p>	<p>(OQ.45) (a measure of an individual's functioning; subscales included Symptom Distress, Interpersonal Relations, Social Role)</p> <p>Impact of Events Scale Revised (IES-R)</p>	<p>diagnostic criteria for PTSD or anxiety or depression.</p>
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					of 16 and 19 Client #3 35-year-old woman, raped by a co-worker at a restaurant toilet when she was 19		
Ringel, 2014 (USA)	The aim of this article is to offer an integrative approach in the treatment of adult survivors of sexual abuse with use of three conceptual models, current neuroscience findings, attachment research and EMDR.	Case Study Summary provided of each theoretical perspective and a case illustration to demonstrate a	EMDR, Attachment Theory, Relational Approach	Chronic pain, fibromyalgia, headaches, and digestive problems, as well as fear and dissociation during sexual contacts	Adult female survivor of CSA	Integration of treatment modalities – no pre/post measures described	This case suggests that with adult survivors of sexual abuse it is important at times to utilize an approach that integrates the uncertainty and fluid nature of a dynamic approach with a more structured, linear model such as EMDR.

		treatment approach that incorporates all three modalities		with her husband social fear, hyperarousal manifested through anger and rage toward her children, dissociative behaviors such as freezing and repetitive rituals			
Shields, 2015 (Australia)	An Investigation into EMDR and Imagery Rescripting for PTSD in adult survivors of CSA	A Case Series	EMDR, Imagery Rescripting (ImRs)	Current self-medicating with benzodiazepines in case #3. Also case	All adult female CSA survivors;	The Impact of Event Scale-Revised (IES-R: Weiss & Marmar, 1997) -measures intrusive and avoidance/numbing symptomatology	Functional gains and/or observed decreases in symptoms severity were found. A significant linear improvement was

				<p>histories of self-medication with illicit drugs and alcohol, although no current dependence</p>	<p>Case #1 - perpetrated by her stepfather during the ages of eight to 13 or 14 years of age</p> <p>Case #2 - single incident of CSA at the age of 15 by an unknown perpetrator, presented with delayed onset PTSD</p>	<p>Medication change questionnaire</p> <p>The Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995; Blake et al., 1990; Weathers et al., 1992) - Clinician-administered structured interview assessing the 17 DSM-IV PTSD symptoms for both frequency and severity and totaled for the three major symptom clusters (intrusion, avoidance, and hyperarousal)</p> <p>Severity of Posttraumatic Stress Symptoms-Adult</p>	<p>observed in the treatment phase of the case treated with ImRs. There was also linear improvement observed in the application of EMDR to PTSD symptoms in a case of a single incident of CSA, but not in the case of a woman who experienced multiple child and adult sexual traumas. However, in all three cases there were clinically significant changes at the end of treatment.</p>
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				<p>Case #3 – perpetrated by her biological father, beginning in infancy and ending at age 9. She also reported several sexual assaults as an adult, but agreed to undertake trauma processing work focusing on CSA memories</p>	<p>National Stressful Events Survey PTSD Short Scale (NSESSS).</p> <p>Qualitative Imagery Interview (allocated in Perth only)</p> <p>Beck Depression Inventory (BDI-II, Beck et al, 1961)</p> <p>Posttraumatic Cognitions Inventory (PTCI, Foa et al, 1999)</p> <p>Trauma-Related Guilt Inventory-Guilt Cognition (TRGI-C; Kubany et al., 1996)</p> <p>Trauma Related Shame Inventory (TRSI, Hoffart et al, 2014)</p>	
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						Symptom Checklist-90-R (SCL-90-R) published by the Clinical Assessment division of the Pearson Assessment & Information group (2016)	
Wright & Warner, 2020 (United Kingdom)	The aim of this study was to assess whether EMDR alters deviant sexual arousal in adult child molesters with a history of childhood sexual abuse (CSA)	Case study identifying changes in client self-report measures. EMDR therapy took place over 11 months and consisted of 32 sessions, including	EMDR	The participant was experiencing some symptoms of PTSD, including intrusive memories, anxiety, anger, nightmares, and avoidance. He described very strong feelings of powerlessness and helplessness, anger	An adult male who had sexually offended against prepubescent children	The Inventory of Altered Self-Capacities (IASC) and Trauma Symptom Inventory 2 (TSI 2) were administered pre- and post-intervention by an assistant psychologist, under the supervision of a doctoral-level clinical psychologist. Measures Used During EMDR Therapy: IASC. The IASC (Briere, 2004) is a 7-scale, 63 item self-report measure that looks at difficulties in the areas of relatedness, identity, and affect regulation.	The client reported positive changes in emotional, cognitive, and physiological functioning, consistent with reductions on a range of subscales of the Trauma Symptom Inventory 2 and the Inventory of Altered Self-Capacities. However, on completion of therapy, he also reported a reduction in the frequency and strength of sexual arousal to children, which was maintained at a 3-year follow-up, although this was not a target for treatment.

		preparation and review phases.		at self, and self-disgust that accompanied intrusive memories of his CSA.		TSI 2. The TSI-2 (Briere, 2011) measures the impact of past traumatic experiences on current functioning. It evaluates a broad spectrum of acute and chronic symptomatology associated with trauma having occurred	
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Appendix 5: Characteristics of Quantitative Comparative Studies Identified in the Present Review.

Paper (Country of Study)	Aim of Study	Study Design	Intervention	Comorbidities	Sample	Outcome (Measures) / Methodology	Findings
Wagenmans et al, 2018 (The Netherlands)	The focus of this study is to test whether the presence of a history of childhood sexual abuse has a negative effect on the outcome of intensive trauma-focused PTSD treatment.	Comparative study (Quantitative)	Prolonged Exposure, EMDR, alongside physical sports activities	Suicide risk according to the MINI was present for the majority of the participants (61.8%, n = 102) Depression (63.6%) Dysthymia (34.5%) Panic disorder & agoraphobia (12.1%) Social Phobia (18.2%) Obsessive compulsive	165 participants comprising of 'four trauma groups; patients with a history of childhood sexual abuse before age 12 (CSA), adolescent sexual abuse (ASA; i.e. sexual abuse between 12 and 18 years	Clinician-Administered PTSD Scale (CAPS; Blake, Weathers, & Nagy, 1995; Hovens, Luinge, & Van Minnen, 2005) - Assesses 17 PTSD symptoms in the past week according to the diagnostic criteria of the DSM-IV-TR (2000) Mini International Neuropsychiatric Interview (MINI; Lecrubier et al., 1997; Overbeek, Schruers, & Griez, 1999) – Establishes comorbid psychiatric	The results do not support the hypothesis that the presence of a history of childhood sexual abuse has a detrimental impact on the outcome of first-line (intensive) trauma-focused treatments for PTSD.

				<p>disorder (7.9%) Alcohol dependency (15.2%)</p>	<p>of age), sexual abuse (SA) at age 18 and over, or no history of sexual abuse (NSA)'</p>	<p>disorders and suicide risk,</p> <p>Modified self-report version of the Interview for Traumatic Events in Childhood (ITEC; Lobbestael, Arntz, Harkema-Schouten, & Bernstein, 2009) - Assesses various dimensions of trauma exposure in multiple contexts</p> <p>The Dutch version of the PTSD Symptom Scale-Self Report (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993; Mol et al., 2005) - Assesses the severity of PTSD symptoms in the past week based on the diagnostic criteria of the DSM-IV-TR (2000)</p>	
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						The Dutch Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979; Van Der Ploeg, Mooren, Kleber, Van Der Velden, & Brom, 2004) – Used to index the frequency of posttraumatic stress reactions.	
Woudenber g et al, 2017 (The Netherland s)	The aim of the study was ‘to determine the effectiveness of an intensive trauma-focused programme over 8 days for individuals suffering from severe PTSD’.	Compari tive Study (Quantit ative)	Prolonge d Exposure (PE) and EMDR, alongside physical activity, and psycho- education	Multiple comorbiditi es (e.g. 87.5% had a mood disorder & 63.7% had anxiety disorder). Suicidal ideation was frequent (73.9%).	347 participan ts (70% women, mean age = 38. 32 years, <i>SD</i> = 11. 69) however those having suffered sexual abuse equated to only	Clinician Administered PTSD Scale (CAPS) PTSD Symptom Scale Self Report (PSS-SR) Impact of Event Scale (IES) inventories	A significant decline in symptom severity was found (e.g. CAPS intention-to-treat sample Cohen’s <i>d</i> = 1.64). At post-treatment, 82.9% showed a clinically meaningful response and 54.9% a loss of diagnosis. Intensive trauma-focused treatment programmes including prolonged exposure, EMDR therapy, and physical activity can be effective for patients suffering from severe

					<p>74.4% hence there was no differentiation in results, pre-post treatment PTSD symptomology was measured as overall outcome</p> <p>For a subsample ($n = 109$), follow-up data at 6 months were available</p>		PTSD and are associated with low dropout rates
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Appendix 6: Characteristics of the Randomised Control Trials (RCTs) Identified in the Present Review.

