go with that magazine

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EMDR THERAPY AND CHALLENGING TEENAGERS

plus:

- How EMDR Helps Teens Return to In-person Learning
- Ten Things about EMDR and Autism
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Have you listened to EMDRIA's new podcast, *Let's Talk EMDR?* Published twice a month, each episode features EMDR therapists and innovators who discuss protocols and treatment approaches to treating trauma. We match the guest expert with any awareness months that are applicable to explore different populations and diagnoses. Check out new episodes on the link below where you can find a complete list of podcast apps where *Let's Talk EMDR* has been published. If you like it, please consider rating the podcast in your listening app. www.emdria.org/letstalkemdrpodcast.

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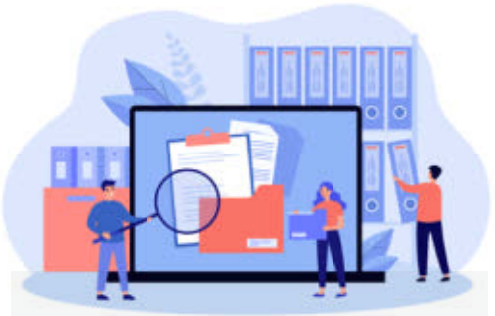
EMDRIA has updated and republished brochures that explain EMDR therapy to your clients. Members can access two types of brochures – one for adults and one for children. Both brochures are available in English and Spanish.

For access to download the high-resolution PDFs, visit www.emdria.org/publications-resources/emdr-therapy-client-brochures.



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- Guidelines for Virtual EMDR Therapy
- Online EMDR Therapy Resources
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These resources can be found at www.emdria.org/publications-resources/practice-resources/online-emdr-therapy-resources.

I don't want to be here.

EMDR Therapy for Challenging Teenagers

By Annie Monaco, LCSW-R RPT and Nicole E. Wolasz, LCSW-R

Most therapists agree that teenagers can be among the most challenging clients we see in our therapy practice, and to have a positive treatment outcome, we need engagement and retention. Many teen clients are not interested in connecting to a strange adult, let alone doing something even stranger like EMDR. This population may refuse to attend sessions, give short answers when they do attend, swear at parents and therapists, and storm out of the room when they hear things they don't like.

"I don't want to be here. This counseling is stupid. I am bored. What time is this over? You can't make me talk. This is my life, and you can't tell me what to do," are typical statements heard in the therapy room. Even the most seasoned therapists may struggle with how to engage a client that does not want to be in therapy.

Developmentally, as teenagers begin to assert their independence and find their identity, they can be challenging to parents. A troubled teen who has experienced adversity may present even more challenges and might exhibit risky behaviors, such as the use of substances, violence, self-harm, and criminal acts. They may be skipping and failing school and could be the victims or aggressors of bullying and cyberbullying as well as having an intense and unhealthy connection to social media. In addition, they may exhibit symptoms of mental health problems, such as depression, anxiety, or eating disorders.

"He refuses to go to school. He walks out of the house, and we don't know where he is all night long. She stays in her room all day. What happened to my loving child who now claims to hate me?" These are common concerns that parents might express to therapists during counseling sessions.

Building effective therapeutic alliances with these youth can seem daunting to even the most experienced counselor. As directors of a teenager offender program in an

outpatient setting at a mental health agency for more than 10 years, we provided intensive family therapy treatment (under the Functional Family Therapy model), EMDR for all family members as needed, and restorative justice programs, such as victim offender meditation and restorative circles. We came to passionately enjoy the resistant teenagers, who put their feet on the coffee table, crossed their arms, pulled their hoods over their eyes, and pretended to go to sleep. We learned to engage them, and their caregivers, to deliver successful EMDR therapy that helped teens function at home, in school, and in the community.

If you can float back to when you were a teen.... it's a time of pushing limits, finding your way, and having a sense of power and control. Between dealing with the changes in the teen body and the social pressures put on adolescents by their classmates and society, the teen years can be a difficult and confusing time of life. Teenagers are in the developmental stage of constant transformation—whether it be physical (growth, sexual development), cognitive (formal operations), moral (values and spirituality), or identity (self-image and self-esteem) development (Eyrich-Garg, 2008). As a result, teens often require a balance between both structure and freedom and dependence and independence in counseling (Veach & Gladding, 2007). We know that brains are not fully developed until the age of 25 years old, and teens can change tremendously during these years in both positive and negative ways. The front part of the brain, called the prefrontal cortex, is one of the last brain regions to mature. This area is responsible for skills like planning, prioritizing, and controlling impulses. Because these skills are still developing, teens are more likely to engage in risky behaviors without considering the potential results of their decisions. This can be very challenging for parents to navigate.

Engaging teens towards change and healing often involves instilling hope and motivation, understanding what is important to the teen, exploring core issues, and involving parents and caregivers in the process. While all phases of EMDR are employed in working with teens, this article will focus on critical pieces needed for Phases 1, 2, and 4 of EMDR therapy, which are the foundation of effective trauma therapy for this age group. History taking, preparing, and engaging the family system will set the stage for good trauma processing.

Engaging the Resistant Teen

Resistance is the language of teens. You must decipher it. Here are common feelings among this population:

- We hate our lives, and we don't feel good enough.
- We may not have people in our lives who believe in us.
- We certainly hate school, and we may struggle to learn like others.
- We are not connecting with our parents, yet we are connecting with friends (that make us feel good in the moment), who don't always encourage us to do the right thing.
- We can't see a future. Doing drugs, drinking alcohol, stealing, vandalism, and violence become part of daily life as these activities are a good way to distract from the emotional pain.
- You (the therapist) look like a probation officer, caseworker, or the last therapist who told me to "be nice to my parents" and "cut this bad behavior out" or "I will end up in a juvenile residential center or worse, prison." It is just way too hard to trust you and give you a chance.
- We don't think we are good enough or have what it takes to have a good, happy, and prosperous life. You will figure it out soon enough too that family members or community supports to assist with stabilizing the family and working towards increasing strengths and communication.

Engaging teens towards change and healing often involves instilling hope and motivation, understanding what is important to the teen, exploring core issues, and involving parents and caregivers in the process.

PHASE 1: HISTORY TAKING AND TREATMENT PLAN

Phase 1 focuses on engaging resistant teens, assessing their risky behaviors, and determining their level of dissociative strategies. Taking an attachment history of not only teenagers but of the caregivers as well provides you with an understanding of how and why certain parenting techniques are being utilized. It is crucial to connect to caregivers and reframe their anger towards their child, so they can be a support to the teen throughout all the phases of EMDR. We encourage therapists to also identify extended

Some Tips for Therapists

- Have fidgety gadgets for teens to become interested in playing with
- Have available drawing materials, painting supplies, clay, and mandalas
- Acknowledge that this is not ideal to be at counseling, and you, too think this sucks for them
- Acknowledge that you are a stranger and not here to force them to talk and tell you things
- Acknowledge their perspective. It's helpful to acknowledge how they see things and how strongly they are feeling about this. Talk about the pain of school, friends, and home life not being what they want. Do not start problem-solving too early in the treatment.
- Don't discuss future effects of risky behavior. Hearing about risky behavior can be very hard for therapists. In the early sessions, do not talk about the long-term effects of their behaviors, such as failing, residential, jail, prison.
- Engage caregivers. Involving caregivers (parents, extended family, school

we are not worth fighting for. We will do everything to push you away and then you will give up on us like everyone else.

Until you engage resistant teens, you cannot move forward with processing traumatic events. The therapist's role is to engage them and help them feel safe in the office to work on the past.

Nicole's Case Example

A 14-year-old teenage boy, who was violent at home, had engaged in sexual offending behavior towards his sibling, depicting violent images in his drawings, and had a strong preoccupation with guns and death. He was disrespectful to all his family members and came into therapy very guarded. "I'm not the problem. How much longer do we have?" were typical statements throughout the first four months of therapy. Having a good snack available at the start of each session helped relax this client. I found that he was masterful in distracting, and providing some options and structure to the session (snack, board game, and drawing) came to be the perfect fit for him. He started to look forward to our sessions, telling me that it was the only time he felt that he was heard. We began to explore dissociated parts of self, and he identified several hostile and agressive parts were coming out in violent drawings. It was evident that these self-states needed their deep wounds to be heard and understood. Resourcing helped to strengthen the idea that "I can do this" when he was hesitant in moving forward with EMDR processing. He identified a time that he felt strong and capable, and mom was able to tap that in for him in an attachment related resourcing experience. This teenager began to identify that his core negative beliefs of self, ("I am different. I am disgusting. There is something wrong with me.") were linked with his early childhood wounds. Moving into phase 4, allowed us to desensitize his early traumatic wounds and the rage that was part of his victimization. Desensiziting and reprocessing his early experiences freed him of his anger and negative beliefs.

This teen was stuck in feeling that he should have done something when it came to his own abuse. As the work continued, he was able to identify that it "wasn't my fault" and that he couldn't have changed things. Good interwearves around having no control as a young child were also helpful. Over time, this client became much more connected to his family, and he became a high achiever in school. An empathetic part of him also emerged following reprocessing, which then improved relationships with family members.

Key Lessons

Slow and steady with teens has to be a strong skill among therapists. Allowing teens to have a sense of control in session is also critical as well as understanding what is important to the client since this can help to move the teen towards doing the work. Identify parts of self to help the teen understand themselves and support the most wounded part receive trauma therapy.

ENGAGING THE RESISTANT PARENTS

Many parents are frightened and worried about their child's behavior and use repetitive ineffective communication techniques, such as yelling, nagging, and threatening. Here are some examples and some possible messages behind the parent's statement.

"If he doesn't get his act together, I am sending him away." (Caregivers' anger can imply fear that their children's choices will harm their future, and they may even end up dead. Caregivers feel helpless and inadequate, and possibly a residential center might keep their children alive.)

"Every day I ask him to do his homework." (Nagging equals the caregiver's feeling about the importance of the future and worrying that the teen will not graduate and end up struggling later in life.)

"He goes out with his friends until all hours of the night; we never see him." (The emotional pain of being disconnected from the child and fear of the teen's behaviors interfere with the caregiver's listening and understanding of the child.)

"Do you see the color of her hair? And the number of piercings? And now he wants to be called by a different name! How will she ever get a job?" (The caregiver is frightened by differences and worried about what this means and how the child might be treated in society.)

TREATING CHALLENGING PARENTS

Acknowledging caregivers' fears and worries (which is underneath their anger) and using relational interventions will improve the relational discord between teen and caregiver. Many therapists will only provide individual therapy to the teen and will not engage or provide collateral or family sessions with the challenging parents as they might feel overwhelmed in dealing with the parents' problem behaviors. The therapist might be upset by the caregiver's behavior toward the teen and feel hopeless that the caregiver can change. In addition, the therapist might feel worried that the teenager will not want to stay engaged if the caregiver is involved or has a relationship with the therapist. It is a difficult and delicate balance to work with the whole family.

Slow and steady with teens has to be a strong skill among the therapist. Allowing teens to have a sense of control in session is also critical as well as understanding what is important to the client since this can help to move the teen towards doing the work.

Annie's Case Example

A 15-year-old boy was encopretic daily and violent at home. He made suicidal statements, which prompted crisis services at the house weekly. In addition, he refused to go to school and was failing all subjects. For all therapy sessions, he didn't speak more than 10 words per session. He exhibited significant dissociative symptoms at any mention of his childhood. Prior to me, he had spent two years with a previous therapist and made no progress. In our therapy sessions, we used creative arts materials, including colored pencils, markers, and modeling clay as well as fidget toys, a yoga ball, and splat balls. He would nod yes or no if I asked about emotions, negative beliefs, and body sensations. Through drawings, he was able to do parts of self work and identify self-states (sabotage parts, wounded parts, etc.) that were interfering with his success. We used the yoga ball to bounce during desensitizing childhood memories (Phase 4), which helped him to stay grounded while we processed small bits of his past. He was able to tolerate about 10-15 minutes of processing traumatic material for each session.

In the beginning, I was meeting separately with mom and providing parenting therapy. After six months of treatment, I helped this teenage client to understand that his father needed to be part of the treatment, so they could repair his early attachment wounds. I began more intense work with both parents separately for four months to teach parenting, emotionally support their son, and preparation to partake in phase 4 sessions to repair past traumas and attachment wounds. His father's first words when he met me were, "I don't believe in therapy." I told him that "he was one of the most important people in his son's life, and he would need to heal his son." In separate trauma processing sessions, each parent sat with the son and engaged in family-style EMDR trauma processing during the toilet training years (verbal arguments, eventual separation and divorce) to gain success around his encopresis. After his trauma processing sessions with both parents, his encopresis and violence diminished. He has been successful in returning back to school and passing classes.

