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Therapists' Perceptions of Eye Movement Desensitization and Reprocessing Treatment for Women Survivors of Child Sexual Abuse

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Abstract

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by

Annette Jones-Smith

MA, Notre Dame of Maryland University, 2000

BS, Morgan State University, 1992

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

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Abstract

Child sexual abuse is prevalent worldwide and can result in adverse psychological effects that persist into adulthood. Therapists must identify therapeutic treatments for adult survivors of child sexual abuse who continue to experience psychological difficulties, such as anxiety, depression, and PTSD. The purpose of this phenomenological qualitative study was to explore the perceptions of therapists about eye movement desensitization and reprocessing (EMDR) as a tool to assist adult women survivors of child sexual abuse through the healing process and to regain their abilities to function and behave appropriately. Data were collected through the Moustakas Theory (1994) with 10 therapists who provided therapeutic or counseling services (or both) through EMDR to women with a history of repeated sexual abuse as children. The therapists perceived EMDR as more effective in treating child sexual abuse trauma than other treatment options because it involved the body and worked rapidly, although the treatment may involve a danger of dysregulating the patient. Results indicated the perceived role of EMDR in a treatment program is to allow patients to remember traumatic events without reliving them and to free patients from shame and prepare them to learn more effective coping skills. The therapists implemented EMDR by building rapport, conducting a thorough assessment, focusing treatment on the most distressing elements of past traumas and present triggers, and teaching the client skills for coping with distress. This study contributes to social change by adding more knowledge and awareness about women survivors of child sexual abuse and the various available treatments, thereby helping the long-term impact of women's health with histories of childhood sexual abuse.

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Dedication

To my phenomenal parents, Willie and Leanna Jones, I want to simply say thank you! I could not have completed this without your love, time, prayers and commitment to making sure I got what I needed in order to be successful. Thank you for all of your support along the way and Happy 60th Wedding Anniversary Mom and Dad!

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I also want to thank my academic advisor, LaToya Johnson. She assisted me in my desperate moments and guided me in the direction of completion with calmness and accuracy. Latoya was the epitome of what customer service should resemble.

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Chapter 1: Introduction to the Study

Over the last few decades, child sexual abuse has received attention in the field of psychology and advances have been made to provide short-term and long-term services to victims (Colangelo & Keefe-Cooperman, 2012; Sinanan, 2015). Child sexual abuse is defined as the act of having sexual contact or conduct between a child (0-12 years old) and an older person, including (a) cases of assault wherein the child resists, (b) inappropriate touching in any part of the child's body, and (c) fondling with a child while having a sexual intent (Gómez, Kaehler, & Freyd, 2014; Irigaray et al., 2013). Scholars have established that being abused as a child has several psychological, physical, and behavioral implications both in the short term and long term (Norman et al., 2012; Sugaya et al., 2012). Short-term effects may include decreased self-esteem and self-efficacy, aggression, and self-injurious behavior (Matulis, Resick, Rosner, & Steil, 2014; Norman et al., 2012). The long-term effects from child sexual abuse may include psychological disorders such as PTSD, anxiety, and depression (Bak-Klimek et al., 2014; Fergusson, McLeod, & Horwood, 2013). Possible long-term effects also include increased risk of suicide attempts, violent behavior, as well as difficulties with sexual functioning and relationships (Colangelo & Keefe-Cooperman, 2012; Fergusson et al., 2013).

Because the experience of child sexual abuse can cause significant psychological difficulties for victims into adulthood, it is important to identify therapeutic treatments for adult survivors that may alleviate symptoms that result from this form of trauma (Cleary & Hungerford, 2015). Eye movement desensitization and reprocessing (EMDR)

is a form of psychotherapeutic treatment that has been found effective in treating the symptoms of PTSD (Chen et al., 2014), and some evidence indicates that it may also be an effective therapy for psychological disorders induced by the traumatic experience of child sexual abuse (Paylor & Royal, 2016).

The aim of the present study was to contribute to the research on EMDR through exploration of its effects on adult women survivors of child sexual abuse based on perspectives of therapists. The findings of this study can be helpful for therapists and women who were survivors of child sexual abuse in determining whether EMDR was an appropriate treatment choice for this population's psychological symptoms. The next sections of this chapter will provide relevant background, as well as articulation of the present study's problem, purpose, research questions, and theoretical framework that will guide inquiry and analysis. This chapter will also provide a brief discussion of the nature of the study, definitions of key terms to be used in the study, assumptions, scope and delimitations, limitations, as well as the significance of the study. Finally, this chapter will conclude with a summary of key points.