Paper (Country of Study)	Aim of Study	Study Design	Intervention	Comorbidities	Sample	Outcome (Measures) / Methodology	Findings
Edmond & Rubin, 2004 (USA)	18month follow up study, client perspectives of the effectiveness of EMDR in reducing trauma symptoms among adult female survivors of CSA.	18-month follow-up study builds on the findings of a randomized experimental evaluation; the present study consisted of an experimental design	EMDR, Routine Individual Therapy or a delayed treatment control group	-	Of the 59 female survivors that were included in the original study conducted by Edmond et al. (1999) which involved an experimental design with random assignment to either	<i>The State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983)</i> - Self-report used to assess anxiety related to any trauma-specific issue of concern. <i>The Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979)</i> - Self-report measure used to assess posttraumatic stress symptoms for any specific trauma. <i>The Beck Depression Inventory (BDI; Beck & Steer, 1993)</i> - Self-report measure for the	The current study provides preliminary evidence that the therapeutic benefits of EMDR for adult female survivors of CSA can be maintained over an 18-month period. Furthermore, there is some support for the suggestion that EMDR did so more efficiently and provided a greater sense of trauma resolution than did routine individual therapy.

		with random assignment			EMDR, Routine Individual Therapy or a delayed treatment control group, 42 (71%) were included as participants in the present study.	<p>purpose of assessing clinically significant levels of depression</p> <p><i>The Belief Inventory (BI; Jehu, Gazan, & Klassen, 1985)</i> - Self-report measure identifying and measuring common distorted beliefs among adult survivors of childhood sexual abuse</p> <p>Subjective Outcome Measures</p> <p>A MANCOVA was also used to test the overall significance of the differences in eighteen-month follow-up scores between the EMDR group and the routine treatment group on the subjective process measures (i.e., the SUDS and VOC). Only the EMDR and routine</p>
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						treatment groups ($N = 31$) have SUDS and VOC scores, since they were process measures used within both treatments, and therefore, the control group could not be included in this analysis.	
Gerardi et al, 2010 (USA)	This article examines changes in salivary cortisol levels pre- to post EMDR or Prolonged Exposure (PE) Therapy treatment in female rape victims	RCT (one of two active treatment groups (EMDR or PE) or a wait list control group (WAIT))	Prolonged exposure (PE), Eye movement desensitization and reprocessing (EMDR)	35% ($n = 21$) of participants had only a PTSD diagnosis, 40% ($n = 24$) had one comorbid diagnosis, and 25% ($n = 15$) had two or more diagnoses in addition to PTSD.	60 female victims of a rape, the index event must have been a rape in adulthood (i.e., age 12 or older) or a single incident of rape in childhood	Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995; Blake et al., 1990) Assault Information Interview (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992), SCID Non-Patient Version (First, Gibbon, Spitzer, & Williams, 1996).	Overall results of the study indicated that improvement in PTSD symptoms was significantly greater in both the PE and EMDR groups as compared with the WAIT group, and that PE and EMDR groups did not differ significantly from each other on measures of outcome at post-treatment and at six-month follow-up. Baseline resting cortisol levels measured prior to initiation of treatment indicated no group differences.

				<p>Posttreatment response was defined in two domains of symptoms: PTSD-related symptoms (50% reduction in CAPS) and depression-related symptoms (50% reduction in BDI scores).</p>	<p>(ages 0–11). Participants were not excluded if they had other traumas in addition to a rape in adulthood, including childhood sexual abuse.</p>	<p>PTSD Symptom Scale Self-Report (Foa, Riggs, Dancu, & Rothbaum, 1993)</p> <p>Impact of Event Scale–Revised (Weiss & Marmar, 1997)</p> <p>Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).</p> <p>Salivary cortisol was collected at baseline, treatment Session 3 (the first exposure session in both treatment conditions), and at treatment Session 9 (the last exposure session in both treatment conditions)</p>	
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<p>Jamshidi, Rajabi & Dehghani, 2020 (Iran)</p>	<p>The current study aimed to investigate the effectiveness of EMDR therapy on reducing PTSD symptoms, suicidal ideations and mind-wandering in female victims of child abuse.</p>	<p>Thirty female victims were assigned to either EMDR or waiting list control in a randomised, double-blind trial. The participants in the EMDR group attended eight twice-weekly</p>	<p>EMDR</p>	<p>Suicidal ideation, interpersonal adjustment problems, lability of affect, depression, PTSD</p>	<p>A total of 30 (EMDR = 15; waiting list control = 15) female survivors of child abuse, aged 18–33.</p>	<p>The participants were examined in pre-test and post-test with Civilian Mississippi Scale for PTSD (CMS), Child Abuse and Self-Report Scale (CASRS), Mind-Wandering Questionnaire (MWQ), Beck Scale for suicidal ideation (BSSI) and Brief Dissociative Experiences Scale (DES-B).</p>	<p>Results of multivariate analysis of covariance showed that EMDR had a significant effect on reducing PTSD symptoms with an effect size of 0.72, suicidal ideations with an effect size of 0.53, and mind-wandering with an effect size of 0.19. It can be concluded that this treatment is effective in improving PTSD, suicidal ideations and mind-wandering in female victims of child abuse.</p>
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		session s.					
Rothbaum et al, 2005 (USA)	This controlled study evaluated the relative efficacy of Prolonged Exposure (PE) and EMDR compared to a no-treatment wait-list control (WAIT) in the treatment of PTSD in female rape victims	RCT	Prolonged Exposure (PE), EMDR	Changes in PTSD symptomology – secondary to adaptations in depression, dissociation and anxiety	Female only sample. Of the 74 women enrolled in the study, 60 women (83.3%) completed the protocol. Inclusion criteria for this study were that 'the index event must have been a rape in adulthood (i.e., age 12 or	Interviews The Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995; Blake et al., 1990; Weathers et al., 1992) - Clinician-administered structured interview assessing the 17 DSM-IV PTSD symptoms for both frequency and severity and totaled for the three major symptom clusters (intrusion, avoidance, and hyperarousal) CAPS Current and Lifetime Version (1-month symptom-duration criteria) - Used for pretreatment and follow-up assessments	PE and EMDR did not differ significantly for change from baseline to either post-treatment or 6-month follow-up measurement for any quantitative scale. In summary, both PE and EMDR equally led to clinically and statistically significant improvements immediately following treatment compared to the waitlist control condition. At posttreatment, 95% of PE participants and 75% of EMDR participants no longer met criteria for PTSD, which was not significantly different.

					<p>older) or a single incident of rape in childhood (ages 0–11) by either a family or a nonfamily member. Participants were not excluded if they had other traumas, including childhood sexual abuse.'</p>	<p>whereas the CAPS One Week Version (1-week symptom-duration criteria) was used for the post waitlist and post treatment assessments</p> <p>Assault Information Interview (All; Rothbaum et al., 1992) - Structured interview investigating relevant aspects of the assault such as acts committed, number of assailants, weapons used, and so on</p> <p>Stressful Life Events Screening Questionnaire (SLESQ: Goodman, Corcoran, Turner, Yuan, & Green, 1998) - Interview developed to ascertain a comprehensive trauma history</p>	
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					<p>SCID Non-Patient Version (First et al., 1996) - Structured diagnostic interview based on criteria from the DSM-IV and is used extensively in research and clinical settings</p> <p><i>Self-Report Measures</i></p> <p>The PTSD Symptom Scale-Self-Report (PSS-SR: Foa, Riggs, Dancu, & Rothbaum, 1993; Rothbaum, Dancu, Riggs, & Foa, 1990) - corresponds to the 17 DSM-IV symptoms of PTSD</p> <p>The Impact of Event Scale-Revised (IES-R: Weiss & Marmar, 1997) -measures intrusive and avoidance/numbing symptomatology</p>	
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					<p>The Beck Depression Inventory (BDI: Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961; Beck, Steer, & Garbin, 1988) - evaluates cognitive and vegetative symptoms of depression</p> <p>The Dissociative Experiences Scale-II (DES-II; Bernstein & Putnam, 1986; Carlson & Putnam, 1993) – Qualifies frequency and intensity of a wide range of experiences that are indicative of absorption, dissociation, de-realization, amnesia, and depersonalization</p> <p>The State-Trait Anxiety Inventory (STAI: Spielberger, Gorsuch, & Lushene, 1970) - Assesses state anxiety and trait anxiety</p>	
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Appendix 7: Platinum Standard (PS) Scores for Included EMDR Studies

Study	PS #1	PS #2	PS #3	PS #4	PS #5	PS #6	PS #7	PS #8	PS #9	PS #10	PS #11	PS #12	PS #13	TOTAL PS score
Aranda et al, 2015	1.0	1.0	0	1.0	1.0	0	0.5	1.0	1.0	1.0	0.5	0	0	8
Edmond & Rubin, 2004	1.0	1.0	0.5	0.5	1.0	1.0	1.0	0.5	0	0.5	0	1.0	1.0	9
Gerardi et al, 2010	1.0	1.0	1.0	0.5	0.5	1.0	1.0	0.5	0.5	1.0	1.0	1.0	1.0	11
Jamshidi, Rajabi & Dehghani, 2020	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.5	1.0	1.0	1.0	12
Hutchins & Mason, 2017	1.0	1.0	0.5	1.0	1.0	0	0.5	0	0	0.5	1.0	0	0	6.5
Ringel, 2014	1.0	0	0	0.5	0	0	0	0	0	1.0	0	0	0	2.5
Rothbaum et al, 2005	1.0	1.0	1.0	0.5	1.0	1.0	1.0	1.0	0.5	1.0	1.0	1.0	1.0	12
Shields, 2015	1.0	1.0	1.0	0.5	0.5	0	0.5	0	0.5	0.5	0.5	0	0	6
Wagenmans et al, 2018	1.0	1.0	0.5	0.5	0.5	0.5	0.5	0	0.5	1.0	1.0	0.5	1.0	8.5
Woudenberg et al, 2017	1.0	1.0	0.5	0.5	0.5	0.5	0.5	0	0.5	1.0	1.0	0.5	1.0	8.5
Wright & Warner, 2020	1.0	1.0	0	1.0	0	0	0.5	0	0	1.0	0.5	0	0	5

EMDR, Eye movement desensitization and reprocessing; #1 clearly defined target symptoms (0, no clear diagnosis or symptom definition; 0.5, not all participants meet target symptom criteria; 1.0, all participants met target symptom criteria); #2 reliable and valid measures (0, did not use reliable and valid measures; 0.5, measures used inadequate to measure change; 1.0, reliable, valid, and adequate measures used); #3 use of blind evaluators (0, assessor was therapist; 0.5, assessor was not blind; 1.0, assessor was blind and independent); #4 information regarding an assessor's training (no training in administration of instruments used in the study); #5 manualized, replicable and specific treatment (0, treatment was not replicable or specific; 0.5, treatment replicable and

specific but not standard EMDR protocol; 1.0, treatment followed EMDR training manual); #6 random assignment (0, assignment not randomized; 0.5, only one therapist or other semi-randomized designs; 1.0, unbiased assignment to treatment); #7 treatment adherence (0, treatment fidelity poor; 0.5, treatment fidelity variable or self-monitored by therapist only; 1.0, treatment fidelity independently checked and adequate); #8 non-confounded conditions [0, most participants exposed to confounds with no control for variables; 1.0, confounds nonexistent or controlled for (e.g., exclusion, matched assignment, etc.)]; #9 use of multimodal measures (0, self-report measures only; 0.5, self-report plus interview or physiological or behavioral measures; 1, self-report plus two or more other types of measures); #10 length of treatment (0, 1–6 sessions; 0.5, 7–10 sessions; 1.0, 11+sessions); #11 level of therapist training (0, no qualifications for treating clinicians provided; 0.5, qualifications for treatment group, clinicians provided; 1.0, qualifications for treatment and comparative group, clinicians provided); #12 use of a control group (0, no use of a wait control/comparison group; 0.5, use of a comparison group but no control; a.0, use of a no-treatment control group); #13 effect size reporting (0, no effect size reported; 1.0, effect size reported).