Key Lessons

It was challenging that he did not speak in sessions (he still doesn't!), but finding creative ways to communicate was key. Engaging his challenging parents in the therapeutic process was vital for him resolving the attachment wounds that his body was holding on to.

THE NECESSARY USE OF PARENTAL REFRAMES

The child's problems and symptomatic behaviors may be the initial causes of concern; nevertheless, these are only one manifestation of discord and tension in a dysfunctional family system. The chronic blaming behaviors have significantly affected communication and cohesiveness within the family.

The goal is to use reframes to help change the family's view of the problem, and shift how the family communicates by working with all family members to search for alternative behavioral, cognitive, and affective responses.

"Mom, when you nag, you just are trying to make sure your son is successful with school and his future. However, the way that you are communicating this to him, unfortunately, is only pushing him away."

"You are so worried about him and his future. When he does risky behavior and you use punitive punishment, it causes more problems between you two."

Annie's Case Example

An adopted mom of three children had a 13-year-old son, who was engaging in risky behavior of stealing, and not coming home after school. The mom's strategies were to shave his hair, make him sleep on the couch, and give physical punishment. These parenting strategies only further strained their relationship.

There were many conversations of acknowledging her fears and worries about his future and that he would end up arrested and in jail like his birth father. She was using these parenting tactics as a fear response.

"Mom, I know how much you are worried about him, worried he will do something stupid and ruin the rest of his life. I too am worried. You are using punishments that make him mad and unfortunately do not result in any better behavior. I know I can help you (instill hope). Let's try some different approaches that will make you two closer." I said this statement about five different ways in the session, and she wouldn't back down. I started laughing and said, "I am not backing down either!" She laughed and agreed to try a different approach. My request was to playfully hug him multiple times a day! I had her do it in the waiting room before she left, and the teen smiled and laughed and said, *"Were you two smoking weed in the office?"* The next week, she described playfully chasing him around the house and kissing and hugging him. She recognized that he loved it, and instantly there was a significant reduction in behavioral problems in school and at home. This allowed him to start to work on his attachment wounds of his biological parents.

We acknowledge that not all caregivers are capable of being involved and repairing attachment wounds. We encourage therapists to find other adults and support to be part of the treatment. It is not unusual for us to have extended family, neighbors, teachers, and/or caseworkers be part of our sessions.

ATTACHMENT HISTORY OF TEENS AND CAREGIVERS

Through history taking and questioning, the clinician begins to understand the connection between the parent and the child. The attachment relationship is considered critical in establishing a foundation children will use to interact with others and dictate how they feel about themselves. This can impact three key areas:

1. A child's sense of self,
2. A child's sense of others, and
3. the caregiver and the child. (Bowlby, 1958)

Assessment tools, such as the Parental Bonding Instrument, Family Experiences Scale, and creating a family diagram or genogram that tracks at least three generations, are

an excellent method for gathering this information (Bowen, 1980; McGoldrick, Gerson, & Shellenberger, 1999). Therapists need to inform parents that understanding their attachment history is important to knowing how they came to use certain parenting strategies. Taking an attachment history of parents is often overlooked as many therapists do not know how to broach this topic with parents. In the beginning, we meet with all parents separately to understand their backgrounds and how they were parented. This history and knowledge helps the therapist empathize with the problematic strategies and work to change how they communicate and parent within the home.

ATTACHMENT AND SOCIAL MEDIA

"With heads down and screens lit up, watching our teens plug in can feel confusing, disappointing and even like rejection to us." (D. Siegel, 2013). We find that securely and insecurely attached teenage clients seek connection and attachment using social media. To get ready to leave the home nest, adolescents seek out membership in groups of other adolescents not only to feel good, but to *survive*. And feeling connected to others doesn't just *seem* crucial to contemporary teenagers. In fact, our brains' very engrained genetic programming gives us a feeling that connection is a matter of life and death. Parents often feel confused, hurt, and rejected as the pull to peers strengthens. It is important to encourage understanding of this connection and the need for teens to find a balance between connection with peers and maintaining a connection with family.

PHASE 2: PREPARATION

This phase is about expanding the Window of Tolerance and finding soothing and grounding techniques that manage hyper and hypo aroused dissociation. In Phase 2, we are also establishing a safe place that works for teens. We are helping teens invest in their future by mapping out their true dreams and desires so that they are open to reprocessing their past, which is the obstacle to moving forward.

WOT

Staying in the optimal Window of Tolerance and understanding Soothing and Grounding tools/skills to manage hypo and hyperarousal may look different with teens. Options could include utilizing creative arts material such as painting and clay, or a yoga ball to bounce to stay present, playing upbeat music, eating snacks, watching Tik Tok, or throwing splat balls at the wall... all this to get teens in the optimal window of tolerance to move towards Phase 4.

Future Self

"A teen who feels hopeless about their future is unlikely to invest their time in therapy let alone do trauma therapy." (Greenwald, 2013). Asking teens to see into the future and envision how they see themselves in five to 10 years can be done using Future Self (Monaco, 2022) intervention. Dreaming about their future and identifying details on how to get to their goals gives hope to teens that they will not always be living in this situation, and they can live different lives. A teen who has future possibilities is more likely willing to improve or get better and to do trauma therapy.

PHASE 4

At this point in treatment, client, caregivers, and supports are engaged and informed of EMDR and clear expectations on how to support the teen during this time have been discussed. If the teens are hesitant, we recommend having a conversation about their future selves and how working through the past can help them get to their dreams. The therapist has tools to manage the teen's dissociation and small targets have been indentified to start. These are called "bee stings" or recent events or discreet memories. Both types of memories are non-family, low SUDS memories. This can help the client see how the process works and have success with a small memory.

Dreaming about their future and identifying details on how to get to their goals gives hope to teens that they will not always be living in this situation, and they can live a different life.

Safe Place

Nicole developed "the GOAT" (Greatest of All Time), which is a safe place for teens. It is a magical place where all of the best options are available to help relax and soothe the client. This can also be a place of fun and excitement that will house the resources that may have been installed. Drawing out the GOAT on paper, or a pillowcase or making this out of clay will help the client use it more consistently, especially during stressful times.

Annie's Case Example

A mom of a 17-year-old adopted boy asked for counseling services for her son, who was drinking, snorting substances, vandalizing property, and failing school. Mom and her son could not be in the office together without extensive yelling between the two. In separate sessions with mom, and through the use of reframes, I helped her understand that her nagging and yelling was indicative of her profound fear that her son would die (her husband had passed away right before the adoption) and how she so much wanted to give him a better life because of his orphanage experience. She didn't understand why her love for him was not enough, and I did extensive psychoeducation about trauma, dissociation, and the need for trauma therapy. After a few sessions, she started to communicate her concerns and fears to him, and their relationship improved so that we could have effective family therapy sessions.

The client was extremely resistant to therapy and was often not genuine in his responses. He would come in pretending to have different psychotic symptoms, and it became apparent that he was reading diagnostic manuals online. I also found out that he had created an online forum and posed as a therapist and provided diagnosis and treatment recommendations. I used this to my benefit to talk about how smart he was and how he was providing excellent advice, and we talked about how he could use these strategies with himself.

He had no interest in sharing experiences about the orphanage that he lived in until he was age nine. We did the "Future Self intervention." He was able to imagine 10 years into the future, and he was able to identify that he saw his final vision was him being with his girlfriend and getting their son onto a school bus on his first day of kindergarten. He burst into tears (I almost did, too!). By sharing his desire to have a typical and loving family, he understood that the past was the reason for his deep emotional pain and acting out behaviors. He agreed to do trauma work, and we worked through his early attachment wounds memories. After treatment with me, he went into a substance abuse residential center. A year later I received a long letter talking to me about how doing the future self-vision was the reason that he kept on living and working so hard to get better. His last statement in the letter, "My dream will come through."

In working with teens, it's important to be flexible and open. Not every session will go smoothly, but keeping things structured, consistent, and connected with core issues is the most helpful.

Nicole's Case Example

A 16-year-old boy was in therapy due to a referral from school. His behaviors included skipping/missing school, struggling to get along with teachers, being arrested once, and being suspected of drug use use. The client and father came into therapy for first session, and the dad immediately began to cry saying, "I'm not sure where things went wrong." Dad's tearfulness often led to the client to begin screaming. The client would yell, saying, "I just can't handle him, he makes it all about himself." Dad's anxiety and fear led to client being nagged constantly. When the client went out of the house, dad would follow him, call his friends, etc. This pushed client farther away from dad. Dad was encouraged to meet for education on trauma and attachment (biological mother was not involved due to her substance use). As a female therapist, I also considered my role in working with a young man who did not trust women. This was something that was discussed openly in session.

Reframing helped dad understand that his yelling was centered around the fear of losing his son (the only thing he truly cared about). Dad was able to acknowledge that he needed strategies to do things differently. Dad was open to a referral to work through his issues during his son's treatment.

Through reframing with dad, the client began to engage/connect with the therapist, understanding that he was not solely the issue. There was family work that also needed to be done for things to change/shift. While looking at the client's perspective and keeping trauma glasses on, the client slowly began to relax in the therapy space. His hyperarousal began to minimize. He was often grounded using scents and physical movement. He did not like to deep breathe but instead loved to stretch and do progressive muscle relaxation.

The client was able to identify the negative cognition of "I am not good enough" as a theme. This connected to mom not getting her life together,

the client not doing well in school, and getting into trouble with friends. He began to understand that his early childhood wounds of his mom leaving caused him to feel "less than." Work was done with dad in talking through examples of why his son *was* "good enough." These examples were used in EMDR processing as cognitive interweaves and resourcing experiences when the client was "stuck."

The GOAT for this client was a car repair shop. The client was in charge at this shop, surrounded by beautiful cars, rap music blasting, the sun shining, and a kitchen full of his favorite food. When installing this place, client's face relaxed, and a slow smile spread. The GOAT was talked about often throughout treatment.

In working with teens, it's important to be flexible and open. Not every session will go smoothly, but keeping things structured, consistent, and connected with core issues is the most helpful. This specific client went through highs and lows but never gave up. The therapeutic attachment relationship was helpful for this client to be able to do EMDR. Dad leaning into a place of support for his son during the process was also critical.

It can be overwhelming to work with challenging parents, and risky teens and do family therapy. High risk teens need to be seen weekly, and often we are providing separate collateral sessions with parents. Therapists need to have energy and have creative arts options to engage this population. A good sense of humor and thick skin is a must! The reward is facilating the attachment repair with their caregivers and watching them work hard towards their dreams. This is the population that seeks us out years later to say "thank you" when they enter their adult years.

Annie Monaco, LCSW-R, RPT is a New York State Licensed Clinical Social Worker, Registered Play Therapist and a faculty member of the Child Trauma Institute & Trauma Institute of University at Buffalo School of Social Work. She is an EMDRIA approved trainer of EMDR, Progressive Counting, and STAR (Strategies for Trauma Awareness and Resiliency). Monaco also provides specialty trainings on attachment, dissociation, and EMDR with teenagers and with younger children. She was a director of restorative justice programs at a non-profit agency where she oversaw juvenile and adult offender programs for over 10 years. She has extensive experience and training in teens, family therapy and working with the juvenile justice population. Monaco is the co-editor and contributor of chapters for EMDR with Children in the Play Therapy Room: An Integrated Approach.

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USING EMDR TO HELP TEENS WITH SCHOOL REFUSAL BEHAVIOR AFTER THE PANDEMIC

BY CAROLYN SETTLE, MSW, LCSW

There have been many challenges facing adolescent clients during the pandemic. This has been a time of upheaval, isolation, loneliness, and languishing. Teens rapidly went from in-person school to online school, missing many significant landmark moments in their lives like proms, graduations, sports, and club activities. This social isolation has affected many students' academically and socially, leading to a decline in self-esteem and self-confidence with increased teen anxiety and depression diagnoses.

Now that vaccines are available to adolescents, schools are navigating a return to school. However, there are still many uncertainties teenagers face. As they are emerging from virtual school, one of the predominant issues parents/caregivers and teenagers are reporting is anxiety and hesitancy in returning to in-person schooling. Although many adolescents are excited to return to the classroom, many others are ambivalent and resist in-person school, causing a surge in school refusal behavior (Nathwani & Shoaib, et.al. 2021) (Richardson, 2019).