Background

Child sexual abuse is prevalent on a worldwide basis, although multiple factors create barriers to establishing reliable prevalence estimates (Murray, Nguyen, & Cohen, 2014). Researchers have used varied definitions of child sexual abuse (i.e., age limits, types of abuser behavior) in their studies of prevalence, which may result in variation in estimates (Colangelo & Keefe-Cooperman, 2012; Murray et al., 2014). Additionally, feelings of shame and stigma may deter victims from disclosing abuse histories, further

limiting the reliability of current prevalence estimates (McElvaney, 2015; Murray et al., 2014). Results of meta-analyses of sexual abuse prevalence studies indicated that about 12% of children experience sexual abuse globally, whereas the results of multiple surveys in the United States indicated that about 10% of children had experienced child sexual abuse (Murray et al., 2014; Pérez-Fuentes et al., 2013). A consistent finding of prevalence studies is that girls are more likely to experience child sexual abuse compared with boys; specifically, girls in the United States are about three times more likely to be sexually abused than boys (Murray et al., 2014; Pérez-Fuentes et al., 2013). Possibly related to delayed disclosure, child sexual abuse prevalence rates tend to be higher when obtained retrospectively from adult samples; recent estimates indicate that approximately 25% of women in the United States experienced some form of sexual abuse in childhood or adolescence (Colangelo & Keefe-Cooperman, 2012).

Researchers have associated the experience of child sexual abuse with several adverse long-term effects that can persist into adulthood (Fergusson et al., 2013; Pérez-Fuentes et al., 2013). A history of child sexual abuse has been associated with increased risk for anxiety disorders in adulthood, including PTSD (Maniglio, 2013). Compared with individuals who experienced child abuse without a sexual component, adult survivors of child sexual abuse were more likely to report psychological symptoms associated with a range of mental health disorders and were more likely to attempt suicide (Pérez-Fuentes et al., 2013). Although several psychological disorders have been associated with history of child sexual abuse, the most frequently reported have been depression and PTSD (Pérez-Fuentes et al., 2013). The relationship between the severity

of child sexual abuse and adult psychological outcomes has been debated in the literature, as some survivors report no adverse long-term psychological effects whereas others experience severe psychological suffering many years later (Bak-Klimek et al., 2014). For example, Bak-Klimek et al. (2014) found no correlation between severity of adult psychopathology and child sexual abuse characteristics, including age of abuse onset, frequency of abuse, number of perpetrators, and victim-perpetrator relationship. Conversely, Fergusson et al. (2013) found that the severity of child sexual abuse was associated with higher risk of psychological disorder in adulthood.

Regardless of the specific characteristics of child sexual abuse, the experience of this trauma creates an increased risk of psychological disorder for victims into adulthood (Maniglio, 2013; Pérez-Fuentes et al., 2013). Identifying effective treatment for long-term psychological effects of child sexual abuse is therefore an important aim of research (Calvert, Kellett, & Hagan, 2015; Cleary & Hungerford, 2015). Research supports the effectiveness of EMDR in reducing the symptoms of PTSD, which often include anxiety and depression, although the effects of this therapeutic modality among women who are survivors of child sexual abuse has not been thoroughly investigated (Paylor & Royal, 2016). The EMDR approach was developed by Francine Shapiro in 1989 and utilizes eye movements that are guided by the therapist during therapy sessions (Shapiro, 2014). Eye movements are induced in connection with exposure to the patient's traumatic memories, which facilitates access to stored memories and desensitization to related anxiety (Chen et al., 2014). Therapists using EMDR guide patients to retrieve their traumatic memories and gradually integrate them into healthy cognitive and emotional schemas (Chen et al.,

2014). Although both EMDR and trauma-focused cognitive behavior therapy (CBT) have been found effective in treating PTSD and related symptoms, EMDR often helps patients achieve positive results in shorter time periods and through use of less complex therapeutic procedures (Shapiro, 2014). Understanding how EMDR affects adult women survivors of child sexual abuse was important in determining its appropriateness as a treatment modality for this population (Paylor & Royal, 2016).

Problem Statement

There were several therapies used to cater to the needs of patients with trauma caused by different abuses. One of these is EMDR, which is classified as a trauma-focused treatment (Chen et al., 2014; van den Berg & van der Gaag, 2012). The EMDR approach has been demonstrated as effective in treating PTSD, depression, and anxiety, which are commonly experienced disorders among adult survivors of child sexual abuse (Fergusson et al., 2013; Pérez-Fuentes et al., 2013). However, there was a lack of consensus on whether treatments for adult onset trauma were suitable for adults who experience psychological difficulties resulting from childhood trauma (Ehring et al., 2014). Furthermore, although EMDR may be applicable in the treatment of psychological symptoms in survivors of child sexual abuse, uncertainty or lack of familiarity with EMDR may reduce therapists' use of the modality with victims of sexual abuse or assault (Edmond, Lawrence, & Schrag, 2016). Nevertheless, other scholars have obtained evidence to support the efficacy of EMDR in treating patients suffering from psychological trauma (de Bont, van Minnen & de Jongh, 2013; Ehring et al., 2014; Shapiro, 2014), especially patients who suffered childhood maltreatment or different

physical abuses (Ricci & Clayton, 2016; Shapiro, 2014). The specific problem addressed by this study was that recent scholars have not fully explored the perceptions of therapists about EMDR as a tool in assisting adult women clients through the healing process and regaining their abilities to function and behave appropriately.