Reference

Hertlein, K, M & Ricci, R, J. (2004 Jul) A systematic research synthesis of EMDR studies: implementation of the platinum standard. *Trauma Violence Abuse*. 5(3):285-300.

Appendix 8: Updated PRISMA (2020) Systematic Review - Related Tables and Figures

On 18 March 2021, 24 databases were searched as well as a 'snowball' search to identify additional studies by searching the reference lists of publications eligible for full-text review and using Google Scholar to identify and screen studies citing them, results with use of the search terms as stated below, in Table 1.

Table 1: Database Literature Search Results

SOURCE	SEARCH TERM LINES
	<p><i>Line 1: EMDR or "Eye Movement Desensitization and Reprocessing" or "Eye Movement Desensitisation and Reprocessing"</i></p> <p><i>Line 2 (when searched with line 1): "posttraumatic stress disorder*" or "post-traumatic stress disorder*" or PTSD or "post-traumatic stress" or "posttraumatic stress" or "posttraumatic distress" or "post-traumatic distress" or "complex PTSD" or cPTSD or "complex posttraumatic*" or psychotrauma or trauma</i></p> <p><i>Line 3 (when searched with line 1): "sexual assault" or "sexual trauma" or "sexual violence" or</i></p>

	<i>"sexual attack" or "sexual molestation" or "sexual violation" or "sex abuse*" or "sexual abuse" or "child abuse" or "childhood abuse" or "childhood sexual abuse" or "sexual harassment" or rape or "sexual traumatic**"</i>
CINAHL (with corresponding search headings) (Time period searched: 04/10/18-18/03/21) (Date search completed: 18/03/21)	2
Google Scholar (Time period searched: 10/10/18-18/03/21) (Date search completed: 18/03/21 and 20/03/21)	6 (snowball search yielded duplicate results)
JSTOR (Time period searched: 07/10/18-18/03/21) (Date search completed: 18/03/21)	0
PsycINFO part of MEDLINE PsycARTICLES full text part of MEDLINE Ovid Online 8 Resources selected as follows; SalfordUniversityJournals@Ovid Journals@Ovid Full Text PsycARTICLES Full Text Books@Ovid AMED (Allied and Complementary Medicine) Ovid MEDLINE® and In-Process and Other Non-Indexed Citations	12 (from all 4 databases)

Ovid MEDLINE® without Revisions (1946-Sept 2018)
Ovid MEDLINE® without Revisions (1996-Oct 2018)
Ovid MEDLINE®
PsycEXTRA
PsychINFO (1906-Oct 2018)
PsychINFO (1806-Oct 2018)
PsychINFO (2002-Oct 2018)
Ovid MEDLINE® and Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Daily and Versions® (1946-Oct 2018)
Ovid MEDLINE® and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily (1946-Oct 2018)
Ovid MEDLINE® and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily (2014-Oct 2018)
Ovid MEDLINE® and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily without Versions® (2014-Oct 2018)
Ovid MEDLINE® and Epub Ahead of Print (Oct 2018)
Ovid MEDLINE® (Sept 2018)

MEDLINE (Ovid, with use of MeSH terms)

(title search)

8 Resources selected as follows;

SalfordUniversityJournals@Ovid

Journals@Ovid Full Text

PsycARTICLES Full Text

Books@Ovid

AMED (Allied and Complementary Medicine)

PsycEXTRA

PsychINFO

Ovid MEDLINE® and Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Daily and Versions®

(Time period searched: 04/10/18-18/03/21)

(Date search completed: 18/03/21)

Oxford Reference Online (Time period searched: 13/10/18-18/03/21) (Date search completed: 18/03/21)	0
PILOTS Published International Literature On Traumatic Stress ProQuest Central (abstract search) All 13 databases searched; <u>Art and Architecture Archive</u> Art and Humanities Database Asian and European Business Collection British Nursing Index British Periodicals Early European Books Performing Arts Periodicals Database Periodicals Archive Online ProQuest Central ProQuest Dissertations & Thesis A&I Social Science Premium Collection (Time period searched: 13/10/18-18/03/21) (Date search completed: 18/03/21)	14 (from 2 databases)
SCOPUS (Time period searched: 13/10/18-18/03/21) (Date search completed: 18/03/21)	17
Web of Science: Core Collection (Time period searched: 08/10/18-18/03/21)	2

(Date search completed: 18/03/21)	
Wiley Online Library	1
(Time period searched: 09/10/18-18/03/21) (Date search completed: 18/03/21)	

Table 2: Database Search Results of Excluded and Included Literature

Article Details	Databases	Included/Excluded and Why
<p>Riede, E. (2018) 'Therapists' Perceptions of Eye Movement Desensitization and Reprocessing Treatment for Women Survivors of Child Sexual Abuse.', Therapists' Perceptions of Eye Movement Desensitization & Reprocessing Treatment for Women Survivors of Child Sexual Abuse. Walden University: Walden University</p>	<p>PsycINFO PsycARTICLES full text Ovid Online MEDLINE CINAHL Google Scholar</p>	<p>EXCLUDED</p> <p>Already covered in previous version of review</p>
<p>Covers, M. L. V., De Jongh, A., Huntjens, R. J. C., De Roos, C., Van Den Hout, M., & Bicanic, I. A. E. (2019) Early intervention with eye movement desensitisation and reprocessing (EMDR) therapy to reduce the severity of posttraumatic stress symptoms in recent rape victims: study protocol for a randomised controlled trial. <i>Eur J Psychotraumatol.</i> 10(1):1632021. 10.1080/20008198.2019.1632021. PMID: 31303971; PMCID: PMC6610517.</p>	<p>PsycINFO PsycARTICLES full text Ovid Online MEDLINE CINAHL SCOPUS ProQuest</p>	<p>EXCLUDED</p> <p>Did not fully meet inclusion criteria e.g. adult rape sample, not CSA</p>
<p>Lewey, J. H., Smith, C. L., Burcham, B., Saunders, N. L., Elfallal, D., & O'Toole, S. K. (2018). Comparing the Effectiveness of EMDR and TF-CBT for Children and Adolescents: a Meta-Analysis. <i>Journal of child & adolescent trauma</i>, 11(4), 457–472. https://doi.org/10.1007/s40653-018-0212-1</p>	<p>SCOPUS PILOTS ProQuest</p>	<p>EXCLUDED</p> <p>As per original systematic review; meta-analysis, literature reviews and systematic reviews were all excluded</p>

<p>Chen, R., Gillespie, A., Zhao, Y., Xi, Y., Ren, Y., & McLean, L. (2018). The efficacy of eye movement desensitization and reprocessing in children and adults who have experienced complex childhood trauma: A systematic review of randomized controlled trials. <i>Frontiers in Psychology</i>, 9(APR). https://doi.org/10.3389/fpsyg.2018.00534</p>	<p>Google Scholar SCOPUS</p>	<p>EXCLUDED</p> <p>Already covered in previous version of review</p>
<p>Fateme, J., Soran, R., & Yousef, D. (2020). How to heal their psychological wounds? Effectiveness of emdr therapy on post-traumatic stress symptoms, mind-wandering and suicidal ideation in iranian child abuse victims. <i>Persian Gulf University, Bushehr, Iran. Wiley</i>. 10.1002/capr.12339</p>	<p>PsycINFO PsycARTICLES full text Ovid Online MEDLINE SCOPUS Wiley</p>	<p>INCLUDED</p>
<p>Tichelaar, K. H., Deković, M., & Endendijk, J. J. (2020) Exploring effectiveness of psychotherapy options for sexually abused children and adolescents: A systematic review of randomized controlled trials. <i>Children and Youth Services Review</i>. Volume 119, 105519, ISSN 0190-7409. https://doi.org/10.1016/j.chilyouth.2020.105519.</p>	<p>PILOTS ProQuest Web of Science SCOPUS</p>	<p>EXCLUDED</p> <p>As per original systematic review; meta-analysis, literature reviews and systematic reviews were all excluded</p>
<p>Katz, C., Tsur, N., Nicolet, R., Klebanov, B., & Carmel, N. (2020). No way to run or hide: Children's perceptions of their responses during intrafamilial child sexual abuse, <i>Child Abuse & Neglect</i>, Volume 106, 104541, ISSN 0145-2134, https://doi.org/10.1016/j.chiabu.2020.104541.</p>	<p>PILOTS ProQuest Web of Science</p>	<p>EXCLUDED</p> <p>Did not fully meet inclusion criteria e.g. child-only sample '40 transcripts of forensic interviews with children aged 4–14, who have been sexually abused by their fathers' and no specific EMDR treatment</p>

<p>Rowe, T. (2019) The Efficacy of Eye Movement Desensitization and Reprocessing (EMDR) in Individuals Diagnosed with Either C-PTSD or PTSD. Northcentral University, ProQuest Dissertations Publishing, 2019. 27670979.</p>	<p>ProQuest Google Scholar</p>	<p>EXCLUDED</p> <p>As per original systematic review; meta-analysis, literature reviews and systematic reviews were all excluded</p> <p>Also, not specific CSA sample 'quantitative, meta-analysis study was to determine EMDR therapy treatment efficacy in individuals diagnosed with either C-PTSD or PTSD'</p>
<p>Lewis, C., Roberts, P. N., Andrew, M., Starling, E., & Bisson, I. J. (2020). Psychological therapies for post-traumatic stress disorder in adults: systematic review and meta-analysis, European Journal of Psychotraumatology, 11:1, 10.1080/20008198.2020.1729633</p>	<p>Google Scholar</p>	<p>EXCLUDED</p> <p>As per original systematic review; meta-analysis, literature reviews and systematic reviews were all excluded</p>
<p>Houben, S. T. L. (2020) Dissertation.</p>	<p>Google Scholar</p>	<p>EXCLUDED</p> <p>Grey literature</p>
<p>Melton, H., Meader, N., Dale, H., Wright, K., Jones-Diette, J., Temple, M., Shah, I., Lovell, K., McMillan, D., Churchill, R., Barbui, C., Gilbody, S., & Coventry, P. (2020). Interventions for adults with a history of complex traumatic events: the INCiTE mixed-methods systematic review. Health technology assessment (Winchester, England), 24(43), 1–312. https://doi.org/10.3310/hta24430</p>	<p>Google Scholar</p>	<p>EXCLUDED</p> <p>As per original systematic review; meta-analysis, literature reviews and systematic reviews were all excluded</p>