School refusal behavior has existed long before the pandemic, though the pandemic has amplified this problem. Therapists are balancing supporting students in resuming in-person school with their concerns about Covid-19 variants, vaccine options, and mask uncertainties still being present. EMDR therapy offers a unique solution for clinicians in resolving school refusal behavior by integrating EMDR phobia protocol (Shapiro, 2018, p. 228) with family therapy, resource development, and a behavioral modification. Combining these therapeutic interventions can improve adolescents' chances of returning to the in-person classroom.

HISTORY TAKING

In the history taking phase of EMDR, the therapist inquires about the specifics of teens' anxiety and their avoidance of school in a curious, non-judgmental way. Then the therapist explores with the parents/caregivers their perceptions of the student's school avoidance and asks what methods they have tried to solve the problem. A clinician will want

I can't handle this.

One helpful RDI exercise is called "The Captain of My Ship" (Adler-Tapia & Settle, to be published 2023). This exercise focuses on the ever-changing reality of life, which has been highlighted during the pandemic. Everything is always changing. The students are going back to school, and then there is another Covid-19 outbreak. Some schools have the students return to online school and/or masks, or some schools leave these decisions to students and their families, causing anxiety.

In the "Captain of My Ship Exercise," the therapist explains the metaphor of being on a ship in the ocean, "is like trying to navigate the hard stuff in life." The tides are ever changing under the ship; the wind and weather are always changing in the air over the ship. The client is the captain of the ship steering through the changes; sometimes the water is calm, and sometimes it has strong currents and waves. The weather and wind can be peaceful, and other times there are storms and gales; just like life itself. The captain (who is the client) has knowledge, the ship's rudder, sails, a map, and a compass to get to the destination (return to school).

The clinician teaches the captain/client internal and external regulating skills to know how to be centered and navigate through a storm. Internal tools are mindfulness skills where the therapist educates the client on how to be calm, notice their body, and notice their thoughts. Once the client can do that, the therapist then strengthens the experience with bilateral stimulations (BLS) in slow, short sets. The purpose is for the client to know how to be calm while making difficult decisions during rough times. External skills, also for calming and grounding, involve the therapist having the adolescent simply focus on the five senses saying, and then add BLS. Once captains/clients are resourced and centered, they are more able to see clearly how to use their tools to pilot through the waters.

The rudder, sails, map, and compass are all instruments the captain/client can use metaphorically to pilot the ship through difficult waters. The therapist invites teens to think about having a crew to help them. They can imagine having their crew made up of friends, family, coaches, pets, characters, books, or movies, etc. These are all resources the captain/client uses to move across the ocean. The rudder helps them steer through the water (i.e., outside forces), and the sails help them use the wind (i.e., outside forces) to their advantage. The map helps them know where they are going, and the compass tells them which direction they are moving.

Then the clinician has teens imagine sailing their ship into the chosen struggle (i.e., returning to school). The therapist asks them to imagine being the captain of their ship using their centeredness skills, their ship's instruments, and their crew as they navigate the changing waters towards the destination (returning to school). The therapist is applying slow, short sets of BLS throughout this process, similar to reprocessing in the Desensitization Phase, except the sets are slower and shorter. It's helpful for the therapist to ask the client for one challenge at a time, so the client does not become overwhelmed. This exercise can be used for any challenge, not just for school attendance issues.

to know what has been helpful to the teen and what has not. As the history information is gathered, the therapist also listens for any possible secondary gain issues.

TREATMENT PLANNING AND CASE CONCEPTUALIZATION

From an Adaptive Information Processing (AIP) perspective, the first order of business is determining what is contributing to the adolescent's school hesitancy. The clinician does this by following the traditional three-pronged EMDR therapy protocol, exploring with the student and parent/caregiver past and present school avoidance and possible future school apprehensions.

Past events to consider related to school refusal behavior are previous school avoidance behavior, obsessive-compulsive disorder (OCD), social anxiety, academic failures, and bullying (in-person or online). Other issues affecting school refusal may be related to Covid-19 grief. The grief can be over the loss of friends, activities, clubs, proms, graduations, and Covid-19 related illnesses and deaths. These potential targets may be experiences occurring before, early on, or amid the pandemic.

When the student cannot identify a specific past experience, the therapist

can do a Floatback. They can ask, "How does your body feel when you think of returning to school now?" Then say, "Floatback to an earlier time when you may have felt that way. What do you notice?" Using the standard EMDR protocol, the therapist targets and reprocesses previous fears, incidents, and avoidances of school.

Next, the therapist explores the current issues related to school hesitancy. The student may be experiencing loss of confidence in connecting with other teens, worrying about falling behind in school, or feeling distress associated with the uncertainty of toggling back and forth between in-person school and online school. The therapist targets the most recent triggers for resisting school. Present triggers are actual experiences, situations, or events that activate the client's anxiety now. Using the process phobia protocol, the clinician targets each experience activating the student's anxiety in the present. Present targets for school refusal are addressed in incremental segments. Examples of present triggers to target are getting ready for school, driving up to school, seeing a bully from the past, seeing new people looking at them, or being called on in class. When processing present triggers, the clinician wants to target each trigger chronologically and apply the Future Template (FT) before moving on to the next trigger. (Adler-Tapia & Settle, 2018, p. 319-321)

PREPARATION PHASE

Education on Anxiety and Calming Skills

Many clients with school refusal behavior have a prior history of generalized anxiety and school-related anxiety. Due to the long period of pandemic-related social isolation, this anxiety may have intensified. And therapists are finding that teens who never struggled with in-person schooling are now reluctant to go to school after attending school virtually for so long. During the Preparation Phase, the therapist gets the client ready for reprocessing by educating the client and parent/caregiver about anxiety and the psychological and neurobiological underpinnings. The therapist assists teens in developing self-management skills by identifying the anxiety and teaching them to simply observe their emotions, body sensations, and thoughts through mindfulness exercises. (Geneva, WHO, 2020) They also help clients learn to handle their anxiety by teaching them relaxation exercises. There are several apps like "Calm" or "Headspace" that are user-friendly and can support adolescents in dealing with anxiety.

Family Therapy for Secondary Gains

Once the adolescent and parent/caregiver understand the nature of the anxiety and have anxiety management tools, the therapist concentrates on any secondary gains related to school refusal behavior. Perhaps adolescents have found it's easier to stay at home and avoid the challenges they faced previously at school. This may be especially true if the student struggled with social anxiety or OCD before the pandemic. Perhaps the teen is escaping the discomfort and vulnerability of growing up and attempting harder academic and social struggles. Many teenagers have found staying home is more comfortable, safer, and quieter during the pandemic, and this has become their way of avoiding stress.

It's also important to consider that the parent/caregivers may enable the teen by not having high expectations about returning to school and making it too easy to stay home. It may have become simpler for the parent/caregiver to ignore the problem than trying to hustle teens out of the house and fight with them to get to school. And many parent/caregivers are dealing with their struggles with Covid-19, work, home, family, or their addictions, making it overwhelming to deal with their teens. In addition, parent/caregivers can over-identify with students and make excuses for their school avoidance. Parent/caregivers may say "school is too hard" or "the expectations are too unreasonable" for their child. Studies show that enmeshed families or families with poor boundaries are more likely to have ineffective responses to school refusal behavior. (Columbia Univ., 2021)

Working through secondary gains issues in family therapy involves identifying and discussing the dynamics within the family and developing a plan. First, the therapist collaborates with the parent/caregiver in fostering firm expectations, and creating meaningful rewards for achieving and addressing any roadblocks. After that, the therapist talks to the parent/caregiver about enabling teens to avoid school by allowing them to be online, play video games, watch television, or sleep during school time. The therapist discusses ways for the parent/caregiver to discourage avoidant behavior by removing fun activities. Instead, the parent/caregiver is encouraged to require the teen to do schoolwork, chores, or some work activity during school time.

Behavior Modification Reward System

The therapist then collaborates with the parent/caregiver to incentivize school attendance. Parent/caregivers discuss the type of meaningful rewards they are willing to offer the teen to achieve the incremental goals established in session. "Meaningful

School Refusal Case Example

Quinn is a 15-year-old sophomore in high school. They have been doing online schooling for the last year and a half and had never attended in-person high school. Quinn has a history of social anxiety but was always able to attend school until this year. When the school administration announced a return to in-person school, Quinn felt immediately "sick to my stomach" and pleaded with their mother to continue online school. When gathering information about Quinn's past social anxiety, they listed concerns over past comments from students about their body. Quinn also mentioned their grandmother dying of Covid and the fear of sitting next to an unmasked classmate and carrying Covid home to their family. Quinn has anxiety about driving up to the school, kids looking at them, and teachers talking to them. Quinn has difficulty imagining the goal of sitting comfortably in class and learning.

The therapist processed the old incidents with the positive cognition (PC): "It wasn't my fault grandma died. I'm a good person." And, "I'm fine the way I am." Then the clinician broke the present triggers into segments and reprocessed them; driving up to school, kids looking at them, choosing seats in the classroom distanced from others, and teachers talking to them. After reprocessing, the therapist assigned the client and mom to practice doing the behavior. The rewards for accomplishing each of these goals were

1. extra time on a video game
2. a trip to a beloved pet store
3. a set of art pencils
4. watching a movie with mom.

The larger reward for attending school every day for a month was a much-desired art design app.

An example of this is, the therapist had the client imagine driving up to school with mom with the NC "I can't handle it." Then the client reprocessed it to the chosen PC, "I can handle it." The therapist had Quinn run a movie of it with BLS until the SUD was a 0 and the VoC was a 7. Then the therapist asked mom to drive Quinn to school every day when school wasn't going on. Any disturbances were to be brought into the session for them to reprocess. Once driving to school didn't activate the client, they could drive to school, Quinn received the chosen reward. This process continued with each FT followed by an in vivo experience with a reward when the goal was met.

During this process, the therapist had the mom contact the school and see what support the staff could offer. The school counselor said they would be available to practice walking with Quinn to all their classes after school to get familiar with the route before returning to school full-time. The counselor then agreed to meet Quinn first thing in the morning to walk to class with them during the first week of school. She would be available to talk if Quinn had difficulty. Any disturbances were brought to the therapy session to reprocess with the therapist. When not at school, Quinn was expected to do chores and homework throughout school time until they returned to in-person school full time.

After the client had processed through each FT and completed each in vivo experience, they were ready to go to school. On the occasion that Quinn began expressing nervousness, the mom was instructed to listen kindly and then firmly say, "I know. And you can do this." There were a few anxious mornings and a couple of phone calls during school to mom, but she followed through on listening and standing firm. After a month of attendance, Quinn received their final reward of the art design app. They felt proud of themselves and were happy they had even made a new friend in their art class.

rewards," means that the adolescent must be interested in the incentive. The parent/caregiver may have ideas about what is appealing, but it is worthwhile to get the youth's input. Rewards can be simple, such as earning time to watch TV, play a video game, or do a social activity with a family member or friend, and allowing students to be a part of this discussion is empowering and helps them be part of the solution. It's valuable to include a reward system for the parent/caregivers. It's stressful to create, maintain, and adhere to a school attendance strategy, and parent/caregivers need to take care of themselves during this process.

School Involvement

A possible roadblock to getting the student back in school may be a lack of school involvement. When easing a school hesitant student back into school, it is most helpful to have school support. However, during Covid-19 times, school personnel have been stretched with absenteeism, resignations, or dealing with multiple student and administrative issues.

Encouraging the parent/caregiver to reach out to the school administration to see if they can assist in supporting the teen back into the classroom is central to a successful return-to-school plan. (Columbia Univ., 2021)

Resource Development and Installation (RDI) Exercises

Resource skills can be added at any time. Therapists can do RDI (Leeds & Korn, 2012) or Mastery Resource exercises (Tapia & Settle, 2017) in the Preparation Phase in between reprocessing sessions or in addition to the Future Template (FT). Traditional RDI exercises focusing on the positive qualities a student needs to return to school can be done in every session to reinforce positive experiences and thinking.

ASSESSMENT PHASE

The Assessment Phase is the same as the standard EMDR therapy protocol. The only element that may be unique is the possible targets related to school, Covid-19, or pandemic social isolation anxiety. There may be some common themes for school fears and Covid-19-related anxieties with these topics.

Covid-19 School Refusal NCs

When clinicians gathers information about the student's school anxiety, they may hear emerging themes. It's helpful to listen for those themes as they will help to pinpoint the teen's negative cognition(s) (NC).