Purpose of the Study

The purpose of this phenomenological qualitative study was to explore the perceptions of therapists about EMDR as a tool to assist adult women survivors of child sexual abuse through the healing process and to regain their abilities to function and behave appropriately. The study was focused on 10 to 12 therapists who provided therapeutic or counseling services (or both) through EMDR to women with a history of repeated sexual abuse as children. Therapists were interviewed instead of adult women victims to avoid retraumatizing these clients. The participants of the study were recruited from therapists in the Newark, NJ area who provided services to sexually abused women and children.

Research Questions

RQ1: What are the perceptions and experiences of therapists about EMDR as a tool in assisting adult women clients through the healing process and regaining their abilities to function and behave appropriately?

RQ2: How have therapists perceived the effects of EMDR with women who had histories of child sexual abuse? What changes did they observe, and what did they like and/or dislike about EMDR?

RQ3: How did therapists perceive EMDR in comparison with other treatment approaches for this population? What were benefits or drawbacks observed?

RQ4: When is the right time to introduce client into EMDR treatment?

RQ5: How did therapists implement EMDR treatment with women survivors of child sexual abuse?

Theoretical Framework for the Study

The transactional theory of stress and coping, developed by Lazarus and Folkman (1987), was the theoretical framework for the present study. The basis for this theory is the proposition that stress and coping processes occur in a transactional fashion, emerging from the relationship of the person with the environment (Lazarus & Folkman, 1987). Another core proposition of this theory is that psychological stress has two aspects or phases that may occur consecutively or simultaneously: (a) primary appraisal or evaluation of the stressor, which involves the determination of the significance or meaning of an event for a person; and (b) secondary appraisal, which helps explore coping or the individuals' perceptions of whether they are capable and have the tools to address the stressor (Lazarus, 1993). Depending on an individual's primary and secondary appraisals of stressors, coping methods will then be employed accordingly (Lazarus & Folkman, 1987). *Emotion-focused coping* refers to methods that directly address the individual's aversive emotional reactions to the stressor, and *problem-focused coping* refers to strategies aimed at addressing the underlying causes of stress (Lazarus, 1993). Lazarus and Folkman further proposed that patterns of more or less adaptive coping might be related to overall psychological functioning and well-being.

In Lazarus's (1993) psychological stress theory, stress is regarded as a relational concept. Instead of viewing stress as a kind of external stimulation or a specific pattern of physiological, behavioral, or subjective reactions, Lazarus described it as a relationship between individuals and their environments. In essence, Lazarus focused on the cognitive aspect of assessing a stressor—through the two forms of appraisal. In the context of this study, psychological stress was felt from (a) the interaction between the victim (woman) during childhood and the perpetrator of sexual abuse at that time, and (b) the interaction between the victim (woman) as an adult and the people that surround her. In relation to psychological stress theory, the victim in this study (i.e., adult woman with history of childhood sexual abuse) would assess the act of sexual abuse as a child and as an adult through the two forms of appraisal. It is also the same environment that may help in coping with such stress (Lazarus, 1993). Therefore, if the proper treatment of coping mechanism is placed in the environment of the victim, then coping will be made easier. One way of improving the ability to cope through trauma is by undergoing therapy, which, for the case of this study is EMDR. Hence, the transactional theory of stress and coping was expected to provide a useful framework for exploring therapists' perspectives on EMDR as a treatment for women who were survivors of child sexual abuse.

Nature of the Study

A qualitative approach was chosen for this study because it allowed for exploration of participants' perspectives and experiences in a flexible manner (Merriam & Tisdell, 2015). Conversely, quantitative methods involve measurement of predetermined variables based on numerical scales (Maxwell, 2012), which did not suit

the purpose of this study to explore therapists' experiences and perspectives related to EMDR with women survivors of child sexual abuse. A phenomenological design was most appropriate for this study because it allows researchers to gain meaningful insights about their phenomena of interest (Moustakas, 1994). Phenomenology is defined as a research design that involves the need to understand and comprehend different phenomena based on experiences of individuals who lived through the said phenomena (Groenewald, 2004). For this study, the phenomenon was the therapists' perceptions of EMDR as a tool in assisting adult women survivors of child sexual abuse.

For this study, 10 therapists providing therapy to women who survived childhood sexual abuse were asked to participate in semistructured interviews. According to Mason (2010), sample sizes for qualitative studies, such as phenomenology, have ranged from 10 to 20 participants as being sufficient to achieve data saturation. Meanwhile, Beck (2009) noted that a sample size ranging from six to 25 was more appropriate. The participants were selected or recruited through purposive sampling in the Newark, New Jersey area who agreed to be part of the study. Analysis was performed using Moustakas's (1994) steps for analysis of phenomenology based on van Kaam's (1966) initial method for analysis.

In Moustakas's (1994) method for analyzing phenomenology, the first phase involves identification of relevant and initial grouping, wherein each relevant expression was listed through horizontalization. *Horizontalization* refers to the process wherein analysts develop a list of unique and nonoverlapping important statements. The second phase consists of reduction and elimination of each statement by evaluating whether the

expression was (a) related to the experience being explored, and (b) could be labeled as a part of the spectrum of the whole experience. Those who could not satisfy these criteria were eliminated. The third phase involves clustering and thematizing the data. The fourth phase involves the final identification of themes. The fifth phase involves using the finalized themes and providing individual textural descriptions for each. The sixth phase involves the development of individual structural descriptions based on the individual textural description. The seventh and last phase consists of development of meanings and essences for each textural-structural description (Moustakas, 1994).