<p>Kizilhan, I. J., Steger, F., & Noll-Hussong, M. (2020). Shame, dissociative seizures and their correlation among traumatised female Yazidi with experience of sexual violence. <i>The British Journal of Psychiatry: Disasters and Trauma Themed Issue</i>. Cambridge University Press</p>	<p>PILOTS ProQuest</p>	<p>EXCLUDED</p> <p>Did not fully meet inclusion criteria e.g. adult female rape sample, not CSA</p>
<p>Boterhoven de Haan, K. L., Lee, C. W., Fassbinder, E., van Es, S. M., Menninga, S., Meewisse, M. L., ... & Arntz, A. (2020) Imagery rescripting and eye movement desensitisation and reprocessing as treatment for adults with post-traumatic stress disorder from childhood trauma: randomised clinical trial. <i>British Journal of Psychiatry</i>;217(5):609-615. 10.1192/bjp.2020.158. PMID: 32892758.</p>	<p>PILOTS ProQuest</p>	<p>EXCLUDED</p> <p>Did not fully meet inclusion criteria e.g. not sexual abuse</p>
<p>van Westrhenen, N., Fritz, E., Vermeer, A., Boelen, P., & Kleber, R. (2019) Creative arts in psychotherapy for traumatized children in South Africa: An evaluation study. <i>PLoS One</i>. 14(2):e0210857. 10.1371/journal.pone.0210857. PMID: 30759101; PMCID: PMC6374007.</p>	<p>PILOTS ProQuest</p>	<p>EXCLUDED</p> <p>Did not fully meet inclusion criteria e.g. child sample 'age between 7 and 13 years' and working primarily with 'Creative Arts in Psychotherapy (CAP) intervention'</p>
<p>Coventry, P. A., Meader, N., Melton, H., Temple, M., Dale, H., Wright, K... & Gilbody S. (2020) Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis. <i>PLoS</i></p>	<p>SCOPUS</p>	<p>EXCLUDED</p> <p>As per original systematic review; meta-analysis, literature reviews and systematic reviews were all excluded</p>

Med. 7(8):e1003262. 10.1371/journal.pmed.1003262. PMID: 32813696; PMCID: PMC7446790.		
Karadag, M., Gokcen, C., & Sarp, A. S. (2020). EMDR therapy in children and adolescents who have post-traumatic stress disorder: a six-week follow-up study. <i>International Journal of Psychiatry Clinical Practice</i> . 24(1):77-82. 10.1080/13651501.2019.1682171. Epub 2019 Oct 30. PMID: 31663396.	SCOPUS	EXCLUDED Did not fully meet inclusion criteria e.g. working with child and adolescent populace
Cowan, A., Ashai, A., & Gentile, J. P. (2020) Psychotherapy with Survivors of Sexual Abuse and Assault. <i>Innovative Clinical Neuroscience</i> ;17(1-3):22-26. PMID: 32547843; PMCID: PMC7239557.	SCOPUS	EXCLUDED Grey literature, namely guidance points
Mollon, P. (eBook published 28 June 2019) Jane: EMDR and psychotherapy with a traumatized and abused woman. <i>Psychanalytic Perspectives</i> . London, Routledge	SCOPUS	EXCLUDED Grey literature, book chapter
Wright, L., & Warner, A. (2020). EMDR treatment of childhood sexual abuse for a child molester: self-reported changes in sexual arousal. <i>Journal of EMDR practice and research</i> . 14(2). 10.1891/EMDR-D-19-00060	SCOPUS	INCLUDED
Barron, I., Bourgaize, C., Lempertz, D., Swinden, C., & Darker-Smith, S. (2019). <i>Eye Movement Desensitization Reprocessing for</i>	SCOPUS	EXCLUDED

Children and Adolescents With Posttraumatic Stress Disorder: A Systematic Narrative Review. <i>Journal of EMDR Practice and Research</i> . 13. 270-283. 10.1891/1933-3196.13.4.270		As per original systematic review; meta-analysis, literature reviews and systematic reviews were all excluded
Caro, P., Turner, W., & Macdonald, G. (2019). Comparative effectiveness of interventions for treating the psychological consequences of sexual abuse in children and adolescents. <i>Cochrane Database of Systematic Reviews</i> , 2019(6), 1-25. [CD013361]. https://doi.org/10.1002/14651858.CD013361	SCOPUS	EXCLUDED Did not fully meet inclusion criteria e.g. 'sexual abuse in children and young people up to 18 years of age'
Kratzer, L., Heinz, P., Schennach, R., et al. (2019) Inpatient Treatment of Complex PTSD Following Childhood Abuse: Effectiveness and Predictors of Treatment Outcome. <i>Psychotherapies, Psychosomatic Medicine</i> . 69(3-04):114-122. 10.1055/a-0591-3962.	SCOPUS	EXCLUDED Did not fully meet inclusion criteria e.g. inpatient sample of mixed childhood abuse, EMDR difficult to differentiate
Schouten, A. K., van Hooren, S., Knipscheer J. W., Kleber, R. J., & Hutschemaekers, G. J. M. (2019) Trauma-Focused Art Therapy in the Treatment of Posttraumatic Stress Disorder: A Pilot Study. <i>Journal of Trauma Dissociation</i> .20(1):114-130. 10.1080/15299732.2018.1502712. Epub 2018 Aug 15. PMID: 30111254.	SCOPUS	EXCLUDED Did not fully meet inclusion criteria e.g. Art Therapy investigated as alternative to 'evidence-based treatments: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or Eye Movement Desensitization and Reprocessing (EMDR)'
van Vliet, N. I., Huntjens, R. J. C., Van Dijk, M. K., & de Jongh, A. (2018). Phase-based treatment versus immediate trauma-focused treatment in patients with childhood trauma-related posttraumatic stress disorder: Study	SCOPUS	EXCLUDED Already covered in previous version of review

protocol for a randomized controlled trial. Trials, 19(1). https://doi.org/10.1186/s13063-018-2508-8		
Wohl, A., & Kirschen, W. G. (2018) Betrayal of the Body: Group Approaches to Hypo-Sexuality for Adult Female Sufferers of Childhood Sexual Abuse, Journal of Child Sexual Abuse, 27:2, 154-160, 10.1080/10538712.2018.1435597	SCOPUS	EXCLUDED Grey literature, namely guidance points
Wagenmans, A., Van Minnen, A., Sleijpen, M., & De Jongh, A. (2018). The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD . European Journal of Psychotraumatology, 9(1). https://doi.org/10.1080/20008198.2018.1430962	SCOPUS	EXCLUDED Already covered in previous version of review

Appendix 9: Greater Manchester Mental Health (GMMH) Trust Approval Letter



**Greater Manchester
Mental Health**
NHS Foundation Trust

Research & Innovation
1st Floor, Harrop House
Bury New Road
Prestwich, Manchester
M25 3BL

Tel: 0161 271 0607
Email: researchoffice@gmmh.nhs.uk
Date: 23 August 2019

Confirmation of Capacity & Capability at GMMH

Re: A systematic case series study investigating the effectiveness of Eye Movement Desensitization Reprocessing (EMDR) in the treatment of childhood sexual abuse (CSA) in adolescents and adult survivors

IRAS Reference: 261312

Research & Innovation Reference: x398

Sponsor: University of Salford

Dear Miss Halima Bibi

On behalf of Greater Manchester Mental Health NHS Foundation Trust I am pleased to confirm Capacity and Capability for the above research to commence at our site.

Approved Documents

Protocol Version 4 dated 10/06/2019 is recognised as the most current to date.

The documents approved for use at this Trust are as listed in the Health Research Authority Letter dated: 06/08/2019.

Any subsequent, relevant amendments are additionally approved to date.

Metrics and Recruitment

First Participant Target	Total Target Recruitment	Recruitment Target Date
16/09/2019	4	August 2020

Please inform the Research and Innovation office when you have consented your first participant, and update them on recruitment on a monthly basis.

To comply with national research performance requirements the Trust will monitor and publish performance data for interventional studies:

If you miss these targets you will be required to give reasons that can be reported to the NIHR.

Safety Reporting Requirements for Clinical Studies



C&C Letter Template portfolio & interventional studies
version 01 31/12/2018

Please note in accordance with Trust Policy, you are required to report all Serious Adverse Events (SAEs), other than those specified in the protocol as not requiring immediate reporting, to the Research & Innovation Office.

Study Staff

The CV and relevant training of the PI has been reviewed.

Conditions of Approval

The following conditions apply to this approval:

- a) The study is conducted in compliance with all the relevant legislation and the relevant GMMH Policies and R&I SOPs. These can be found on the R&I website: www.gmmh.nhs.uk/research
- b) All staff working on the study have the appropriate training and experience and have responsibilities formally delegated to them. If there are any new members of staff working on the study, please notify your GMMH Study Lead. A Research Passport is required for non-GMMH staff that require access to GMMH services or facilities.
- c) Serious Breaches of GCP or the protocol will be notified to the Research & Innovation researchoffice@gmmh.nhs.uk within one working day of awareness.
- d) Should you plan to leave your position in GMMH, you will notify R&I immediately of your plans to enable discussions around the future of study conduct.
- e) All relevant documents will be maintained and will be made available to R&I personnel, to facilitate compliance checks, formal audits and regulatory inspections.
- f) You will notify R&I of any subsequent protocol amendments.
- g) You will promptly inform R&I of the end of the study and share a copy of the end of study notification and report.

I wish you every success with the study.

Yours sincerely,



Mark Dawson
Research Initiation & Delivery Manager



Appendix 10: University of Salford - Ethics Approval Letter



**Research, Enterprise and Engagement
Ethical Approval Panel**

Doctoral & Research Support
Research and Knowledge Exchange,
Room 827, Maxwell Building,
University of Salford,
Manchester
M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk

19 June 2019

Dear Halima,

RE: ETHICS APPLICATION–HSR1819-085 'A systematic case series study investigating the effectiveness of Eye Movement Desensitization Reprocessing (EMDR) in the treatment of childhood sexual abuse in adolescents and adult survivors'

Based on the information that you have provided, I am pleased to inform you that application HSR1819-085 has been approved.

If there are any changes to the project and/or its methodology, then please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

A handwritten signature in black ink, appearing to read 'A Clark'.