Common Covid-19 related (NC)s associated with school refusal targets are:

- I don't have a voice.
- I don't have a choice.
- I might catch the virus and die.
- No one cares what I think.
- I can't handle this.
- The world is uncertain. I might die.
- Kids will think I'm dumb (or ugly, awkward).

FUTURE TEMPLATE PROTOCOL

When using the process phobia protocol for school refusal behavior in the Future Templates (FT) protocol, the clinician focuses on each segment of the school anxiety. (Shapiro, 2018, p. 228), (Adler-Tapia & Settle, 2017, p. 319-321). The therapist has clients run a movie of the desired behavior in their heads, imagining the positive outcome. As they do that, the therapist is applying fast, longer sets of BLS. Once running the movie of the positive outcome is completed, the clinician gives the teen homework to practice the action in real life. Once teens do the in vivo experience, they receive the pre-arranged reward for that segment. After that, the therapist moves on to another anxiety-provoking segment of going to school. The therapist reprocesses each of the segments, and then they have the teen run a completed movie of getting ready for school, attending school, and handling potential difficulties until the student is back in school. Once students are is back in school for a month, they receive the larger agreed-upon reward.

LOOKING TO THE FUTURE

As clinicians are assisting their clients in moving from the pandemic to an endemic, it's especially important for EMDR therapists to reprocess trauma caused by Covid-19. When students process through Covid-19 school fears, it helps them generate a sense of empowerment and resiliency. Clinicians are encouraged to trust their creative skills with EMDR in processing pandemic-related trauma. They are urged to use their experiences in developing RDI exercises focused on strength, courage, and resiliency. And finally, clinicians are encouraged to foster a sense of connection, alliance, and community with with clients and their families, which is essential in moving towards a more positive future.

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A rapid review of randomized control trials.

Eye Movement Desensitization Reprocessing for Adolescents with Post-Traumatic Stress Disorder

By Professor Ian Barron and Susan Darker-Smith

Adolescence is understood as the period between childhood and adulthood, although the exact age range is often debated. Due to population trends, the proportion of adolescents in society changes over time; it's currently at 12.7 percent in the U.S.A. (OASH, 2022). Adolescence is one of the most complex and dynamic periods of human development. Neurobiologically, adolescents, compared to pre-adolescents, experience changes in dopamine and oxytocin systems resulting in behavioral changes in sensation and risk-seeking. Physical growth spurts and sexual maturation (puberty) occur. Cognitively, adolescents become more abstract in their thinking; their emotions may intensify, and socially, they orient more toward their peers than primary caregivers as they develop independence and a changing sense of identity (Nakkula & Toshalis,

Table 1 Randomized control trials inclusive of adolescents

Author/date	Population	Design	Exposure	Sessions	Measures
Jaberghaderi et al (2004)	14 (12-13)	CBT	CSA	12	CROPS, PROPS, RTS
Jiminez et al (2020)	32 (12-17)	TAU	Sexual/Physical	2-9	CAPS-5, PCL-5, HADS
Chemtob et al (2002)	32 (6-12)	WL	Hurricane	3	CRI, RCMAS, CDI
Soberman et al (2002)	29 (10-16)	TAU	DV	3	CROP, PROPS, PRS
Ahmad et al (2008)	33 (6-16)	WL	DV	8	DICA, PTS
Kemp et al (2010)	27 (6-12)	WL	RTA	1-4	CPTS-RI, PTS, STAI
Farkas et al (2010)	40 (14.3 ave)	RC	In care	12	DISC,TSCC,CBLC,LITE
De Roos et al (2011)	52 (4-18)	CBT	Explosion	4	CROPS, PROPS, CBLC
Diehle et al (2015)	48 (8-18)	CBT	Single/multiple	8	CRIES, RCADS, CAPS, ADIS, SDQ
De Roos et al (2017)	103 (8-18)	CBW/WL	Single	6	RCADS, SDQ, ADIS,

2020). Despite studies looking at trauma-related brain changes in young children, there is a paucity of information on the implications of trauma occurring in adolescence and its consequences for later life (Dun et al. 2017). As such, traumatic events which impact brain biology in adolescents require special consideration alongside the implications of treatment for adolescents.

In contrast to the neurobiology of trauma for adolescents, considerable research has been conducted about the risks in adolescence, the nature and extent of trauma exposure, and resultant consequences (Kwon et al. 2022). Risk-taking behaviors, which are assumed to be hardwired into the adolescent brain's biological etiology, may further place adolescents in situations of increased risk of exposure to traumatic events and raises questions regarding mechanisms of change for this period of development (Gutermann et al. 2016).

Risks for adolescents are both situational and a result of adolescent behavior. The risks vary according to ethnicity, socioeconomic status, and gender (Assari et al. 2020). Trauma exposure for adolescents in the U.S.A. includes a range of poly-victimization, such as child sexual abuse, physical and sexual assault, home and community violence, neglect, witnessing violence, substance use, and unsafe sex (Turner et al. 2017). Globally, almost a quarter of adolescents experience trauma, indicating a significant problem for society and resulting in post-traumatic stress disorder (PTSD) ranging from 16-60 percent (Putman, 2003; Alisic et al. 2014). Symptoms in adolescents, especially where the primary caregiver is abusive, are more pervasive and can include depression, anxiety, relationship difficulties, structural dissociation, and self-harm (van der Kolk et al. 2009). Adolescents can also experience problems with executive functioning, aggression, and delinquency, which limit the adolescent trajectory of development, resulting in negative outcomes including psychosocial problems, psychiatric disorders, and reduced quality of life (Connell et al. 2018; Tonnaer et al. 2016; De-Andre et al. 2012).

Currently, the American Psychological Association (APA) recommends Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as a well-established treatment for adolescent trauma, whereas EMDR is recognized as promising (APA, 2017). In contrast, the International Society of Traumatic Stress Studies recommends EMDR as an effective treatment for adolescents, and the World Health Organization recommends EMDR as a first-line treatment (rather than TF-CBT) due to adolescent tolerance of treatment without the need for homework tasks (ISTSS, 2018; WHO, 2013).

A recent systematic review (Barron et al. 2019) and update review, including non-randomized control trials (Matthijssen et al. 2021) inclusive of children and adolescents, indicates that there are now sufficient studies of quality for EMDR to be reconsidered by national treatment guidance as a treatment of choice for children and adolescents. Questions remain, however, as RCTs have treated childhood as homologous rather than recognizing the differences in development between pre-adolescents and adolescents. Similarly, narrative reviews and meta-analyses of EMDR mirror the omission of analyzing the difference between the two developmental periods, despite adolescents presenting with more adult-like responses than pre-adolescents and more complex symptoms than adults (van der Kolk et al. 2009). As a consequence, EMDR therapists working with adolescents are reliant on "childhood" studies rather than on understanding the

	Signif. Outcomes	Maintenance
	PTSD; Behav	
	PTSD, Dep. Anx.	3 months
	PTSD, Dep. Anx.	6 months
	PTSD; Behav.	2 months
	PTSD	
	PTSD, Dep, Anx. Behav.	3, 12 months
	PTSD, Behav	3 months
	PTSD, Dep. Anx.	3 months
	PTSD, Dep	
	PTSD, Dep, Anx.	3, 12 months

WL = Waitlist; TAU = Treatment as Usual; RC = routine care; CBT = Cognitive Behavioral Therapy; CSA = Child Sexual Abuse; DV = Domestic Violence; RTA = Road Traffic Accident; PROPS = Parents Report of Posttraumatic Stress: CROPS = Child's Report of Posttraumatic Stress; RTS = Rutter Teacher Scale; CAPS = Clinician Administered PTSD Scale; PCL = Posttraumatic Stress Disorder Checklist; HADS = Hospital Depression and Anxiety Scale; CRI = Child Reaction Index; RCMAS = Revised Children's Manifest Anxiety Scale; PRS = Problem Behavior Rating Scale; DICA = ; CPTS-RI = Child Posttraumatic Stress- Reaction Index; STAI = State-trait Anxiety Scale for Children; DISC = Diagnostic Interview for Children; TSCC = Trauma Symptom Checklist for Children; CBLC = Child Behavior Checklist; LITE = Life Incidence of Traumatic Events Scale; RCADS = Revised Child Anxiety and Depression Scale; ADIS = Anxieties Disorder Interview Schedule; SDQ = Strengths and Difficulties Questionnaire; CPTCI = Child Posttraumatic Cognitions Inventory; CSI = Child Somatization Inventory; CRTI = Child Revised Traumatic Response Inventory

impact of EMDR, specifically with adolescents. Further, the current authors argue that because adolescence covers a broad trajectory of development, RCTs may need to focus on the inception, middle years, and the end of adolescence with the transition to adulthood to understand the differences needed in treatment fully.

To evaluate the efficacy of EMDR therapy with adolescents, a rapid review was conducted to analyze the best evidence available, that is, gold standard RCTs, where adolescents were either sole participants or were part of the participant sample. The rapid review, typically used for emergent directions in research and practice, aimed to capture the quality and outcomes of available research and make recommendations for future research and practice.

METHOD

To provide confidence in the analysis of the efficacy of EMDR with adolescents, the rapid review includes the most rigorous research design of a RCT. The RCT is the only design where researchers can conclude with certainty that treatment, in this case, EMDR, is more effective than compared to a waitlist and/or another treatment (Ginsburg & Smith, 2016).

The literature search for EMDR RCTs for adolescents with PTSD included the keywords adolescent(s), teens, EMDR, Eye Movement Desensitization and Reprocessing, efficacy, effectiveness, PTSD, randomized control trial, and R.C.T. The University of Massachusetts library search function covers all the main social science search engines. Inclusion criteria involved studies with adolescents who presented clinically significant levels of PTSD that were published over two decades from 2002 to 2022 and used the standard EMDR protocol. Studies of participants with sub-clinical PTSD, non-randomized control designs, where EMDR was implemented in combination with another protocol, and not written in English were excluded. Adolescence was defined as between 12 to 18 years of age to fit with most adolescent studies in the trauma field (Dun et al. 2017).

RESULTS

Excusive Adolescent RCTs

Ten RCTs were identified that were either exclusive or inclusive of adolescents (see Table 1). Only two RCTs, to date, focused exclusively on adolescents (Jaberghaderi et al. 2004; Jiminez et al. 2020), an incredible 16 years apart. Jaberghaderi et al., (2004) compared EMDR with CBT with 14 Iranian girls aged 12 to 14 who had been sexually abused. The number of sessions delivered varied, dependent on decreases in the level of reported distress with EMDR showing a significant reduction in PTSD and doing so in fewer sessions that TF-CBT (6.1 vs. 11.6 sessions, respectively). Jiminez et al. (2020) studied the efficacy of EMDR compared to treatment as usual with 32, 12- to 17-year-olds, who had experienced physical or sexual assault. Significant reductions were found in PTSD, depression, and anxiety, which were maintained for three months following treatment.

Soberman et al. (2002) was excluded because of the inclusion of pre-adolescents despite the average adolescent age (10-16 years, m = 13.35 years). In an EMDR versus treatment as usual RCT, a significant reduction in PTSD was found for adolescents who had experienced multiple trauma. Farkas and colleagues' RCT (2010), involving 40 "in care" adolescents with a mean age of 14.3, was also excluded because EMDR was used in combination with the MASTR protocol compared to routine care. Although excluded from this rapid review, Farkas and colleagues' (2010) found that adolescents with cumulative trauma and complex symptoms who received EMDR combined with MASTR experienced significant reductions in PTSD and behavior, with gains maintained at three months. The scarcity of EMDR adolescent-only RCTs is stark; however, indications of efficacy are promising when included and excluded studies are considered.

Studies Inclusive of Adolescents

Of the eight RCTs inclusive of adolescents, all found significant reductions in PTSD (see Table 1). Five of the studies reported significant reductions in the co-morbid symptoms of depression (Chemtob et al. 2002, Kemp et al. 2010; de Roos et al. 2011; 2017 Diehle, 2015), and four reported reduced anxiety (Chemtob et al. 2002; Kemp et al. 2010; de Roos et al. 2011; 2017). Three of the studies reported significant reductions in problematic behavior (Soberman et al. 2002; Kemp et al. 2010; Farkas et al. 2010), and one study reported an increase in quality of life for participants (de Roos et al. 2017). Six of the studies reported that the gains in PTSD were maintained at follow up from two to 12 months. As the number of sessions, ranged from two to 12, questions are raised about the variability of the dose of EMDR needed to be effective with adolescents.