Definitions

The following included definitions of key terms that were used in the study:

Child sexual abuse: Although definitions vary, child sexual abuse is defined in this study as the act of having sexual contact or conduct between a child (0-12 years old) and an older person, including (a) cases of assault wherein the child resists, (b) inappropriate touching in any part of the child's body, and (c) fondling with a child while having a sexual intent (Gómez et al., 2014; Irigaray et al., 2013).

Complex post-traumatic stress disorder (PTSD): In addition to symptoms of PTSD, this disorder may include deficits in arousal or attention regulation, somatization, and disruptions of self-perception and interpersonal relations (Dorrepaal et al., 2014).

Eye movement desensitization and reprocessing (EMDR): A psychotherapeutic modality that uses guided eye movements to desensitize patients to anxiety, while also integrating traumatic memories into healthy schemas (Shapiro, 2014).

Post-traumatic stress disorder (PTSD): A psychological disorder that results from exposure to one or more traumatic events, and which is characterized by symptoms such as anxiety, depression, hypervigilance, insomnia, and avoidance of thoughts or activities that are associated with traumatic events (Chen et al., 2014).

Trauma-focused therapy: A therapeutic approach that supports patients through exposure to trauma-related thoughts and memories, with building adaptive coping skills, and with integration of traumatic memories into healthy emotional and cognitive schemas (Shapiro, 2014).

Assumptions

Because I used a phenomenological qualitative design, it was necessary to assume that participants would respond to interview questions with honesty and accuracy. It was assumed that therapists who participated in interviews had the reflective and analytical abilities to identify how EMDR affected the therapeutic progress of women who were survivors of child sexual abuse. I also assumed that their descriptions would accurately reflect these women's experiences. These assumptions were necessary because phenomenological researchers rely on the first-person perspectives of participants to relay experiences and the meanings of those experiences during data collection. In addition, in the interest of avoiding retraumatization of women who experienced child sexual abuse, the choice was made to interview therapists about EMDR regarding child sexual abuse treatment. In keeping with this choice, I assumed that therapists could reliably report on the treatment progress and outcomes of patients they treated.

Scope and Delimitations

This study included only therapists who have experience using EMDR as a treatment for adult women survivors of child sexual abuse. Focusing recruitment in such a way ensured that participants were sufficiently qualified and experienced to share perspectives on EMDR as a treatment modality for women who were sexually abused as children. Because the aim of this study was to explore EMDR among women survivors of child sexual abuse, participants were encouraged to focus on this population in their discussions of EMDR. Delimitations to the study were reflected in the exclusion of certain topics from interviews such as EMDR as treatment for children or men or EMDR as a general treatment for trauma.

Limitations

One potential limitation of this study stemmed from its small and homogenous sample of 10-12 therapists working in the Newark, NJ area. Although small samples are appropriate for qualitative research, these might also result in findings that are not transferable to other regions or environments. Therefore, findings from this study might accurately represent the experiences of therapists who treated women survivors of child sexual abuse in this locality, yet fail to represent fully the experiences of therapists working in other regions of the United States or globally. Similarly, the experiences of therapists who used EMDR with women might not be fully reflective of those who treated male survivors of child sexual abuse. Provision of thick description of the setting, participants, and data were used to address this potential limitation, as thick description

allows readers to evaluate the transferability of a study's findings for themselves (Petty, Thompson, & Stew, 2012).

Significance

The significance of the study was classified as relevant to three specific sectors: (a) academic researchers, (b) clinical psychologists and psychotherapists, and (c) abused women. First, the study is significant to the academic research field of childhood sexual abuse because the findings provided empirically-based information to address the gap in literature on the use of EMDR for treating cases of adult women with childhood history of chronic sexual abuse. The findings provide additional information regarding the therapists' perceptions of the implications of childhood sexual abuse to adult women victims and the EMDR concepts that are helpful to their healing. The study is significant to this field of clinical and research psychology, as it provides recommendations for future research about similar or related topics based on the findings and limitations of the study. Studies similar in scope and purpose were compared with the results of this study to ascertain consistency or contradiction in results, interpretations, and implications.

Second, the results of this study are significant to clinical psychologists and psychotherapists by providing information that could be used as basis for developing a broader range of proven strategies for clinical interventions for long-term symptoms related to chronic childhood sexual abuse. These psychologists and psychotherapists might become aware of the different long-term and short-term implications of childhood sexual abuse to a person, especially to a female victim. These clinical practitioners might then use the findings of this study as basis for developing or modifying existing treatment

procedures and concepts to improve the potential outcomes for patients with experiences of childhood sexual abuse.

Third, this study might lead to positive social change through its benefits to women who were repeatedly sexually abused as children. This study's findings might improve therapists' abilities to provide effective treatment to women survivors of child sexual abuse, resulting in reduction or elimination of psychiatric symptoms stemming from child sexual abuse. Positive social change might also result because women could use the findings from this study to implement new strategies for the self-healing process. In addition to expanding their current repertoire of coping skills, the study results could serve as a guide for women for handling and quickly recovering from current difficult interpersonal and social situations. Informing and educating the public about the long-term impact on women's health with histories of childhood sexual abuse could also help increase its reporting and decrease number of occurrences.