Professor Andrew Clark
Deputy Chair of the Research Ethics Panel

Appendix 11: National Research Ethics Service (NRES) - Conditions Met Approval Letter



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales



Miss Halima Bibi
Psychotherapist (CBT & EMDR)
Greater Manchester Mental Health Trust - NHS
Chorlton House, 70 Manchester Road
Chorlton-cum-Hardy
Manchester
M21 9UN

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

06 August 2019

Dear Miss Bibi

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title:	A systematic case series study investigating the effectiveness of Eye Movement Desensitization Reprocessing (EMDR) in the treatment of childhood sexual abuse in adolescents and adult survivors
IRAS project ID:	261312
Protocol number:	N/A
REC reference:	19/YH/0241
Sponsor	University of Salford

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **261312**. Please quote this on all correspondence.

Yours sincerely,
Hayley Henderson
Approvals Manager

Email: hra.approval@nhs.net

Copy to: *Dr Linda Dubrow-Marshall, University of Salford*

Appendix 12: Invitation to Participate in Research Study

PARTICIPANT INVITATION LETTER

Halima Bibi
University of Salford
School of Health and Society
Allerton Building, XXX)
Salford
Greater Manchester
M6 6PU
Tel (GMMH Central IAPT Team Admin): 0161XXXXXXX
Email: XXX@edu.salford.ac.uk

Invitation to Participate in Research Study

I am a doctoral candidate on the Professional Doctorate (DProf) programme at the University of Salford. I am undertaking a research project to find out about the effects of EMDR therapy upon *neuropsychological, behavioural, emotional functioning and quality of life when treating survivors of childhood sexual abuse and equally, your views of your therapy experiences*. If you would like to consider participating in the [study](#) you will be asked to fill in a collection of questionnaires upon certain time points in therapy to measure changes in functioning and quality of life. You will also be invited back for a one month follow-up appointment whereby you will be invited to attend for a semi-structured interview which will last approximately one to one and a half hours as an opportunity to reflect on your EMDR experience. If you decide to take part in the research all the information you give will be [anonymised](#). Equally if you decide not to take part, this is entirely your choice and will not affect present or future therapy with your EMDR therapist.

Enclosed with this letter is an information sheet to provide you with more details about the research project and what you will be asked to do if you decide to partake. Please read the included information and if you feel that you would like to participate in the research, please contact me on the phone number or address provided at the top of this letter. Please feel free to ask as many questions as you [desire](#) and I will attempt to answer them before you decide to participate.

Thank you for your consideration. If you decide to participate in the [study](#) then the information you provide will be kept confidential unless you disclose any risk to self or others. Also, if you agree to have an audio-taped follow-up interview you will be called by a different name/alias and will make sure you do not say anything that would reveal your identity during the session. However following commencement of the project if you do decide to no longer participate in the research the information you have provided will be destroyed and not used in the research.

If you are interested, please contact me via phone or email (details can be found on the top [left hand](#) side of this letter)

Your help would be greatly appreciated

Kind Regards,

Halima Bibi
Psychological Therapist and Researcher

Appendix 13: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of study: A systematic case series study investigating the effectiveness of Eye Movement Desensitization Reprocessing (EMDR) in the treatment of childhood sexual abuse (CSA) in adolescents and adult survivors

Name of Researcher: Halima Bibi

1. Invitation paragraph

The aim of this study is to investigate the effectiveness of Eye Movement Desensitisation Reprocessing (EMDR) when working with survivors of childhood sexual abuse (CSA). The study will explore (a) neuropsychological, emotional (namely low self-esteem, anxiety and depression), behavioural functioning and quality of life issues and (b) your perspectives of such changes.

Please note: This study will take place within the usual NHS 'Improving Access to Psychological Therapies' (IAPT) service. All participants will have treatment as usual, including routine questionnaires - the only change will be the slight addition of two questionnaire, a simple neuropsychological computer-based assessment and a follow-up interview.

2. What is the purpose of the study?

We will explore the following:

- What is your experience of EMDR treatment; what did you find helpful or unhelpful and in what ways?
- Were there any changes in your daily neuropsychological, behavioural, emotional functioning and quality of life issues throughout the course of EMDR treatment?

3. Why have I been invited to take part?

As you are attending IAPT services for trauma-focused therapy, if EMDR is your treatment of choice, the researcher would like to invite you to participate in the study to explore whether you feel your EMDR therapy has been effective, identify your views of helpful and unhelpful aspects of therapy in the hope to use findings to improve future services.

INCLUSION CRITERIA - You will be considered for this study if you are:

Aged between 18 and 25; Have experienced CSA before the age of 16; Have shown signs of PTSD/trauma for over three-months; Are fluent in the English language; If taking medication, it has been stable for a period of at least 2-months before therapy; Not attending alternative trauma treatment from start to finish

EXCLUSION CRITERIA - You will not be considered for this study if you are:

Experiencing severe psychiatric comorbidity; Alcohol or drug dependent; At risk of suicide

Experiencing severe PTSD from trauma that has occurred within the past 6 months; Have undertaken trauma-focused treatment within the past 3 months or are due to begin this in the near future; Currently or have recently been involved in any research prior to this study

4. Do I have to take part?

No, you do not have to partake, this is entirely your decision. If you decide that this is not for you it will not affect the care you receive in any way.

5. What will happen to me if I take part?

Before participating you will be asked to sign a consent form. If you wish, the form will be verbally explained to you so that you are clear about what you are agreeing to do.

Baseline Assessment – As per standard practice, during this assessment session a history of previous relevant traumatic life events, any medication and current issues will be explored. This will consist of seven questionnaires and a simple computer-based assessment.

Part 1 – The researcher will explain that you will be allocated to a therapist and receive questionnaires during each EMDR session in order to evaluate your progress throughout treatment. Many of these questionnaires are routine in treatment regardless of partaking in this research, any additional questionnaires will take approximately 5-10 minutes to complete.

Part 2 – Following treatment completion, you will be invited to attend a one-month follow-up interview with the researcher, this will last approximately one hour (give or take, to meet your needs); the baseline measures will again be taken. This will generally take place at your usual place of therapy appointments. As per your permission, the interview will be audio taped. You will be free to terminate the interview at any time.

6. Expenses and payments?

No expenses or payments apply for this study. All assessment and treatment will be conducted free of charge via the NHS Improving Access to Psychological Therapies (IAPT) service

7. What are the possible disadvantages and risks of taking part?

Talking about your experiences of the treatment you have received during the follow-up interview may be distressing. If this occurs at any point, the researcher will turn off the audio-recorder during interview and provide an opportunity if you feel the need to talk about any aspects of the session/interview that you found distressing. This will not form part of the research.

If you feel that you would like further support the researcher will be able to direct you to appropriate services that you can choose to contact: a list of these 'Additional Support Services' can also be found at the bottom of this information sheet.

8. What are the possible benefits of taking part?

By sharing your experience of your EMDR you can help others to get an idea of what is useful about this kind of treatment, how it helped or hindered your progress. Also, this information can be used in

therapist knowledge of what works or doesn't work and this is useful to help develop EMDR and improve services.

9. What if there is a problem/complaint?

If you have a concern about any aspect of this study, you should ask to speak to the researcher by email (H.Bibi1@edu.salford.ac.uk) who will do their best to answer your questions.

Following this, if you have any issues or complaints, you may contact the research supervisors Dr. Linda Dubrow-Marshall or Dr. Clare Sarah Allely by email (L.Dubrow-Marshall@salford.ac.uk or C.S.Allely@salford.ac.uk) or by telephone (0161 295 5000)

Supervisor details:

Dr. Linda Dubrow-Marshall or Dr. Clare Sarah Allely
University of Salford
School of Health and Society
Allerton Building (room C809)
Salford
Greater Manchester
M6 6PU

If you remain dissatisfied and wish to complain formally, please forward your concerns to Professor Susan McAndrew, Chair of the Health Research Ethics Approval Panel, Room MS1.91, Mary Seacole Building, Fredrick Road Campus, University of Salford, Salford, M6 6PU. Tel: 0161 295 2778. E: S.McAndrew@salford.ac.uk

Alternatively, you can contact the NHS Customer Care Team
Greater Manchester Mental Health (GMMH) NHS Foundation Trust,
Trust HQ,
Bury New Road,
Prestwich,
Manchester,
M25 3BL
Telephone: 0800 587 4793 (freephone)
Landline: 0161 358 0600
Email: customer-care@gmmh.nhs.uk

10. General Data Protection Regulation (GDPR, 2018) - Confidentiality

The University of Salford is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Salford will keep identifiable information about you for 3 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

For more information about how we will be using your personal data, and what your rights are under the law in accordance with [GDPR](#) please see <https://www.hra.nhs.uk/information-about-patients/>

Greater Manchester Mental Health ([GMMH NHS Trust](#)) will keep your name, NHS number, contact details and any other identifying information (e.g. your profession, age, marital status, number of children) confidential and will not pass this information to the University of Salford. Hence all transcripts, case studies and any material for publication when describing your case will be fully anonymised. [GMMH NHS Trust](#) will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. The University of Salford will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name, NHS number or contact details.

Interview Transcripts & Questionnaires

All interview recordings will be stored on a password-protected computer. Only the researcher, academic supervisors and approved research staff will be allowed access. Confidentiality during treatment and interview will only be broken if you tell us that you or others may be at risk of harm which the researcher and therapist is duty bound to report. Also, the principal researcher managing this project may discontinue your participation at any time if it is not in your best interests, if for instance an issue of risk is presented which may determine onward referral to a more appropriate service or involvement from an outside agency (i.e. the Police when criminal activity has been reported). If such a situation arises, we would limit the disclosure to only what is necessary. We would also make every effort to fully discuss it with you beforehand.

Some anonymised interview transcript excerpts may be included in the researcher's thesis/report and in professional publications. You will be asked to view your disguised case study before it is used [in order to](#) ensure accuracy. You will be able to do so by either the researcher verbally reading this out to you over the telephone or inviting you in for a short consultation session so you have the opportunity to highlight any concerns.

All questionnaires will be input onto the confidential IAPT [I.T.](#) system as soon as they are collected from you as per standard protocol; these will be directly linked with your personal NHS IAPT record (each holding a unique identifier number) and only those who need valid access will be granted this.

11. What will happen if I don't carry on with the study?

You [are able to](#) drop-out of the study at any time during the actual participation without reprisal. However, you can withdraw at any time up to 1 month of being interviewed and all your data will be removed from the study. If you choose to withdraw from the study, you do not have to give any reasons and your withdrawal will not affect any aspect of your care.