EFFECT-SIZES

Effect-sizes are helpful for researchers and therapists in determining which therapies are the most powerful. Effect sizes range small (0.1-0.3) to medium (0.4-0.7) to large (0.8-1.0). With the latter, therapists can be confident they are implementing a powerful treatment. Across the childhood age range, EMDR was found to have a medium to large effect size for a single event and cumulative traumas. With PTSD, effect sizes ranged from small to large inclusive of dramatic reductions to below clinically significant PTSD (Diehle et al. 2015; De Roos, 2011, 2017). The only exclusive EMDR adolescent RCT found a large effect size of sexually abused girls in Iran. Small effect sizes have been found for depression and anxiety (De Roos 2011, 2017), and small (Jaberghaderi et al. 2004) to medium effect sizes have been found for behavior (De Roos 2011, 2017) and reduced memory-related distress (Soberman et al. 2002). While this indicates that EMDR is an efficacious treatment for children and adolescents, without a specific analysis of an adolescent population or an analysis of adolescent-only outcome data, there is insufficient evidence to determine the effect size of EMDR with adolescents. Likewise, EMDR was equally effective with males and females across childhood, but again there is little indication if the pattern is different in adolescence.

RCT DESIGN ISSUES

There was a good spread of research teams with repetition of the lead researcher (De Roos 2011, 2017) in only two papers, indicating a low

level of researcher bias. Over the two-decade timescale, the publication timeline shows the inclusion of adolescent participants in early RCTs with a decline to occasional participation emerging over the next decade. This is a trend that needs to be reversed.

In terms of addressing types of traumatic exposure, EMDR was effective for single event traumas, i.e., disasters (Chemtob et al. 2002; De Roos et al., 2011; 2017), and child sexual abuse (Jaberghaderi et al. 2004) and domestic violence (Ahmad & Sundelin-Wahlsten (2008; Diehle et al. 2015). Sample sizes were small, ranging from 14 to 103. More large-scale studies are clearly needed. Four studies compared EMDR to a waitlist, four to CBT (Jaberghaderi et al. 2004; de Roos et al. 2011, 2017; Diehle et al. 2015), and two to treatment as usual (TAU: Soberman et al. 2002; Jiminez, 2020). This seems to be a reasonable balance of different types of control groups. There were, however, no multi-site RCTs.

Over 23 measures were used across the nine studies indicating a wide range of measures available for adolescents. On the downside, such variability of measures does make it more challenging to compare results across studies. Regardless of design, EMDR was found to be more effective than waitlist and TAU and as effective but in less sessions that TF-CBT. As noted previously, a concerning omission is that none of the studies compared pre-adolescent with adolescent outcomes. As a consequence, the pattern of outcomes for adolescents is unknown.

DISCUSSION

The rapid review identified only two adolescent-specific gold standard RCTs and a limited number of RCTs ($n = 7$) inclusive of adolescents. Within this narrow range, none of the RCTs analyzed the different periods of development (pre-adolescent vs. adolescent); indeed, there was a lack of analysis of age as a moderating factor. As a consequence, conclusions about outcomes should be considered tentative. Indications are, however, that EMDR therapy is effective with adolescents who experienced a single event and cumulative trauma exposure and that reductions are achieved in PTSD, depression, anxiety, and behavior. One study (De Roos et al. 2017) also found quality of life gains.

While the rapid review focused on RCTs, EMDR, and PTSD, there is a range of non-randomized studies that are signposts to the potential wider impact of EMDR on adolescents. A brief review of non-RCT studies indicates that EMDR is potentially effective with a wide range of adolescent mental health conditions outside of PTSD. These conditions include depression (Bae et al. 2008; Paau, 2009); conduct disorder (Lovelle, 2008; Greenwald, 2000; Pasalic, 2021); adjustment disorder (Bucan-Varatanovic et al. 2021); OCD. (Cusimano, 2018); and coping with surgery (Maroufi, 2016). While considerably more research is required, particularly with rigorous designs, it may be that EMDR has the potential to be a transdiagnostic intervention for adolescents. Beyond the adolescent mental health difficulties, the efficacy of EMDR has been evidenced through different delivery systems. For example, adolescents with complex difficulties have responded well to an intensive treatment format because of the rapid resolution of symptoms and their tolerance of treatment (Greenwald et al. 2014). Similarly, complex trauma studies indicate that adolescents achieve significant gains when EMDR is combined with other treatment approaches that address not only the trauma but also risky behavior, impulsivity, and emotional dysregulation (Greenwald et al. 2012).

In light of the limited number of studies, another source for understanding therapy with adolescents is TF-CBT studies, the other empirically-based intervention of PTSD for children and adolescents. TF-CBT studies have typically found that adolescents with complex trauma tend to make less significant gains than those who experience single event trauma (Miller-Graff & Campion, 2016). Age-wise, TF-CBT meta-analyses indicate that older adolescents make more significant gains than younger adolescents, and in terms of gender, females tend to make less gains than males (Gutermann et al. 2016). Females also have a higher likelihood of relapse (Fitton et al. 2020). Parental support, yet to be assessed in EMDR adolescent studies, appears to be a facilitative factor for TF-CBT treatment effectiveness (Cohen & Mannarino, 2015). In short, future adolescent-specific studies need to include a wider range of moderating factors and investigate whether TF-CBT outcome patterns are replicated or otherwise for EMDR.

Given the significant neurobiological and physical changes that occur in adolescents (DeBellis & Zisk, 2014) compared to pre-adolescents, it may be that the mechanisms of change underpinning adolescent healing require further research and conceptualization. Many experts in the field of EMDR, such as Tinker and Wilson (1999), suggest adaptation of the EMDR protocol is needed for different ages. Despite this, our understanding of the relevance of the Adaptive Information Processing model (AIP: Shapiro, 2018) or the model of memory reconsolidation (Nader, 2003) for adolescence is unknown.

LIMITATIONS

The current review was limited by the lack of adolescent-only RCT participants and the lack of analysis

of adolescent data within EMDR RCTs across childhood. Non-randomized control trials for adolescents, although included in the discussion, were excluded from the review limiting the identification of promising signs for future research. At this early stage of research, studies with diverse populations, differing measures and types of a control group, range in the number of treatment sessions, and variability in follow-up times raises questions about generalizing conclusions. The review was also limited by omitting a mechanism of change analysis for adolescents in any of the RCTs. Finally, the review focused on individualized treatment. Therefore, it has yet to be determined whether a group protocol for EMDR will enhance or undermine change for adolescents depending on the nature of the adversity and presenting difficulties (O'Callaghan et al. 2015; James et al. 2013).

EVIDENCE SUPPORTS THE EFFICACY OF EMDR WITH ADOLESCENTS

Given the medium to large effect sizes of efficacy studies across childhood, the evidence supports the efficacy of EMDR with adolescents. However, because of the childhood populations and lack of analysis of adolescent participants as a group, the size of the effect for adolescents and across the adolescent years is unclear. The optimum number of sessions for adolescents is also currently unknown. Similarly, EMDR is effective with male and female adolescents; however, the differential impact is unknown. Likewise, EMDR is effective for single events and cumulative trauma exposure, but the extent and diversity of events in studies is limited. Finally, it is uncertain how the EMDR mechanisms of change in adolescents differ from pre-adolescents and adults. Such findings could potentially influence how the treatment is delivered to optimize the efficacy of EMDR for

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Continued on next page

the different periods of development. Finally, the efficacy of EMDR with adolescents with subclinical symptoms compared to those diagnosed with PTSD is unknown.

RECOMMENDATIONS FOR PRACTICE

While childhood RCTs support the efficacy of EMDR for adolescents, it is not possible, at this point, to identify the effect size, i.e. power, of EMDR with adolescents. However, the review can conclude that EMDR is an efficacious treatment for adolescents who have experienced single event and cumulative trauma experiences.

RECOMMENDATIONS FOR RESEARCH

Future research needs to use adolescent-only samples to provide an accurate measure of the impact of EMDR with adolescents. Studies need to focus on different types of a single event and cumulative trauma exposure. As well as conceptualizing adolescence as homologous, EMDR RCTs need to analyze the impact on different periods of adolescence. Further, there is a need to understand the EMDR mechanisms of change for adolescents compared to pre-adolescents, and adults, especially given the extent of neurobiological change occurring during the adolescent years.

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Susan Darker-Smith is the clinical director of the Child Trauma Therapy Center, founding member of the Global Child EMDR Alliance, and an EMDR Europe accredited child and adolescent EMDR trainer, consultant, and therapist.

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EMDR

10 Things About EMDR and Autism

By Sherri Paulson, LCSW, EMDRIA Approved Consultant

It is an exciting fact that therapists worldwide are using eye movement desensitization and reprocessing (EMDR) with individuals diagnosed with autism or ASD. Many of them are teenagers. EMDR can and has helped this population in many ways. Unfortunately, there is a lack of research to demonstrate this, so much information gathered here is anecdotal or from personal experience. It is respectfully noted that there is much enthusiasm and discussion around labels for autism. It is acknowledged here that autism is one of the items that can be labeled as neurodiverse. This article focuses on the diagnosis of autism or autism spectrum disorder.

One issue for therapists interested in working with this population is difficulty finding detailed information about the characteristics of this diagnosis so that treatment is more effective.

Recently the *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition: Text Revision* has been released with an improved section on diagnosing ASD. Dr. Francine Shapiro gave her approval for my EMDR and Autism Protocol in 2006 after I presented it during the EMDRIA Annual Conference. It is available for no charge.

Following are 10 things about EMDR and autism and teens.

1 Autism is a neurodevelopmental condition that affects many people from birth. Causes are unclear, but in some cases, there is a genetic basis. Many other theories are available. Autism is now viewed in this country as a spectrum disorder to account for the varying degrees of autism and symptom severity. It is a complex topic. Medical experts have now combined Asperger's Syndrome with ASD in the U.S., but it still exists as a solo diagnosis in other countries. EMDR has been used successfully across the spectrum, although some modifications and extra preparation are required for some clients.

2 It is essential to realize that teens and young adults, autistic or not, have the same concerns about social interaction, being accepted by peers, romantic and sexual matters, school issues, and focus on independence and individuation. However, those with ASD have a harder time achieving these milestones, which increases their anxiety and frustration. It is also acknowledged that not everyone with an autism diagnosis needs or wants therapy. Many are highly intelligent individuals who have found ways to handle their differences and have even made them work to their advantage. Of course, everyone is different, but those on the spectrum have similarities based on diagnostic criteria.

3 Before beginning work with a person or teen on the spectrum, it is imperative to develop a relationship with the client and ensure a communication system is in place. Currently, there is a push to use "autistic" instead of "individuals with autism." None of my clients express concern about this, so I use both. However, please check with your clients as to whether they have a preference. Most autistics have some language differences that may range from non-verbal to some problems with some deficits in social or pragmatic language. Your client likely has a history of being misunderstood or disrespected by many, including some professionals. It will take some time for trust to develop. Also, please remember that to an autistic, environment is everything.

Checking space for sensory overload possibilities, too much noise, changes between sessions, and safety issues is a must. Even florescent lights can be a problem. Due to challenges coping with change and flexibility, developing a predictable schedule and space is important. Psychotherapy sessions, both virtually or in person, with teens and young adults on the autism spectrum can be successful if structure of session is maintained. Shorter sessions may be more effective. The use of visuals, the white board for instance, can maintain interest and improve communication. Some ASD teens are gifted "techies," and the therapist may need to take extra computer classes to keep up with them.

4 During history taking, a trauma history is important. Checking for special interests must be considered and can be useful in therapy. Special interests motivate the individual and provide safety with a ready conversation topic. Some individuals will need a grounding item to bring with them for protection. In teens, this is often their phone, which has become a security item and should be allowed in the session, hopefully in the off mode. It is best to work in small doses to avoid overload, as too much talking is often difficult to process and can result in brain freeze in some. Some need movement to focus and understand. When processing is stuck, pushing forward will not improve the situation. Autism and pressure are not a good combination. Slow processing speed and delays are important to remember as it may be necessary to stop and wait for a while for a response.

Pressure means frustration and sometimes overload. "Just take your time" is a useful response. Be patient and calm; processing might improve because you are building the relationship with this client through the pauses and the silences.