Summary

Child sexual abuse is prevalent globally and girls are more likely to be victimized by such abusers than boys (Murray et al., 2014; Pérez-Fuentes et al., 2013). Because the adverse psychological effects of child sexual abuse may extend into adulthood (Bak-Klimek et al., 2014; Fergusson et al., 2013), it is important to identify effective therapies for women with histories of child sexual abuse (Paylor & Royal, 2016). The aim of this study was to explore EMDR as a treatment for adult women survivors of child sexual abuse through semi-structured interviews with 10-12 therapists working in the Newark, NJ area. Through exploration of therapists' experiences and perspectives on the role and

effects of EMDR with this population, it was anticipated that this study would provide insights that inform future use of EMDR with women who experienced sexual abuse as children. Analysis of data obtained through interviews was performed using Moustakas' (1994) steps for analysis of phenomenology based on van Kaam's (1966) initial method for analysis.

Chapter 2: Literature Review

Introduction

EMDR is a trauma-focused therapeutic approach that has been demonstrated as effective in treating PTSD, depression, and anxiety, which are commonly experienced disorders among adult survivors of child sexual abuse (Fergusson, McLeod, & Horwood, 2013; Pérez-Fuentes et al., 2013). There is a lack of consensus, however, on whether treatments for adult onset trauma are suitable for adults who experience psychological difficulties resulting from childhood trauma (Ehring et al., 2014). Furthermore, although EMDR may be applicable in the treatment of psychological symptoms in survivors of child sexual abuse, uncertainty or lack of familiarity with EMDR may reduce therapists' use of the modality with victims of sexual abuse or assault (Edmond, Lawrence, & Schrag, 2016). In this study, I addressed a gap in the literature through exploring the perceptions of therapists about EMDR as a tool to assist adult women survivors of child sexual abuse in recovering.

This chapter will include a comprehensive review of the research literature that is relevant to this study's research questions, which were centered on therapists' perceptions and experiences related to EMDR as a therapy for women survivors of child sexual abuse. Following sections include the literature search strategy and results, along with the theoretical framework for the current study. The main body of this chapter will provide review and critical analysis of findings in the literature reviewed, which will be organized along the following themes: (a) child sexual abuse prevalence and predictors, (b)

psychological effects of child sexual abuse, (c) therapies for psychological effects of child sexual abuse, and (d) effectiveness of EMDR therapy.

Literature Search Strategy

A thorough search of several databases was completed to identify research that might provide applicable context for the present study. These databases included PsycINFO, MEDLINE, HealthSource: Nursing/Academic Edition, Psychology and Behavioral Sciences Collection, Academic Search Premier, and Google Scholar. Search terms included *eye movement desensitization and reprocessing, EMDR, psychosocial therapies, psychological treatments, psychotherapeutic treatments, trauma-focused therapies, child sexual abuse victims, child sexual abuse survivors, long-term effects of child sexual abuse, psychological effects of child sexual abuse*, and appropriate combinations of these terms. When selecting articles for this review, priority was given to articles published since 2013 in peer-reviewed sources. Of the 75 articles obtained, 64 (85%) were published from 2013 to 2016, and the remaining 11 (15%) were published prior to 2013. Maintaining a focus on recently published sources ensures that this chapter will reflect the most current knowledge related to EMDR and therapy for women survivors of child sexual abuse.

Theoretical Framework

The transactional theory of stress and coping, developed by Lazarus and Folkman (1987), provided the theoretical framework for the present study. The basis for this theory is that stress and coping occurs in a transactional fashion between a person and the environment (Lazarus & Folkman, 1987). Another core proposition of this theory is that

psychological stress has two phases that may occur consecutively or simultaneously: (a) primary appraisal or evaluation of the stressor, which involves determining the meaning of an event for a person; and (b) secondary appraisal, which is used to explore coping or individuals' perceptions of whether they have the tools to address the stressor (Lazarus, 1993). Coping methods depend on an individual's primary and secondary appraisals of stressors (Lazarus & Folkman, 1987). Emotion-focused coping involves an individual's aversive emotional reactions to the stressor, and problem-focused coping involves strategies to address the underlying causes of the stress (Lazarus, 1993). Lazarus and Folkman also proposed that patterns of more or less adaptive coping might be related to overall psychological functioning and well-being.