12. What will happen to the results of the research study?

The researcher may use anonymised interview quotations in the finished report and any associated works that may be presented and/or published. The results of the study will be anonymised in accordance with the [GDPR](#) and published within the researcher's [DProf](#) thesis, [publications](#) and other research outputs. The results will be used to build upon existing research, positive change in service management and possibly in NHS training courses.

13. Who is organising or sponsoring the research?

Permission has been given to conduct this study by Greater Manchester Mental Health (GMMH) Trust. It has been reviewed by the researcher's supervision team at Salford University. It is conducted under the ethical approval of Salford University and the NHS Ethical Committee.

14. What if I have further queries?

Pls contact the researcher, Halima Bibi, on the following phone number (GMMH Central IAPT Team Admin): 0161 2710190

Thank you for taking the time to read this leaflet

Appendix 14: Participant Consent Form

CONSENT FORM

Title of study: A systematic case series study investigating the effectiveness of Eye Movement Desensitization Reprocessing (EMDR) in the treatment of childhood sexual abuse in adolescents and adult survivors

Name of Researcher: Halima Bibi

Please complete and sign this form **after** you have read and understood the study information sheet. Read the following statements, and select 'Yes' or 'No' in the box on the right-hand side. Please note: an original copy of the participant information sheet and completed informed consent form will be given to you, in addition to the original copy that is stored in the researchers file.

- | | | |
|----|--|-------------------------------------|
| 1. | I confirm that I have read and understand the study information sheet version [#5 of PIS], dated [24/07/19], for the above study. I have had the opportunity to consider the information and to ask questions, which have been answered satisfactorily. | <input type="text" value="Yes/No"/> |
| 2. | I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in the study, without giving any reason, and without my rights being affected. However, I can withdraw at any time up to 1 month of being interviewed and <u>all</u> of my data will be removed from the study. | <input type="text" value="Yes/No"/> |
| 3. | I understand that the principal researcher managing this project may discontinue my participation at any time if it is not in my best interests or the interests of the research, if for instance an issue of risk is presented which may determine onward referral to a more appropriate service or involvement from an outside agency i.e., the Police when criminal activity has been reported. | <input type="text" value="Yes/No"/> |
| 4. | I agree to partake by participating in completion of 7 questionnaires, one Neuropsychological battery test and by being interviewed, at one-month follow-up. I am aware that I can refrain from answering any question about which I feel uncomfortable. | <input type="text" value="Yes/No"/> |
| 5. | I give permission for the interview to be audio recorded, transcribed and Analysed. | <input type="text" value="Yes/No"/> |
| 6. | In accordance with the University of Salford guidance notes for research ethics applications I agree that data from the questionnaires and interview transcripts will be stored and archived for a minimum of 3 years, after the graduate award has been made. | <input type="text" value="Yes/No"/> |
| 7. | I understand that my personal details will be kept confidential and will not be revealed to people outside the research team. I am aware that if I reveal anything related to criminal activity and/or something that is harmful to self or others, the researcher may have to share that information with the appropriate authorities. | <input type="text" value="Yes/No"/> |

IRAS Project ID: 261312

Date [24/07/19]

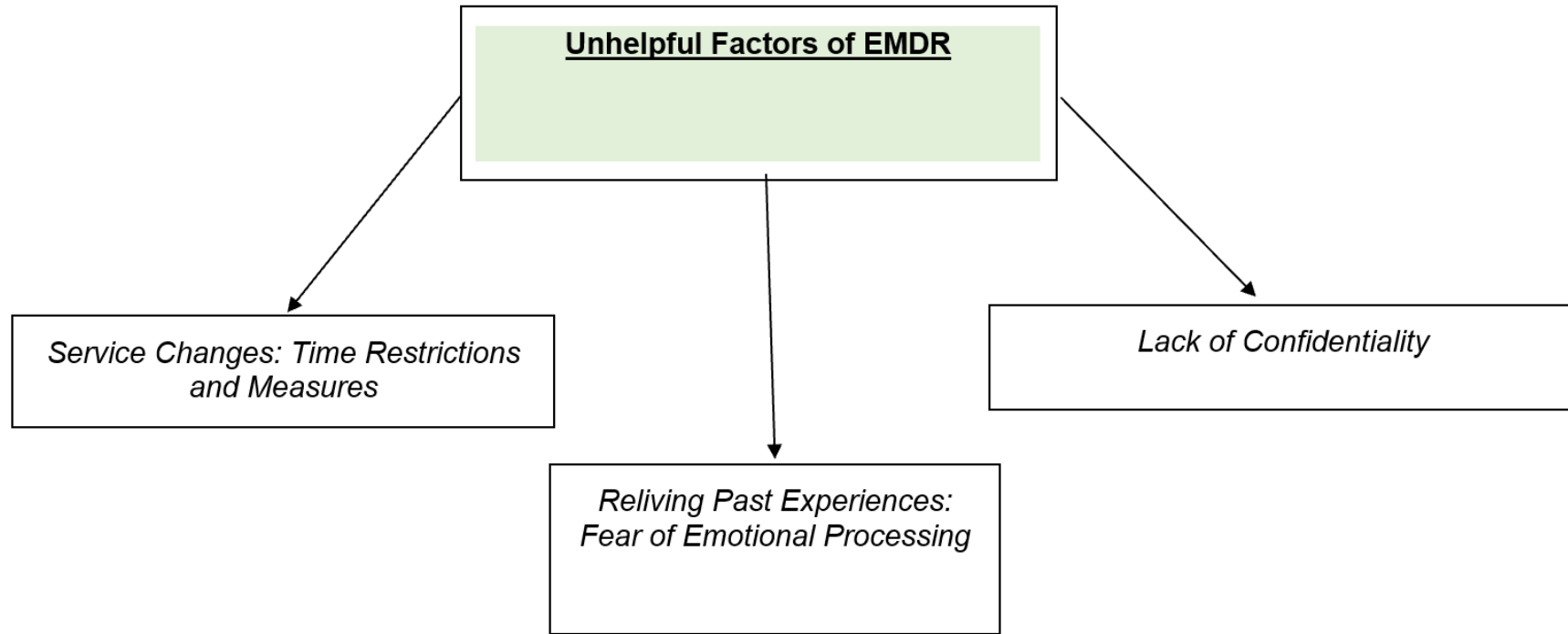
1

Appendix 15: Nvivo Nodes: Categories and Subcategories

The screenshot displays the Nvivo 12 Pro interface with the following components:

- Nodes Panel (Left):** A tree view showing the following categories and subcategories:
 - COVID-19_MIXED RESPONSES (6 files, 21 references)
 - Differences in BLS (hugs vs eye) (1 file, 1 reference)
 - 'In Person' vs 'Online' (6 files, 18 references)
 - HELPFUL FACTORS OF EMDR (6 files, 96 references)
 - Active Listening (5 files, 5 references)
 - Client Preferences and Therapy (5 files, 12 references)
 - Idiosyncratic-Alternative Modal (3 files, 10 references)
 - 'It just happens!' (2 files, 4 references)
 - Practitioner Characteristics and (6 files, 20 references)
 - Resourcing, Psychological-min (6 files, 35 references)
 - Working Memory Hypothesis (2 files, 2 references)
 - OUTCOMES (6 files, 46 references)
 - Attention (5 files, 7 references)
 - Emotions & Behaviours (Anx & (6 files, 11 references)
 - Executive Functioning (4 files, 4 references)
 - Memory (6 files, 6 references)
 - Quality of Life (6 files, 19 references)
 - Self-esteem (2 files, 2 references)
 - UNHELPFUL FACTORS OF EMDR (6 files, 17 references)
 - Fear of Confidentiality (4 files, 4 references)
 - Reliving Past Experiences_Fear (3 files, 4 references)
 - Service Changes_Measures (6 files, 8 references)
- Main Text Area:** Displays interview transcripts from 'B2 Interview Transcript', 'B3 Interview Transcript', and 'K1 Interview Transcript'. The text includes segments like "out of it?", "K1: Umm, I guess part of it was, I just got this sort of, just understanding it better! And a lot of the times when I have, you know, I'm feeling anxious or I have those kinds of feelings at home. Yeah, it's kind of dumb, I kind of learn more about sort of the way that my body responds to things and why so, I think having that then I can kind of bring that knowledge home with me. It helps reduce the impact of things at home, I understand myself much better.", "Oh, and another thing that I wanted to mention that I've just remembered about the first question. If I could just, uh, one thing that I found really helpful I think was when I was starting it, I was a little bit worried because that (CSA) memory was the thing that I originally wanted to talk about but it was sort of the one thing that I didn't have a really clear memory of. I wasn't sure really how we were going to enter into it and how I would find it. And that's one thing that's been really good is this taking more of a holistic approach because we've identified that whilst there was one event, the kind of feelings that crop up and the, and the issues that are related to other events in my life as well, so it's been really good to be able to take a wider approach and deal with things that I didn't even realize were still an issue. Or I knew they were initially, but I didn't think I'd get chance to work on them because they all kind of tied in, so I think that's been really helpful.", "It was good, um, the therapist was providing lots of stuff around what element of you mind works and how and the memory networks and other components. That all contributes as well.", and "Hum. I don't know. I think part of the education part, I mean, I obviously didn't really know much about the therapeutic part anyway so, um, I was given like a picture that explained sort of why trauma memories get stuck and um, how EMDR therapy works and that was really helpful too, but um, I'm just trying to think of other things, so like the environment helped me process and take some of these techniques the therapist introduced."
- Right Sidebar:** A vertical list of nodes with colored bars indicating their frequency in the text. Visible nodes include:
 - Emotions & Behaviours (Anx & Dep/Symptomatic)
 - Active Listening
 - Service Changes_Measures
 - Quality of Life
 - Reliving Past Experiences_Fear of Emotional Processing
 - OUTCOMES
 - Practitioner Characteristics and Competencies
 - UNHELPFUL FACTORS OF EMDR
 - Client Preferences and Therapy Expectations
 - HELPFUL FACTORS OF EMDR
 - Resourcing, Psychological-min/Address & Psycho-education
 - It just happens!
 - COVID-19
- Bottom Panel:** A search bar with the text "Enter node name (CTRL+Q)".