5 Anxiety is an emotion that is always present in individuals with autism; anxiety-related to safety and performance especially. This is usually not included in diagnostic information but is always an issue for consideration. Anxiety is often the source of behavior issues with teens on the spectrum: anxiety about social interactions, safety, loss of self-control, maintaining dignity when others are present, and about knowing the right things to do and say. Bilateral stimulation in the form of tapping is quite useful here. Tapping of various kinds can relax the body and reduce anxiety in difficult situations. Many ASD teens can benefit from learning self bilateral stimulation (BLS) and using it themselves to calm down in difficult situations.

6 Most autistic individuals have had stressful childhoods due to high arousal levels, problems with anxiety, experiencing multiple meltdowns, and general misunderstanding even

from professionals. Humiliation from meltdowns, behavioral issues related to affect flooding, and sensory overload seem to cause a disconnect from body sensations. Body sensations are scary and overwhelming, especially when one has no tools to handle them. Frustration and fear of recurrence lead to disconnect or dissociation from the body. This can work in a circular pattern, so the child or teen experiences a meltdown and the resulting embarrassment. The next time they feel the same sensations, an alarm goes off that another meltdown might be coming, and anxiety increases, leading to exactly that.

This is the most common concern from therapists during consultation. EMDR processing is not going just right with an ASD client. The subjective units of distress scale (SUDS) are not moving. The opposite may also be true. The processing went fast because clients just stayed in their head, and somatic processing did not happen.

The preparation phase is an excellent time to teach skills to manage affect and help clients get back into their bodies with confidence so that they can manage emotions or affect that might come up. Body scans paired with BLS work well for this. Teaching other skills and education about affect is also helpful. This allows EMDR processing to work successfully without fear.

7 Social interaction, which is so important to teens, is a primary diagnostic factor under ASD. Teens with an autism diagnosis have significant difficulty or no ability at all to pick up on social cues during interactions.

They have difficulty reading facial expressions and noticing social cues. The state of mind theory means that the kids know what they think but don't know what others think, so they fill in the blanks with their own ideas. They also have difficulty with initiating actions so social reciprocity is also an issue. They are often social outcasts. EMDR has a place here in processing traumatic social situations and also for performance enhancement. Social stories by Carol Gray are extremely useful in this situation and more effective when they are installed with BLS. She also has some helpful cartoons. These may be adapted for any case and work amazingly well with children and teens. Gray developed these stories to use with autistic children in the schools. She uses a specific format to explain social situations in many different circumstances. She has published several books through Future Horizons Inc. including *Original Social Stories* and *The New Social Stories.* There is also a website. These stories can bring about instant changes in behavior and understanding.

Many ASD children and teens need extra help in school for cognitive delays and general processing problems. Most have different learning styles, so verbal expression and processing

are not their friends. Individuals with autism tend to be visual and hands-on learners, usually creative. Again, too much too fast is always a problem. A good rule is always to slow down and back up if the learner's frustration is evident. Social interactions are always a problem here. EMDR is useful for processing difficult situations, reducing anxiety, and helping kids recognize body sensations to manage emotions and energy during school. Attending any individual education plan (IEP) meetings is never a waste of time for a therapist working with an ASD student to educate professionals and to better understand the student's experience.

Children on the autism spectrum experience many small traumas, often huge ones. By the time they are teens, they have been through many episodes of being misunderstood, ostracized for unusual behaviors, disrespected by many due to ignorance, and often mistreated by peers and adults. Due to cognitive delays, impaired social understanding, and vulnerability, they can be ready victims of abuse and manipulation. Thankfully EMDR can help by processing trauma, reducing anxiety, and boosting self-esteem. For some, modifications are necessary, including the use of stories or pictures, teaching affect regulations skills, and having a parent or caretaker present. Other modifications include recommendations for providing bilateral stimulation. Most prefer tapping using tappers, buzzies, etc. Eye movement often is a distraction. Michelle Morrissey Ph.D. provided some new information via the EMDRIA Consultants Online Discussion Group on May 4, 2022. Following some research, Dr. Morrissey notes that "those with autism cannot follow a moving target from the center visual field to the right visual field." She recommends "bilateral dual attention stimulation using tappers and slower speeds."

With modifications, EMDR has successfully healed sexual abuse, physical abuse, bullying, and abandonment. Following the EMDR protocol, SUDS decreased, and the PC was strengthened using visual scales. Also noted have been improvements in general autism characteristics, including social interaction, verbal skills, and self-regulation. These statements are the result of shared anecdotal experiences from consulting therapists and personal observations.

It seems that most autistic teens want to be "normal." They want to have friends and engage in activities. They want to have romantic and sexual relationships. They want to be respected. EMDR can help them process trauma and increase the necessary skills to have all these things. Thanks to all the therapists that have been willing to take a chance, asking for help and resources to learn how to work with these amazing individuals. However, many more are needed. It is still difficult for parents seeking EMDR for their children and teens on the spectrum. What could be more rewarding than helping an ASD nonverbal preteen recover from sexual abuse and be able to expand his language abilities and return to school, all of this due to EMDR therapy. There are many more stories like this one during which EMDR completely changes the life of a person diagnosed with autism. You could be part of one of these stories.

Sherri Paulson, LSCW, is a trauma therapist at a local hospital in Ashland, Wisc. She began using EMDR with autism in 1998 when recommendations were against this. She won first place in a poster contest at the EMDRIA Conference in Denver in 2003, and this was the beginning of the protocol for EMDR and autism. She presented the protocol in 2006 at the Philadelphia EMDRIA Conference. Dr. Francine Shapiro once again attended and approved the protocol as presented. Since then, the protocol has been shared with individuals from around the world. Paulson has also given presentations at EMDR Canada in Banff, EMDR Europe in Edinburgh, and to the EMDR organization in Sao Paulo Brazil. She has also given a one-day workshop in Minnesota and one in Connecticut. This last one was recorded for streaming on the HAP/Recovery website with any proceeds going to EMDR Humanitarian Assistance. Paulson currently consults with therapists globally regarding EMDR and autism. Her inspiration is her niece, Emily.

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BRIDGING THE GAP TO

As I write this article, I am filled with anguish and heartbreak after learning the devastating news of the mass shooting killing 19 students and two teachers at Robb Elementary School in Uvalde, Texas. I live in Texas, and as a Latina therapist and, most importantly, a human, I am struggling. As a Texas healthcare provider, I carry this tragedy along with the barriers to trans kids, women's healthcare, and children at the border in my broken heart, filled with scar tissue.

I deeply hurt and want to help with my whole heart. As I do my body scan and identify where my tension lives, I feel pain, inflamed fear, frustration, confusion, despair, and grief. I want to name my feelings without armor, without editing, without pleasing others. I love this work and hold it sacred. I do not want to burn out. I want to protect my body, so I can continue to show up with courage. I want to promote that doing the right thing is hard and awkward and feels terrible. I want the warmth of being a learner, not a knower, to guide this work. Welcoming all unarmored parts is building a bridge of belonging.

"May we not just grieve, but give:
May we not just ache, but act;
Maybe everything hurts,
Our hearts shadowed & strange.
But only when everything hurts
May everything change."
—An excerpt from Amanda Gorman's poem, *Hymn for the Hurting*.

By Vanessa M. Sanford

BELONGING

ADULTS: TEENAGERS ARE WATCHING

Teenagers are my favorite developmental group of folks to work with. The particular ones I have been honored to sit with teaching me how much they are paying attention to adults. To the gaps between the sales pitch, adults make the rules to determine value and power and the practice of how adults behave. The gaps are filled with hypocrisy, incongruence, and confusion about what adults promise and promote and what teens are reporting to experience with adults. The brave teens I work with come in with bodies full of silenced stories of harm, shame, trauma, and oppression. Some of these teenagers have carried these untold stories in their bodies for so long they are struggling with sleep, focus, energy, and self-worth.

In my initial session with any teen, I announce a disclaimer. I am not a parent, an authority figure, or a know-it-all. I am an older human to walk alongside them in their work hoping to earn their trust in small moments. They get to decide what we talk about, and resistance is welcome. I let them know I ask many questions, and they do not have to answer any of them. I discuss my style of spending time checking in with the wisdom their body holds and invite them to check in with it too outside of the session. We work on filling the gaps of belonging by revising the old beliefs of

negative cognitions by welcoming all parts of self into the session. We spend time getting curious about being learners, not knowers. We spend a lot of time integrating the wisdom of the body. I remind them, and myself, that I am trying to get it right, not be right. I tell them I work on my welcoming bridge to belonging every day. I get it wrong and keep trying to learn about the gaps. The gaps that get in the way of belonging.

What stories live in the tensions of the shoulders, jaw, and neck? What pains activate in the stomach, hands, and feet? What memories are stuck in the throat, heart, and spine? What experiences are inflaming the hips and knees? I usually get lots of tilted heads, crossed arms, and long deep exhales. I see many tears and have a nearby wooden red tissue box from the company We're Not Really Strangers, that reads, "Cry Proudly."

"my mind
my body
and I
all live in one place
but it feels like we are
three completely different people"
—*disconnected*
home body —rupi kaur

As the reader, notice what comes up for you right now. What is your body telling you? What does your body need right now before reading on? (or not, totally up to you)

Notice that.

Go with that.

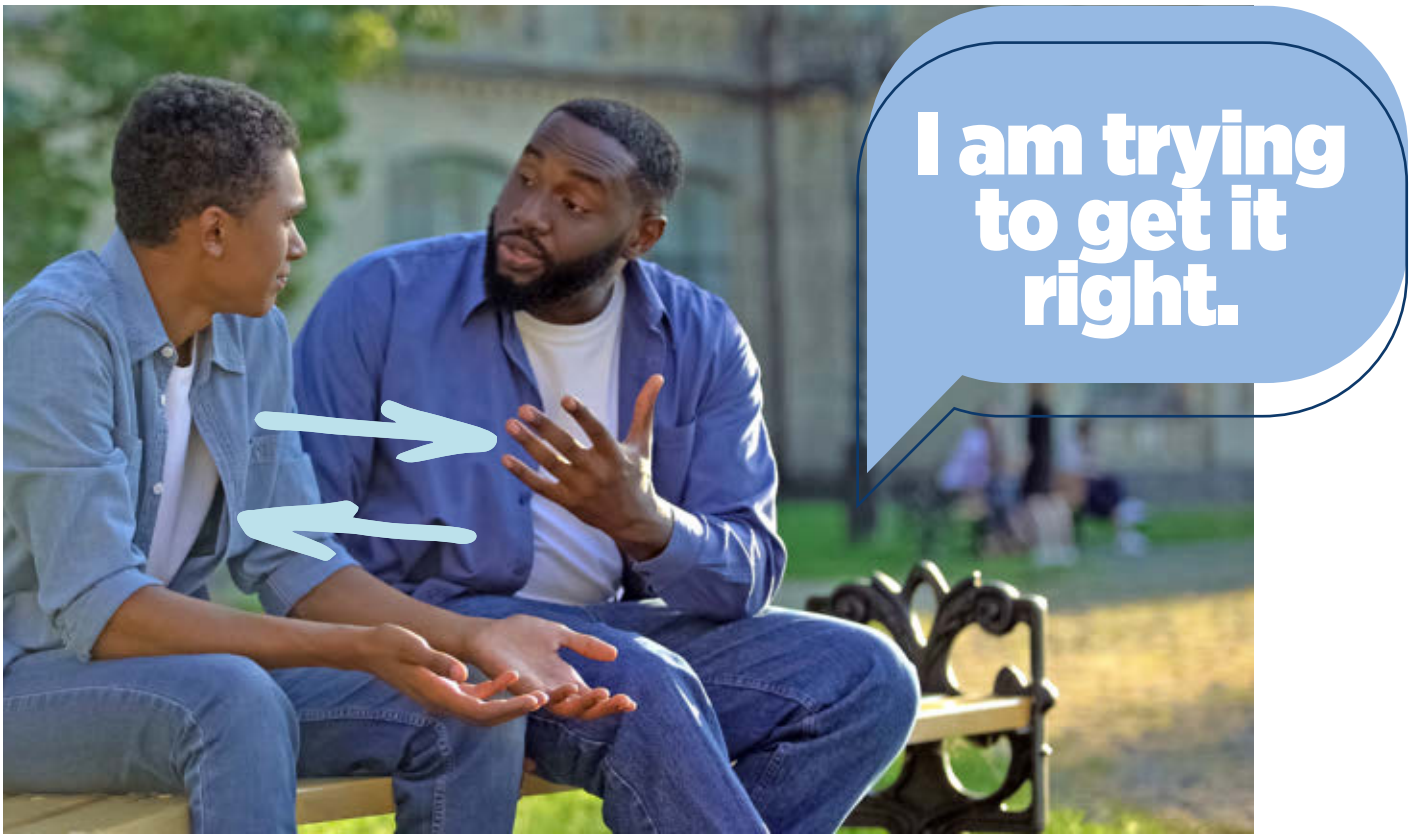
I will never forget when a high school student I was mentoring asked me a question calling out a colossal gap. "Is the point of working so hard to be at the top of my class rankings, be in all Advanced Placement classes, make sure and get in the National Honor Society, be in more than one extracurricular activity, spend time at home doing homework and missing sleep and time with friends, working, being in school organizations that look good for college, get into a good college, get a successful job, is to be an exhausted adult? Is that what adults want us to believe? To work so hard and sacrifice so much to be successful, tired, resentful, and not have time for your kids because you are always working?" Spotlight on a gap getting in the way of belonging. An opening to rest, health, and expanding success to mean more than status. Teens watching us leave a wide gap between what we are telling them is the way and how we are practice it. They see the gap, and the teens I work with are not convinced this is the way to belonging.