According to Lazarus (1993), psychological stress should be regarded as a relational process that is context-dependent and as a relationship between individuals and their environments. The transactional theory of stress and coping is relevant to examinations of psychotherapeutic approaches, which often address maladaptive patterns of stress appraisal and coping exhibited by individuals with psychological disorders (Resick, Suvak, & Wells, 2014). Therapeutic approaches such as CBT and EMDR include coaching on emotion regulation strategies such as acceptance or problem-solving (Chen et al., 2014; Shapiro, 2013), which are reflective of appraisal and coping concepts from the transactional theory (Aldao, Nolen-Hoeksema, & Schweizer, 2010). EMDR involves the use of guided eye movements to support desensitization to anxiety, which would be expected to reduce the patient's tendency to become overwhelmed in response to stressors and support adaptive appraisal and coping (Shapiro, 2013). Therapy for adult

survivors of child sexual abuse may also include concepts from the transactional theory of stress and coping by addressing underlying interactional patterns that stem from abusive conditions in patients' early lives (Calvert et al., 2015). Patterns of coping that were adaptive given a child victim's abusive environment may persist into adulthood, where they become maladaptive and disruptive of the adult survivor's relationships and mental health (Calvert et al., 2015).

In the context of this study, psychological stress was felt from (a) the interaction between the victim (woman) during childhood and the perpetrator of sexual abuse at that time, and (b) the interaction between the victim (woman) as an adult and the people who surround her. In relation to the theory of Lazarus (1993), the victim in this study would assess the act of sexual abuse as a child and as an adult through the two forms of appraisal. It was also the same environment that may help in coping with such stress (Lazarus, 1993). Therefore, if the proper treatment of coping mechanism was placed in the environment of the victim, then coping would be made easier. One way of improving the ability to cope through trauma is by undergoing therapy, which, for the case of this study was EMDR. Hence, the transactional theory of stress and coping provided a framework for exploring therapists' perspectives on EMDR as a treatment for women survivors of child sexual abuse.

Review of Relevant Literature

Research was discovered on the effects of EMDR with various groups of treatment-seeking individuals, although use of EMDR for women with sexual abuse histories has been scantly addressed. Before moving into a discussion of this literature,

this chapter will include a brief review of child sexual abuse prevalence and risk factors. Next, the many adverse immediate and long-term effects of child sexual abuse will be reviewed, including impact on cognitive function, short-term emotional effects, and long-term psychological, relationship, and sexual outcomes. To contextualize discussion of EMDR, this chapter will also provide a review of findings related to other forms of psychotherapeutic treatment for survivors of child sexual abuse.

Child Sexual Abuse Prevalence and Predictors

Child sexual abuse is prevalent on a worldwide basis, although there are barriers to establishing reliable prevalence estimates (Murray, Nguyen, & Cohen, 2014). Researchers have used varied definitions of child sexual abuse in their studies of prevalence, which may result in variation in estimates (Colangelo & Keefe-Cooperman, 2012; Murray et al., 2014). For example, some definitions of child sexual abuse have been confined to actions that involved physical contact of a sexual nature between a child and an adult, whereas other definitions have been expanded to include noncontact actions such as exhibitionism or harassment (Colangelo & Keefe-Cooperman, 2012). Different researchers have also used various upper limit ages for victims ranging from 12 to 17 (Murray et al., 2014). Additionally, feelings of shame and stigma may deter victims from disclosing abuse histories, further limiting the reliability of current prevalence estimates (McElvaney, 2015; Murray et al., 2014). Results of meta-analyses of sexual abuse prevalence studies indicated that about 12% of children experience sexual abuse globally, whereas the results of multiple surveys in the United States indicated that about 10% of children had experienced child sexual abuse (Murray et al., 2014; Pérez-Fuentes et al.,

2013). Possibly related to delayed disclosure, child sexual abuse prevalence rates tend to be higher when obtained retrospectively from adult samples; recent estimates indicate that approximately 25% of women in the United States experienced some form of sexual abuse in childhood or adolescence (Colangelo & Keefe-Cooperman, 2012).

A consistent finding of prevalence studies is that girls are more likely to experience child sexual abuse compared with boys; girls in the United States are about three times more likely to be sexually abused than boys (Murray et al., 2014; Pérez-Fuentes et al., 2013). Family conditions have been found to impact risk of child sexual abuse as well (Murray et al., 2014). Children who live with only one parent and who report other forms of neglect or maltreatment are more likely to experience sexual abuse (Laaksonen et al., 2011). Other factors that increase risk of sexual abuse for children are presence of a disability, drug and alcohol misuse by parents, high poverty, and low parental education (Murray et al., 2014).

Psychological Effects of Child Sexual Abuse

Experiencing child maltreatment, including sexual abuse, causes trauma to victims that may impact brain function and psychological health (Carrion, Wong, & Kletter, 2013; Norman et al., 2012). Interpersonal trauma in childhood has been associated with deficits in volume and functioning of areas of the brain such as the cerebellum, hippocampus, and prefrontal cortex (Carrion et al., 2013). Such brain differences have been observed in children with PTSD resulting from maltreatment and correspond with deficits in associated neuropsychological function in areas such as attention regulation, problem-solving, planning, and impulse control (Carrion et al.,

2013). These findings were supported by a systematic review of 17 studies of cognitive functioning in relation to child maltreatment, which included sexual abuse, physical abuse, emotional abuse, and neglect (Irigaray et al., 2013). In both short- and long-term studies, child maltreatment predicted deficits in working memory, verbal memory, attention regulation, and executive function (Irigaray et al., 2013). Accordingly, Corrigan and Hull (2015) reported that the infliction of extreme stress on a child can disrupt normal development, leading to problems with arousal regulation, attention, and consciousness that can later present as complex or multifaceted forms of PTSD.