Appendix 16: Nvivo Model of Theme: Unhelpful Factors of EMDR



Appendix 17: Interview Initial Noting

K2: I've pretty much barely had any nightmares, especially coz they got worse at first, the doctor did say it can cause some vivid dreams so I thought maybe this is what to expect, but it's kind of done the opposite and I'm just actually dreaming about what I feel is, you know, as crazy as dreams are, it's like *it's* normal dreams. It's not the ones I'd get where I'd feel totally distracted by the whole day. It's a simple thing, just being able to sort of get up knowing you've not had a weird dream or whatever and know it'll help with not thinking about it all day, that's been the case for a long, long time. It's really nice so in terms of that alone, I've been able to better manage emotions and how I behave. I would say it (nightmares) was a big factor in sort of preventing me from getting into college and all these things, I'm also concentrating on things now.

When it does come up, I realize I'm not actually going through it like then, I'm not actually feeling it anymore. I just can tell it like it's a story, that's all there is to it, so I think it's nice that you do feel in control again and I'm much more able to commit myself fully to things which was bothering me before because it was always you know 50/50 because my mind was always somewhere else. Yeah it definitely helps pretty much in all aspects, especially with the education side of it.

I think I'm also able to rationalize in terms of decision making a lot more so I think things are plainer in a way. My memory isn't always great but my memory's not so clouded anymore. I'd say my concentration, like reading a book is like a big thing I think because I have no distractions in my head. Otherwise it would stop me from even reading because it was always with my imagination. It would remain quite a lot whilst I was just doing day-to-day things which I know sounds like hell.

- Halima Bibi**
Quality of life improved, relaxed and slightly happier in tone of voice when discussing changes in dreams and emotions
- Halima Bibi**
Attention, more focused which helps day-to-day (i.e. college)
- Halima Bibi**
Intensity of emotion has reduced
- Halima Bibi**
Control element
- Halima Bibi**
Concentration with aid of psycho-ed
- Halima Bibi**
Improvements in memory, concentration and executive functioning - less rumination

Appendix 18: Dissociative Experiences Scale (DES)

Serenity Programme™ - www.serene.me.uk - Dissociative Experiences Scales (DES)

Dissociative Experiences Scales (DES)

Identifier Date

This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and select the number to show what percentage of the time you have the experience. 100% means 'always', 0% means 'never' with 10% increments in between. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

Never 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% Always

- 1 Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip. Select a number to show what percentage of the time this happens to you
- 2 Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear all or part of what was said. Select a number to show what percentage of the time this happens to you
- 3 Some people have the experience of finding themselves in a place and having no idea how they got there. Select a number to show what percentage of the time this happens to you
- 4 Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Select a number to show what percentage of the time this happens to you
- 5 Some people have the experience of finding new things among their belongings that they do not remember buying. Select a number to show what percentage of the time this happens to you
- 6 Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Select a number to show what percentage of the time this happens to you

7	Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something as if they were looking at another person. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
8	Some people are told that they sometimes do not recognize friends or family members. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
9	Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
10	Some people have the experience of being accused of lying when they do not think that they have lied. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
11	Some people have the experience of looking in a mirror and not recognizing themselves. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
12	Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
13	Some people sometimes have the experience of feeling that their body does not belong to them. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
14	Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
15	Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
16	Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>
17	Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Select a number to show what percentage of the time this happens to you	<input type="text" value="0%"/>

- 18 Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Select a number to show what percentage of the time this happens to you
- 19 Some people find that they are sometimes able to ignore pain. Select a number to show what percentage of the time this happens to you
- 20 Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Select a number to show what percentage of the time this happens to you
- 21 Some people sometimes find that when they are alone they talk out loud to themselves. Select a number to show what percentage of the time this happens to you
- 22 Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were different people. Select a number to show what percentage of the time this happens to you
- 23 Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Select a number to show what percentage of the time this happens to you
- 24 Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Select a number to show what percentage of the time this happens to you
- 25 Some people find evidence that they have done things that they do not remember doing. Select a number to show what percentage of the time this happens to you
- 26 Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Select a number to show what percentage of the time this happens to you
- 27 Some people find that they sometimes hear voices inside their head that tell them to do things or comment on things that they are doing. Select a number to show what percentage of the time this happens to you
- 28 Some people sometimes feel as if they are looking at the world through a fog so that people or objects appear far away or unclear. Select a number to show what percentage of the time this happens to you

Print Form

Clear Form

Mean DES Score

0

The Dissociative Experiences Scale (DES) is a simple questionnaire widely used to screen for dissociative symptoms. Tests such as the DES provide a quick screening method so that the more time-consuming structured clinical interview (SCID-D) can be used for those people with high DES scores.

The higher the DES score, the more likely it is that the person has a dissociative disorder. The DES is not a diagnostic instrument; it is designed for screening only. High scores on the DES do not show that a person has a dissociative disorder; they only suggest that clinical assessment for dissociation may be warranted. Different studies suggest different cut-off scores for the DES, but a score of more than 45 suggests a high likelihood of a dissociative disorder alongside a reduced likelihood of a 'false positive'.

Privacy - please note - this form does not transmit any information about you or your assessment scores. If you wish to keep your results, either print this document or save this file locally to your computer. If you click 'save' before closing, your results will be saved in this document. These results are intended as a guide to your health and are presented for educational purposes only. They are not intended to be a clinical diagnosis. If you are concerned in any way about your health, please consult with a qualified health professional.

Bernstein EM, Putnam FW (1986). "Development, reliability, and validity of a dissociation scale". J. Nerv. Ment. Dis. 174 (12): 727-35.

Frischholz, E.J. et al The dissociative experiences scale: further replication and validation. Dissociation, Vol. III, September 1990.

Appendix 19: Impact of Events Scale-Revised (IES-R)

IMPACT OF EVENTS SCALE-Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to _____ (event) that occurred on _____ (date). How much have you been distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Total IES-R Score: _____

INT: 1, 2, 3, 6, 9, 14, 16, 20
 AVD: 5, 7, 8, 11, 12, 13, 17, 22
 HYP: 4, 10, 15, 18, 19, 21

Weiss, D.S. (2007). The Impact of Event Scale-Revised. In J.P. Wilson, & T.M. Keane (Eds.) *Assessing psychological trauma and PTSD: a practitioner's handbook* (2nd ed., pp. 168-189). New York: Guilford Press.

AETR2N

22

1/13/2012

Revised Impact of Event Scale (22 questions):

The revised version of the Impact of Event Scale (IES-r) has seven additional questions and a scoring range of 0 to 88.

On this test, scores that exceed 24 can be quite meaningful. High scores have the following associations.

Score (IES-r) Consequence

24 or more	PTSD is a clinical concern. ⁶ Those with scores this high who do not have full PTSD will have partial PTSD or at least some of the symptoms.
33 and above	This represents the best cutoff for a probable diagnosis of PTSD. ⁷
37 or more	This is high enough to suppress your immune system's functioning (even 10 years after an impact event). ⁸

The IES-R is very helpful in measuring the affect of routine life stress, everyday traumas and acute stress

References:

1. Horowitz, M. Wilner, N. & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine*, 41, 209-218.
2. Weiss, D.S., & Marmar, C.R. (1997). The Impact of Event Scale-Revised. In J.P. Wilson & T.M. Keane (Eds.), *Assessing Psychological Trauma and PTSD* (pp.399-411). New York: Guilford.
3. Hutchins, E. & Devilly, G.J. (2005). Impact of Events Scale. Victim's Web Site. <http://www.swin.edu.au/victims/resources/assessment/ptsd/ies.html>
4. Coffey, S.F. & Berglind, G. (2006). Screening for PTSD in motor vehicle accident survivors using PSS-SR and IES. *Journal of Traumatic Stress*. 19 (1): 119-128.
5. Neal, L.A., Walter, B., Rollins, J., et al. (1994). Convergent Validity of Measures of Post-Traumatic Stress Disorder in a Mixed Military and Civilian Population. *Journal of Traumatic Stress*. 7 (3): 447-455.
6. Asukai, N. Kato, H. et al. (2002). Reliability and validity of the Japanese-language version of the Impact of event scale-revised (IES-R-J). *Journal of Nervous and Mental Disease*. 190 (3): 175-182.
7. Creamer, M. Bell, R. & Falilla, S. (2002). Psychometric properties of the Impact of Event Scale-Revised. *Behaviour Research and Therapy*. 41: 1489-1496.
8. Kawamura, N. Yoshiharu, K. & Nozomu, A. (2001) Suppression of Cellular Immunity in Men with a Past History of Post Traumatic Stress Disorder. *American Journal of Psychiatry*. 158: 484-486

Appendix 20: Weekly Problems Scale - Children Revised (WPS-CR)

Please mark (X) the answer that best describes your feelings or interactions during the past week.

<p>1. I feel sad <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>	<p>2. I feel nervous or worry about things <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>
<p>3. I like myself <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>	<p>4. I argue or fight with people <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>
<p>5. I get yelled at or get into trouble <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>	<p>6. I get along with my friends <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>
<p>7. I feel like I am as good as other kids/people <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>	<p>8. I feel guilty about things that have happened <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>
<p>9. I am forgetful <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>	<p>10. I have trouble paying attention <input type="checkbox"/> never <input type="checkbox"/> almost never <input type="checkbox"/> a little of the time <input type="checkbox"/> some of the time <input type="checkbox"/> most of the time <input type="checkbox"/> all of the time</p>

**11. I have trouble planning ahead
and following through on tasks**

- never
- almost never
- a little of the time
- some of the time
- most of the time
- all of the time

PHQ-9 Depression

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not all	at Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.....	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3
Column totals	___	+ ___	+ ___	+ ___
	= Total Score _____			

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

ROSENBERG SELF-ESTEEM SCALE

Reference:

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Description of Measure:

A 10-item scale that measures global self-worth by measuring both positive and negative feelings about the self. The scale is believed to be uni-dimensional. All items are answered using a 4-point Likert scale format ranging from strongly agree to strongly disagree.

Abstracts of Selected Related Articles:

Gray-Little, B., Williams, V.S.L., & Hancock, T. D. (1997). An item response theory analysis of the Rosenberg Self-Esteem Scale. *Personality and Social Psychology Bulletin*, 23, 443-451.