TOXIC CULTURE IS A GAP, NOT A BRIDGE BUILDER

Dr. Donald Sull, Charlie Sull, and Ben Zeig wrote an article in the *MIT Sloan Management Review* titled, "How Toxic Cultures Are Driving the Great Resignation." They say that between April and September of 2021, 24 million American employees left their jobs, an all-time record. They write that there are five major reasons for the movement: disrespect, lack of inclusiveness, unethical behavior, cutthroat environment, and abusive behavior. Organizations are recognizing this gap (losing employees) and being asked to update their foundations and leadership. The younger generations leaving adolescence, next in line to vote and enter the workforce, have a low tolerance for toxic work culture. Toxic culture is a gap, not a bridge builder. When I was growing up with my Mexican immigrant parents, they taught to me to find a job and stay there as long as possible. Put your head down, do your work, and pay your bills. I watched my mom get a fancy pen for decades of loyalty, and my dad received a glass plaque.

Brené Brown wrote in *Dare to Lead*, "If we want people to fully show up, to bring their whole selves including their unarmored, whole hearts—so that we can innovate, solve problems, and serve people—we have to be vigilant about creating a culture in which people feel safe, seen, heard, and respected."

Adults have a lot of work to do on this, and teenagers see it. Our work to release outdated norms gifts collective liberation. When they see us working on calling out toxic powers that dehumanize, harm, and exclude and lean into action to build trust, safety, and humanize those that have felt othered, marginalized, and oppressed, teens can see what begins to bridge the gap. The majority of my work with clients is to critically explore rules, social norms, belief systems, negative cognitions, and old dusty outdated stories shaping shame not worthiness. We target and use the three-pronged approach to examine the past, present, and future stories held in their bodies. We work on the gaps. The gaps hidden in our culture, media, homes, and even in healthcare. "What do you want to believe about yourself?" is a question clients are asked to begin the bridge to their positive cognition and rate how true it feels. We begin the work of building the bridge by collecting diverse perspectives, inclusive representation, cultural humility, sensitivity, safety, and resourcing. We work to call out any storage units of dehumanization living in the body. We learn about the full-body contact sport—shame and how it is a tool of oppression and struggles to coexist with accountability. Shame is a gap maker. It thrives with silence, secrets, and judgment and is highly correlated with suicide, addiction, self-harm, violence, aggression, disordered eating, perfectionism, and numbing. Brené Brown says, "We are the most in



debt, overmedicated, obese, addicted human cohort in recorded history. We are numb." Anne Lamott says, "My mind is a bad neighborhood that I try not to go into alone."

Together, we work to revise any shitty first drafts with accuracy and evidence as construction begins on the bridge to belonging. Brené Brown teaches a term called shitty first draft (SFD) as the first story born out of conflict, trauma, or stress. We need a story with a beginning, middle, and end and one identifying safety. The story needs to know who is bad and good, so we can blame and get a chemical release of certainty. The brain dislikes uncertainty and struggles with the vulnerable patience to investigate. It wants a story tying up loose ends and bringing closure. She teaches stories can be full of holes, and the work is to revise these stories with tender truth, data, and courage.

HOW EMDR THERAPY SUPPORTS THE BRIDGE

Eye Movement Desensitization Reprocessing (EMDR) is an embodied framework revising old negative and narrow cognitions with truer and expansive positive cognitions requiring hard work and awareness of these stories living in the body. Humans are prone to filling the gaps with fears and shame, floating back to memories cluttered with epigenetics. The bridge calls for being comfortable in the uncomfortable.

I have certain yoga poses that evoke rage in me. The top of the list is Warrior Two. I hate it. I feel my whole body wants to explode in fury when I am in this pose with arms stretching in opposite directions, left foot facing one way, right foot facing another, one knee bent, the other in line with my leg, pressing down on my feet, and looking forward. My shoulders scream, my back aches, and my feet feel on fire. I struggle to breathe, and my head is flooded with the urgency to swim up to the top to gasp for air. I get hooked, thinking I want to get out of this pose as soon as possible. It is extremely uncomfortable but not painful. Unfortunately, I know this pose is a wise bridge builder, a resource I frequently visit. I forget and then remember I have been in this pose before. There is a beginning, middle, and end, a past, present, and future to it, and I am capable of being in this pose. I am strong and look forward to getting out of it. My self-talk is cranky at first with lots of eye-rolls. Then I recall the evidence I have gotten through this before and will this time too. I compassionately guide my activation and feel relief when I move into another pose. I survived. Another practice to integrate the bridge to belonging. My grumpy, forgetful,

resistant and brave parts of myself were all welcomed and contributed to the bridges construction.

Notice what comes up for you right now. What is your body telling you? What does your body need right now before reading on? (or not, totally up to you)

Notice that.

Go with that.

VALIDITY OF COGNITION BUILDS BRIDGES, TOO

Moving from wanting to "be right" to wanting to "get it right" is another bridge builder and enhances the work of the Validity of Cognition (VOC). The VOC is the remembering. I turn to Dory, from the movie *Finding Nemo*, as one of the greatest representations of mental health and, specifically, the Validator of all Validity of Cognitions (VOC). She knows her way home across the underwater bridge to belonging. Belonging to safety, resilience, self-trust, boundaries, and meaningful connection. Then she forgets. Then she remembers; then she forgets. Something alarms her memory of the directions home; then she forgets. Thank goodness in this children's animated movie, she has trusty friends helping her as they are aware of her strengths and struggles and remind her when she forgets, which is a lot.

I often remember my VOC, my ability to practice tension integrity in the Yoga pose, Warrior Two, when I am out of this pose. When I am in it, I forget, and then with a slow breath, my compassionate-self kindly reminds me of my way home, across the bridge. This integrated embodiment of remembering is like laundry. It never ends. If I do not commit to washing, drying, folding, my laundry consistently, I end up in my bathing suit. I promise to do better when I am in my swimsuit and then forget when my clothes are all clean and put away. Laundry highlights how ordinary and frequent the work of mental health is. The gap of unrealistic expectations gets in the way, and the bridge reclaims the routine work of remembering. When we forget, looking around for trusted supporters and installed resources are markers to the way home to self-love, belonging, and health. The remembering builds self-trust and manages expectations with reality.

ADULTS: DON'T OFFLOAD (ALL) RESPONSIBILITY TO TEENS

A couple years ago, I marched alongside my daughter and many teenagers at a teen-led peaceful protest, March Our Lives, after the tragic massacre at Marjory Stoneman Douglas High school in Parkland, Fla. I remember feeling the collective grief and disappointment when hearing adults tell teenagers to lead and make the changes. I talked to teens reporting confusion about why adults are offloading onto teenagers to make the changes. Another identified gap is discharging the work to someone else.

I also hold so many stories of trans kids in my office. They tell me some of their adult family members are telling them they are "too old to change their ways and refuse to call them by their name or identified pronouns." I have teenagers tell me when they bravely share a story held in their body of sexual trauma, the most common first response from an adult is, "Why didn't you tell me sooner?" Or "What were you doing for this to happen?"

We tell children and teens to make sure and tell an adult if anything ever happens to them, however, this is only the first part of the lesson. The gap connects to the second of the lesson. The adult's response matters. When an adult is actively listening to children and teens sharing a story of harm being released from their body, this is a moment of filling in a gap. If we ask the common and judgmental questions of why didn't you tell me sooner or what were you doing, we quickly close the bridge to their story and trust. When we say thank you for telling me that must have been so hard to hold for so long and how honored we are they chose us to tell, the bridge widens, and a moment of trust is built.

When I work with teens in their senior year of high school, we spend time discussing the awkward comments adults make. They teach me their experiences of the gaps of adults feeling free to ask invasive questions like, "What school are you going to? That school? You should go to this school instead. What do you want to study? Don't study that. You won't make a living. You should study this instead." Teen clients tell me they don't remember asking for advice while getting gas in their car or at the grocery store but they know the social rules that live in the body requiring them to make eye contact, smile, and answer the question, from the adult they do not know very well or don't have trust with or appear rude. We work on recalling the resources installed and do a body scan of where there is activation and identify a skill to remember some adults have not earned the right to hear their story: To untangle a narrative takeover from adults and practice story stewardship. Protecting the story is a bridge builder.

Unsolicited advice is like a flea market. So many items to browse and you can even pick them up to look closer, but you get to decide if you want to purchase or not. We joke and wonder what it would be like for adults to be asked by teens they do not know well, "What are your retirement plans? How much money have you saved? You should invest in this or do that for your retirement." We talk about how this would be considered disrespectful.

Why didn't you tell me?

We talk about how confusing it is for adults to believe they have the right to ask these questions, and teens are not allowed to. We talk about the gaps. The gaps of expectations, rules, and embodiment of healthy practices adults profess but like us all, struggle to do consistently.

The poet Cleo Wade wrote, "Tend to your thoughts with care. They have the power to grow weeds or flowers."

Notice what comes up for you right now. What is your body telling you? What does your body need right now before reading on? (or not, totally up to you)

Notice that.

Go with that.

I remember the first time I testified in court as an expert witness in a child abuse case, while working at an advocacy center. I ignorantly decided to procrastinate learning more about court until after I was there a year, as I was advised in my orientation. Three months into my internship, earning hours towards my license, I sat on the witness stand after raising my right hand and swearing to God I would tell the truth. I felt like I was on the TV show "Law and Order." I looked around, waiting for someone to yell action, and hopefully, there would be snacks. My belly was full of fire as if I had just eaten a handful of jalapeños. I felt uncomfortable in the chair and kept moving the microphone closer to my mouth. When asked what my name was, I forgot my name. I stared blankly and then, with almost a whisper, remembered my name and stated it with a shaky voice. I thought this wasn't a good start.

They asked me more questions, and I found myself focused on wanting to sound competent and would rush to answer before the questions were finished being asked. One attorney, when cross-examining me, moved closer to me. She leaned in and placed her hands on the space in front of me. I could smell her breath. She yelled and glared at me, and I tried to collect her rapid-fire questions as fast as I could and respond quicker than my brain was able to answer intentionally. I remember noticing the exit sign and wishing I could slide down my chair and crawl to the doors. I looked around at the judge, and the prosecutor, and the jury and was trying to send messages of help through my eyes. Help me get out of this. Two hours of testimony is too long. Too long to stay regulated, engaged, and focused, and apathy set in. I gave one-word answers to end it. I knew I failed. I knew I did not promote competency. Finally my body slid down the chair, literally. I had lost all professionalism. I was directed to leave the stand. I did the walk of shame. Tears falling, head down, tight fists, sweaty armpits, and stomach tight and twisty. My thought walking out was, I am done being a therapist, I am terrible, and I do not belong. I will find something else for a career. I got in my car and muddied by the shame spiral I was in, ran right into a concrete wall as I drove out of the parking garage.

I was not in my body. I was trapped in a dissociative tunnel of shame. I was not safe to drive or testify, and walking was hard enough. I wish I had learned the container skill back then. I would have been able to learn how to close up a moment of activation, get back into my body in the present moment, and then build back up my tolerance to safely drive. I would have been able to complete the stress cycle with some tears, maybe some walking, tapping, or dancing, and then revisit this memory later to help revise any drafts of shame, blame, and unworthiness. Looking back at this memory now, I have compassion for her. My right hand promised to tell the truth, and the rest of my body was not prepared to handle this kind of pressure.