Trauma may result from exposure to terrifying events such as being in auto accidents, living through natural disasters, and witnessing assaults on other people (Cleary & Hungerford, 2015). Interpersonally inflicted trauma, however, involves a different element of terror for the victim because of the experience of being deliberately targeted by another person (Cleary & Hungerford, 2015). Child sexual abuse is often committed by a person who is known to the child, and the abuser may occupy a position of responsibility and trust in the victim's life (Gómez, Kaehler, & Freyd, 2014). Being violated and dominated by a person with a duty of care in the child's life can result in both terror and feelings of betrayal, compounding the experience of trauma (Gómez et al., 2014). Betrayal is a significant aspect of sexual abuse of children, as it represents a failure of the family system to uphold its expected duties to protect and nurture the child (Sinanan, 2015). Even when the perpetrator is a nonfamily member, the child may experience a sense of being inadequately protected from harm by the adults who hold this responsibility (Sinanan, 2015).

The experience of sexual abuse can be confusing for children (Cleary & Hungerford, 2015; Foster & Hagedorn, 2014). In trauma narratives written by sexually abused children and adolescents as part of a therapy program, some victims expressed feeling conflicted over the issue of disclosure because they were concerned about the consequences the abuser might receive (Foster & Hagedorn, 2014). Some children also feared that they would be viewed as responsible for the abuse and would be punished if they disclosed (Foster & Hagedorn, 2014). These conflicting feelings reflect the emotional turmoil experienced by children who are abused by adults they know and trust (Cleary & Hungerford, 2015; Foster & Hagedorn, 2014). Conflicting thoughts and emotions over the abuse may persist into adulthood, as women who experienced child sexual abuse reported feeling continuing guilt and self-blame over their abuse (Sigurdardottir & Halldorsdottir, 2013).

Another effect of single-occurrence or ongoing sexual victimization of children is the experience of continuing fear (Cleary & Hungerford, 2015). In trauma narratives, sexually abused children commonly wrote about feeling afraid of seeing the abuser again, as they feared it might lead to retaliation or additional events of abuse (Foster & Hagedorn, 2014). Furthermore, sexual abuse may be accompanied by threats to the child and others who may learn of the abuse, creating a condition of continuing fear for the victim (Cleary & Hungerford, 2015). Victims reported feeling overwhelming fear in response to their powerlessness against the abuser, particularly at being overpowered when trying to stop the abuse (Foster & Hagedorn, 2014; Sigurdardottir & Halldorsdottir, 2013). The neurobiological effects of living in an ongoing state of fear or hyperarousal

may deter a child's development and create a vulnerability to subsequent development of psychological dysfunction (Carrion et al., 2013; Maniglio, 2013).

Child sexual abuse and psychological dysfunction. The experience of child sexual abuse has been associated with adverse psychological symptoms and disorders that can persist into adulthood (Fergusson et al., 2013; Pérez-Fuentes et al., 2013). Histories of child sexual abuse were associated with dysfunctional behavior in adolescence and adulthood (Pérez-Fuentes et al., 2013; Morais, Alexander, Fix, & Burkhart, 2016) Compared with individuals who experienced child abuse without a sexual component, adult survivors of child sexual abuse were more likely to engage in acts of self-injurious behavior (i.e., cutting) and were more likely to make suicide attempts (Pérez-Fuentes et al., 2013). Child sexual abuse has implications for antisocial behavior as well, as adolescent males who have been sexually abused were found to be more likely to perpetrate sexual offending behaviors themselves (Morais et al., 2016).

Adverse emotional effects of child sexual abuse were frequently noted by researchers. For example, in a prospective study of 987 individuals in New Zealand, Fergusson et al. (2013) found that the experience of child sexual abuse was associated with lower self-esteem and life satisfaction at age 30. Furthermore, in a sample of 109 adult survivors of child sexual abuse, participants overall reported high levels of negative emotions such as sadness, fear, and anger (Coyle, Karatzias, Summers, & Power, 2014). Notably, Coyle et al. (2014) found the strongest relationship between ongoing experiences of disgust and diagnosis of PTSD among child sexual abuse survivors, suggesting that the emotion of disgust plays a prominent role in the development and/or

continuation of this disorder. Other adverse emotions that were associated with child sexual abuse histories among adult survivors were guilt, shame, and self-blame (Rahm, Renck, & Ringsberg, 2013; Sigurdardottir & Halldorsdottir, 2013). Importantly, Rahm et al. (2013) found that women survivors who reported higher levels of shame were more likely to experience symptoms of PTSD and other psychological disorders, suggesting the destructive nature of this emotion.