The Rosenberg Self-Esteem Scale, a widely used self-report instrument for evaluating individual self-esteem, was investigated using item response theory. Factor analysis identified a single common factor, contrary to some previous studies that extracted separate Self-Confidence and Self-Depreciation factors. A unidimensional model for graded item responses was fit to the data. A model that constrained the 10 items to equal discrimination was contrasted with a model allowing the discriminations to be estimated freely. The test of significance indicated that the unconstrained model better fit the data—that is, the 10 items of the Rosenberg Self-Esteem Scale are not equally discriminating and are differentially related to self-esteem. The pattern of functioning of the items was examined with respect to their content, and observations are offered with implications for validating and developing future personality instruments.

Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. D. (2003). Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles? *Psychological Science in the Public Interest*, 4, 1-44.

Summary – Self-esteem has become a household word. Teachers, parents, therapists, and others have focused efforts on boosting self-esteem, on the assumption that high self-esteem will cause many positive outcomes and benefits—an assumption that is critically evaluated in this review.

Appraisal of the effects of self-esteem is complicated by several factors. Because many people with high self-esteem exaggerate their successes and good traits, we emphasize objective measures of outcomes. High self-esteem is also a heterogeneous category, encompassing people who frankly accept their good qualities along with narcissistic, defensive, and conceited individuals.

The modest correlations between self-esteem and school performance do not indicate that high self-esteem leads to good performance. Instead, high self-esteem is partly the result of good school performance. Efforts to boost the self-esteem of pupils have not been shown to improve academic performance and may sometimes be counterproductive. Job performance in adults is sometimes related to self-esteem, although the correlations vary widely, and the direction of causality has not been established. Occupational success may boost self-esteem rather than the reverse. Alternatively, self-esteem may be helpful only in some job contexts. Laboratory studies have generally failed to find that self-esteem causes good task performance, with the important exception that high self-esteem facilitates persistence after failure.

People high in self-esteem claim to be more likable and attractive, to have better relationships, and to make better impressions on others than people with low self-esteem, but objective measures disconfirm most of these beliefs. Narcissists are charming at first but tend to alienate others eventually. Self-esteem has not been shown to predict the quality or duration of relationships.

High self-esteem makes people more willing to speak up in groups and to criticize the group's approach. Leadership does not stem directly from self-esteem, but self-esteem may have indirect effects. Relative to people with low self-esteem, those with high self-esteem show stronger in-group favoritism, which may increase prejudice and discrimination.

Neither high nor low self-esteem is a direct cause of violence. Narcissism leads to increased aggression in retaliation for wounded pride. Low self-esteem may contribute to externalizing behavior and delinquency, although some studies have found that there are no effects or that the effect of self-esteem vanishes when other variables are controlled. The highest and lowest rates of cheating and bullying are found in different subcategories of high self-esteem.

Self-esteem has a strong relation to happiness. Although the research has not clearly established causation, we are persuaded that high self-esteem does lead to greater happiness. Low self-esteem is more likely than high to lead to depression under some circumstances. Some studies support the buffer hypothesis, which is that high self-esteem mitigates the effects of stress, but other studies come to the opposite conclusion, indicating that the negative effects of low self-esteem are mainly felt in good times. Still others find that high self-esteem leads to happier outcomes regardless of stress or other circumstances.

High self-esteem does not prevent children from smoking, drinking, taking drugs, or engaging in early sex. If anything, high self-esteem fosters experimentation, which may increase early sexual activity or drinking, but in general effects of self-esteem are negligible. One important exception is that high self-esteem reduces the chances of bulimia in females.

Overall, the benefits of high self-esteem fall into two categories: enhanced initiative and pleasant feelings. We have not found evidence that boosting self-esteem (by

therapeutic interventions or school programs) causes benefits. Our findings do not support continued widespread efforts to boost self-esteem in the hope that it will by itself foster improved outcomes. In view of the heterogeneity of high self-esteem, indiscriminate praise might just as easily promote narcissism, with its less desirable consequences. Instead, we recommend using praise to boost self-esteem as a reward for socially desirable behavior and self-improvement.

Ciarrochi, J., Heaven, P. C. L., & Fiona, D. (2007). The impact of hope, self-esteem, and attributional style on adolescents' school grades and emotional well-being: A longitudinal study.

We examined the distinctiveness of three "positive thinking" variables (self-esteem, trait hope, and positive attributional style) in predicting future high school grades, teacher-rated adjustment, and students' reports of their affective states. Seven hundred eighty-four high school students (382 males and 394 females; 8 did not indicate their gender) completed Time 1 measures of verbal and numerical ability, positive thinking, and indices of emotional well-being (positive affect, sadness, fear, and hostility), and Time 2 measures of hope, self-esteem, and emotional well-being. Multi-level random coefficient modelling revealed that each positive thinking variable was distinctive in some contexts but not others. Hope was a predictor of positive affect and the best predictor of grades, negative attributional style was the best predictor of increases in hostility and fear, and low self-esteem was the best predictor of increases in sadness. We also found that sadness at Time 1 predicted decreases in self-esteem at Time 2. The results are discussed with reference to the importance of positive thinking for building resilience.

Scale:

Instructions

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.
Strongly Agree Agree Disagree Strongly Disagree
2. At times I think I am no good at all.
Strongly Agree Agree Disagree Strongly Disagree
3. I feel that I have a number of good qualities.
Strongly Agree Agree Disagree Strongly Disagree
4. I am able to do things as well as most other people.
Strongly Agree Agree Disagree Strongly Disagree
5. I feel I do not have much to be proud of.
Strongly Agree Agree Disagree Strongly Disagree
6. I certainly feel useless at times.

Strongly Agree	Agree	Disagree	Strongly Disagree
7. I feel that I'm a person of worth, at least on an equal plane with others.			
Strongly Agree	Agree	Disagree	Strongly Disagree
8. I wish I could have more respect for myself.			
Strongly Agree	Agree	Disagree	Strongly Disagree
9. All in all, I am inclined to feel that I am a failure.			
Strongly Agree	Agree	Disagree	Strongly Disagree
10. I take a positive attitude toward myself.			
Strongly Agree	Agree	Disagree	Strongly Disagree

Scoring:

Items 2, 5, 6, 8, 9 are reverse scored. Give "Strongly Disagree" 1 point, "Disagree" 2 points, "Agree" 3 points, and "Strongly Agree" 4 points. Sum scores for all ten items. Keep scores on a continuous scale. Higher scores indicate higher self-esteem.

Valued Living Questionnaire (VLQ)

Author: Kelly Wilson & Groom

The VLQ is an instrument that taps into 10 valued domains of living. These domains include: 1. Family, 2. Marriage/couples/intimate relations, 3. Parenting, 4. Friendship, 5. Work, 6. Education, 7. Recreation, 8. Spirituality, 9. Citizenship, and 10. Physical self-care.

Scoring: Respondents are asked to rate the 10 areas of life on a scale of 1–10, indicating the level of importance and how consistently they have lived in accord with those values in the past week. For detailed information on scoring the VLQ see Wilson and Murrell (2004).

Reliability: The instrument has shown good test-retest reliability.

Validity: Currently being collected.

Reference:

Wilson, K. G. & Groom, J. (2002). *The Valued Living Questionnaire*. Available from Kelly Wilson.

Wilson, K. G. & Murrell, A. R. (2004). Values work in acceptance and commitment therapy: Setting a course for behavioral treatment. In S. C. Hayes, V. M. Follette, & M. M. Linehan (Eds.), *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 120-151). New York, NY: Guilford Press.

Revised date (4 October 2006)

Valued Living Questionnaire

Below are areas of life that are valued by some people. We are concerned with your quality of life in each of these areas. One aspect of quality of life involves the importance one puts on different areas of living. Rate the importance of each area (by circling a number) on a scale of 1-10. 1 means that area is not at all important. 10 means that area is very important. Not everyone will value all of these areas, or value all areas the same. Rate each area according to **your own personal sense of importance**.

<u>Area</u>	not at all important										extremely important
1. Family (other than marriage or parenting)	1	2	3	4	5	6	7	8	9	10	
2. Marriage/couples/intimate relations	1	2	3	4	5	6	7	8	9	10	
3. Parenting	1	2	3	4	5	6	7	8	9	10	
4. Friends/social life	1	2	3	4	5	6	7	8	9	10	
5. Work	1	2	3	4	5	6	7	8	9	10	
6. Education/training	1	2	3	4	5	6	7	8	9	10	
7. Recreation/fun	1	2	3	4	5	6	7	8	9	10	
8. Spirituality	1	2	3	4	5	6	7	8	9	10	
9. Citizenship/Community Life	1	2	3	4	5	6	7	8	9	10	
10. Physical self care (diet, exercise, sleep)	1	2	3	4	5	6	7	8	9	10	

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Contact: kwilson@olemiss.edu

Revised date (4 October 2006)

In this section, we would like you to give a rating of how consistent your actions have been with each of your values. We are **not** asking about your ideal in each area. We are also **not** asking what others think of you. Everyone does better in some areas than others. People also do better at some times than at others. **We want to know how you think you have been doing during the past week.** Rate each area (by circling a number) on a scale of 1-10. 1 means that your actions have been completely inconsistent with your value. 10 means that your actions have been completely consistent with your value.

During the past week

<u>Area</u>	not at all consistent with my value					completely consistent with my value				
1. Family (other than marriage or parenting)	1	2	3	4	5	6	7	8	9	10
2. Marriage/couples/intimate relations	1	2	3	4	5	6	7	8	9	10
3. Parenting	1	2	3	4	5	6	7	8	9	10
4. Friends/social life	1	2	3	4	5	6	7	8	9	10
5. Work	1	2	3	4	5	6	7	8	9	10
6. Education/training	1	2	3	4	5	6	7	8	9	10
7. Recreation/fun	1	2	3	4	5	6	7	8	9	10
8. Spirituality	1	2	3	4	5	6	7	8	9	10
9. Citizenship/Community Life	1	2	3	4	5	6	7	8	9	10
10. Physical self care (diet, exercise, sleep)	1	2	3	4	5	6	7	8	9	10

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Contact: kwilson@olemiss.edu

Revised date (4 October 2006)

6. Did anything happen *during treatment* which might have been hindering? YES NO
Please describe this event briefly:

7. What do you think makes EMDR therapy effective?

8. How effective would you say EMDR therapy was for you, particularly within quality of life stressors, neuropsychological (memory, attention and executive processing), emotional and behavioural functioning?

9. How do you feel about the ending to your EMDR sessions?

10. Would you recommend EMDR to someone else based on your treatment choice and preparedness for treatment?

11. Is there anything I've not asked that you would like to tell me about?

Please note this is a framework of the kinds of questions that will be explored in the interview.