I have been able to mind the gap and bridge a better practice of belonging. I leaned in as a learner after this experience and grew in tension integrity to be able to return to the witness stand with breathing, slowing the pace down to take time to listen to the question with courage, and focusing and exhaling before answering as best I can. My right hand still promises to the tell the truth, and my body knows it has worked hard to listen to what experiences and perspectives I have to tell the truth I know. Dedicated to identifying gaps getting in the way of my bridge to belonging is to call out blind spots, barriers, and ignorance. I continue to work on this all the time. I practice the humility of sensing my body's activation, the brave and vulnerable work of embodying quietly and without spotlight, listening to diverse perspectives to expand my own awareness, and feeling the discomfort of when I mess up and owning it and attuning to it. My job is to learn from this and do better. I am committed to doing better. To listen and be responsible for my own work to ensure I am not harming in the name of helping. I will continue to fail and improve all the time.

Rupi kaur wrote in her poetry book, *homebody*,

"After feeling disconnected for so long
My mind and body are finally
Coming back to each other."

Notice what comes up for you right now. What is your body telling you? What does your body need right now before reading on? (or not, totally up to you)

Notice that.

Go with that.

TLDR

Bridging gaps to belonging embodies being a learner, not a knower.

Comparing this work to the ordinary and frequent laundry practice, it never ends.

Practicing skills rather than professing them as teens watch, next in line to vote, and enter the workforce.

The bridge calls for being comfortable in the uncomfortable.

Trust in small moments is a bridge builder.

When we forget our VOC or where the bridge is, look around for trusted supporters and installed resources as markers on the way home to self-love, belonging, and health.

The remembering builds self-trust and manages expectations with reality.

Protecting our story is a bridge builder and releasing these stories held in the body to those that have earned the right is a loving gift of EMDR therapy.

Including the body, senses, feelings, and beliefs into this work is a bridge builder to integration.

Vanessa M. Sanford, LPC-Supervisor, RPT-S, is a Licensed Professional Counselor/Supervisor, EMDRIA certified therapist, Registered Play Therapist/Supervisor, Certified Daring Way Facilitator based on the research by Brené Brown, and a Registered Yoga Instructor. Sanford provides bilingual therapy to children, teens, and families in her private practice called Support System in Frisco, Texas, and was awarded the 2007 Texas Mental Health Professional of the Year for Child Advocacy Centers of Texas. She has spoken locally, statewide, and nationally on addiction, anxiety, wholehearted living, court preparation for therapists, trauma, animal assisted therapy, and abuse. Sanford has co-authored two chapters in two books and written blogs and articles focusing on mental health. She was featured in educational films bringing awareness to child abuse. She has been interviewed on a local radio show and podcasts, has been a mentor for local high school students, has been on the advisory council for Frisco Gifted Association, and APT's Inclusion, Equity, Diversity Awareness Team, and is a proud member of Frisco ARTS. Sanford wants to live a brave life full of courage, compassion, creativity, and kindness. She enjoys collaborations and co-facilitating with amazing teachers to offer more diverse service to the community.

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BIPOIC PERSPECTIVE ON EMDR WITH TEENAGERS

Could you offer a specific example of how some aspect of a client's culture/race was deeply meaningful as a resource and/or as a challenge in using EMDR with Teenagers?"

The answers may have been condensed for clarity and space.

As a newly trained EMDR therapist in 2014, one of my challenges was that my training did not include examples of working with teens children or the adaptations of culture/race. EMDR training is full of information and experiential exercises to provide the necessary tools for therapists to begin implementing EMDR therapy. As a LatinX therapist, the inclusion of culture/race came from my experience, research, and talking to other Black Indigenous People of Color (BIPOC) therapists who normalized my needs and gave examples of how they were integrating culture/race with their clients. I am also aware that EMDR training is shifting, including working with other populations and the naming of culture in EMDR therapy.

One example of using EMDR and culture/race is processing negative cognitions due to messages and experiences teenagers adopt due to their view of self, view of others, and view of the world. Teenagers deal with many phases in their lives, like growing up and readjusting to parents' views and expectations, friend demands, and identity formation, which are normal developments. However, the cultural/race experience can add negative cognitions due to their experiences with the world. Imagine growing up in a family that speaks a language that is devalued, witnessing and experiencing colorism, and seeing your family mistreated and discriminated against often. Picture your parents not speaking the expected language, and when they try, they are ridiculed. Imagine having a front row to these experiences and going to school, where they give you a message to assimilate, individuate, and adapt to the majority norms (e.g., identity, language, appearance).

As an EMDR bilingual and bicultural therapist, I have helped teens with their EMDR therapy with processing their negative cognitions and experiences, including the role of these cultural issues. Most teenagers share how helpful it was to have language for their experiences and someone who understands their families/traditions/norms and feels seen.

In my practice, something valuable in my work with teenagers who identify as BIPOC has been the use of drawings, storytelling, metaphors, sandtray, switching languages, honoring family healing tools, adapting bilateral stimulation methods (e.g., toys, drawings, sound, touch, visual), and building on existing cultural resources.

—Liliana Baylon, LMFT-S, RPT-S
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UCDenver: Lecturer / School of Education and Human Development
AAMFT Approved Supervisor
EMDR Approved Consultant & EMDR Certified Registered Play Therapist - Supervisor Synergetic Play Therapist Consultant ICEEFT Certified EFT Therapist and Supervisor-in-Training

I have spent most of my career generalizing teenage behaviors. Mostly, as a strategy for building rapport with caregivers of teenagers to explain teenage development. Unfortunately, I and other caring adults have contributed to the negative stereotypes that teenagers have learned to internalize.

Working with teens, particularly teens from within the Black Indigenous People Of Color (BIPOC) community, requires individual clinicians and other mental health systems to evaluate their values related to working with and or "being with" teens in their practices. One issue that Black teens often contend with at school and in the community is

"adultification bias," a form of racial prejudice where children of minority groups are treated as being more mature than they are by reasonable social standards of development. adultification bias often impacts how adults see Black children, yes, even in the clinical community.

Teens within the BIPOC community often experience a unique paradoxical situation. On one hand, there is an expectation for them to comply with adult directives, stay in a child's place, and respect adult boundaries while simultaneously thinking for themselves, meeting school expectations, being responsible for familial obligations, and being assertive (but not angry). This became apparent to me during an assessment with a teenage Black girl. She shared that she was "tired of talking to therapists" that didn't truly see her or hear her. She went on to say, "There was so much going on in my life and my head that it seemed as though I had an attitude but my sadness had turned into anger."

Black teens are acutely aware that their behaviors are less likely to be seen as "typical" child development and are more likely to be punished for expressing their emotions. Some adults seem to be more likely to have unconditional positive regard for teenagers that are compliant, perhaps because it makes them feel competent. Teenagers' sense of self and identity is often wrapped up in how they are perceived by the adults in their lives, which can complicate the process of identifying their negative cognition during EMDR case conceptualization. Furthermore, race-based offenses can further complicate things, particularly when committed by the very adults responsible for teens' social, emotional, and physical safety and overall well-being. Black teenagers' negative self-concepts can be so implicit that they struggle with the idea of not being responsible for their trauma.

Teenagers often minimize the impact of their negative experiences; due to adults minimizing the teenage experience. As caring adults, we must reflect on how we feel, think, and speak about young people when they are present or not. Let's commit to interpreting problematic behaviors as symptoms of a bigger problem, including ALL teenagers, even the "angry" Black child.

Teens in the BIPOC community often carry the burdens of adult expectations despite the inappropriate nature of such expectations. A teenage Black boy recently said, "When teenagers speak, adults often listen but don't understand, and they offer solutions that are not applicable and at times unhelpful." "Just listen and stay in your lane." His statement is a reminder that all people, including teenagers, can problem-solve and self-determine. It would behoove us as adults to listen and be present without judgment.

—*Ava M. Hart, LCSW, IMH-E*

Accessing and integrating strengths within a teen's race and culture can be a powerful resource when doing EMDR Therapy. As a play therapist, I often try to find ways to use movement and play in my EMDR, even with teens! For example, many of my inner-city Black teens have strong interests and cultural influences rooted in basketball. They come from communities with little resources yet always have a basketball court. This is where their social networks, attachments, positive role models, and the 'Greats' (as one of my black male teens regularly informs me) clash onto one court. I have used various aspects of basketball in all eight phases of EMDR. For example, in phase one, clients identify a target memory, go to a 0-10 numbered card on the floor (identifying the SUD), and shoot the basketball into a basket or make-shift bucket. This helps with the mind-body connection by using their internal cultural resource as a tool to widen their tolerance of the traumatic material and allows movement of energy. I then can contain this exercise and exposure of traumatic memories by either transitioning into one of the greatest debates: "Who's better? Kobe or Michael Jordan?", start an old-school basketball game of 'HORSE', or have my client tell me about their favorite team or experience with basketball. Identifying cultural channels of internal resources and integrating them into a teen's EMDR therapy helps increase attunement and protective factors of connectivity when tackling traumatic experiences. Plus, it's fun!

—*Renata S. Huewitt, LPC, RPT*
Registered Play Therapist
EMDR Certified Therapist, EMDR Consultant in Training
SPACE (Supportive Parenting for Anxious Childhood Emotions) Provider, Certified AutPlay Therapist

Summer 2022 Advertising Index

How do you create a sense of connection via telehealth in a high stress situation?

–Reg Morrow Robinson, Ed.S., LMFT, LMHC
EMDRIA Virtual Basic Trainer & R-TEP/G-TEP Trainer, Approved Consultant

This month's discussion highlight comes from the Ukrainian Conflict Collaboration Network. A tip to share:

As we work with people far away, struggling with immense loss and disconnection, finding ways to let them know they are seen and cared for matters. Bill Brislin and MaryJo McHaney have provided several group interventions now in Ukraine via Zoom. This is how Bill begins his Group Resource Enhancement Protocol sessions:

"We see you. We are here with you. You matter. Your lives matter. Your families' matter. Your clients matter. Your country matters… The world sees you and feels your pain."

How do you create a sense of connection via Telehealth in a high stress situation?

ANSWERS:

I am a bit more subtle. I wear a yellow blouse and a turquoise pullover. I start with earth, wind, and water as a grounding technique. Earth notices the texture of your pants, wind—inhale exhale until your shoulders drop, and water—notice the saliva in your mouth and swish it around. I excluded fire because I figured it might be traumatic. You could also consider sunflowers in your virtual (or office) background. Cut sunflowers, plastic sunflowers, or a child's drawing of sunflowers. Color and symbol are paramount. No words necessary.
—Scarlett Williams, LPC

The Four Elements stabilization exercise is used in both R-TE, G-TEP, and GREP. We typically do change from fire to light. Light up your imagination with a place that represents calm. We take the SUD at the start and at the end of Four Elements (without requesting they hold the disturbing material in mind). It is a general measure. This is an additional screening measure. Can they currently change state, follow the instructions? If done in a group setting, we may invite sharing of the calm place. We do not invite sharing of the distress.

I have been asked what GREP is. It is Group Resource Enhancement Protocol. Dr. Maria Masciandaro, R-TEP/G-TEP trainer, created it. Elan Shapiro (developer of both R-TEP and G-TEP) and accredited trainers of the R&G international training team provided feedback to polish it off.

This was accomplished immediately after the Ukraine conflict began. I was immensely impressed with the team effort. It is being translated in several languages now.

The purpose is to assist groups of Ukraine therapists identify and strengthen resources to support themselves and their clients. It incorporates qualities of early intervention protocols designed for safety and containment. It uses a worksheet similar to G-TEP, which can be hand drawn at the time group begins.

It is NOT a trauma processing protocol. It is a resource building protocol. It does use DAS.

The timing of processing trauma material is important to consider. Does the client have the current necessary resources (internally and externally) to process trauma? If not, just as in traditional EMDR, reprocessing is not provided until there is sufficient resources and supports. If a lack of resources exists, processing trauma may do more harm than good. This is particularly true if there is no follow up occurring with the client.

It would be great to hear from you how you determine readiness to process trauma when working so far away and often without a solid plan for follow up. I am not sure we are completely clear on all the variables to consider. What are your thoughts?
—Reg Morrow

Your question is a great one and one for which I have little to offer. I do agree that not processing trauma with these people is important, but wonder about your thoughts about using IGTP by Jarred?
–Susan Goodell, MA, MS, MFT
EMDRIA Certified & Consultant
EMDR/HAP Facilitator

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