In addition to adverse psychological states and symptoms, a history of child sexual abuse has been associated with increased risk for diagnosable psychological disorders in adulthood, particularly anxiety disorders (Fergusson et al., 2013; Maniglio, 2013). A meta-analysis by Mauritz, Goossens, Draijer, and van Achterberg (2013) revealed that women with serious mental illnesses such as schizophrenia and bipolar disorder were significantly more likely to report histories of child sexual abuse than women in the general population. In a U.S. national sample of over 34,000 18-year-old individuals, however, the most frequently reported psychological disorders associated with previous sexual abuse were depression and PTSD (Pérez-Fuentes et al., 2013). Accordingly, in a systematic review of four meta-analysis studies, Maniglio (2013) found that of all anxiety disorders, PTSD was the most strongly associated with histories of child sexual abuse for both male and female victims.

PTSD is a psychological disorder that results from exposure to one or more traumatic events, and which is characterized by symptoms such as anxiety, depression, hypervigilance, insomnia, and avoidance of thoughts or activities that are associated with traumatic events (Chen et al., 2014). Psychosis or psychosis-like experiences may also be

experienced in the context of PTSD for survivors of child sexual abuse, particularly those who are socially isolated and experience comorbid neurotic disorders (Murphy, Shevlin, Houston, & Adamson, 2014). A more severe form of PTSD, referred to as complex PTSD or PTSD with associated features, has also been associated with histories of child maltreatment including sexual abuse (Dorrepaal et al., 2014). In addition to the previously described symptoms, complex PTSD may include deficits in arousal or attention regulation, somatization, and disruptions of self-perception and interpersonal relations (Dorrepaal et al., 2014).

Although depressive symptoms may be features of PTSD, they may also represent a separate psychological disorder that occurs with or without PTSD (Chen et al., 2014). Major depression is a mood disorder that is characterized by symptoms such as feelings of hopelessness, fatigue, loss of interest in formerly enjoyable activities, difficulty concentrating, sleep difficulties, and withdrawal or isolation (Comijs et al., 2013). Multiple researchers have found that major depression in adulthood was associated with histories of child sexual abuse (Fergusson et al., 2013; Pérez-Fuentes et al., 2013). Men survivors of child sexual abuse who participated in interviews reported recurrent depression with tendencies toward extreme anger, rage, and even physical aggression toward others (Sigurdardottir, Halldorsdottir, & Bender, 2012). Depression at any time in adulthood may be associated with history of childhood maltreatment including sexual abuse; in some cases, onset of depression may be delayed until mid- or late-life years (Comijs et al., 2013).

Child sexual abuse and maladaptive coping strategies. Contributing to the risk of psychological dysfunction, adult survivors of child sexual abuse may be more inclined to employ maladaptive coping strategies compared with non-abused individuals (Cleary & Hungerford, 2015; Coyle et al., 2014). For example, in a sample of 109 adults who had been sexually abused as children, Coyle et al. (2014) found that participants with PTSD were significantly more likely to report use of dysfunctional coping strategies (i.e., self-harm, aggression toward others) compared with survivors without this diagnosis. Notably, Johnson and Lynch (2013) found that incarcerated women survivors of child sexual abuse were more likely to use maladaptive coping strategies (i.e., avoidance) if they harbored feelings of self-blame over their abuse.

Substance misuse was another common form of maladaptive coping among child sexual abuse survivors (Cleary & Hungerford, 2015; Fergusson et al., 2013). Women who were sexually abused as children have demonstrated an increased likelihood of misusing drugs and alcohol to cope with anxiety and other distressing psychological symptoms (Cleary & Hungerford, 2015). Men survivors of child sexual abuse who participated in interviews expressed that they used drugs or alcohol to achieve emotional numbness, in an attempt to cope with angry and self-destructive feelings (Sigurdardottir et al., 2012). Fergusson et al. (2013) similarly found that a history of child sexual abuse was associated with higher risk for alcohol dependence and illicit substance dependence in adult survivors. In a related finding, Delker and Freyd (2014) found that young adults who had experienced betrayal trauma (i.e., being sexually abused by a parent) in childhood or adolescence were more likely to misuse alcohol. This finding underscored

the harmful nature of betrayal as an aspect of child sexual abuse, and its long-term effects on victims' capacities to cope effectively (Delker & Freyd, 2014; Sinanan, 2015).

Child sexual abuse effects on relationships and sexuality. The experience of being sexually abused as a child may have pervasive effects on an individual's abilities to trust others, which may adversely affect the quality of intimate and social relationships into adulthood (Colangelo & Keefe-Cooperman, 2012; Sigurdardottir & Halldorsdottir, 2013). Women survivors of child sexual abuse who participated in interviews expressed feeling both a lack of trust and chronic fears of rejection in relationships (Sigurdardottir & Halldorsdottir, 2013). Even in the context of healthy and stable relationships, women who had been sexually abused as children reported feeling a sense of separation or isolation (Sigurdardottir & Halldorsdottir, 2013). Similarly, men survivors of child sexual abuse expressed chronic feelings of self-rejection and fears that others would reject them; these persistent fears resulted in the men isolating themselves from others and avoiding relationships (Sigurdardottir et al., 2012). Relationship difficulties associated with child sexual abuse may exist not just in intimate partner relationships, but in whole family relationship functioning (King, Wardecker, & Edelstein, 2015). Women with child sexual abuse histories reported significantly poorer family functioning than women without abuse histories (King et al., 2015).

Multiple researchers have found that adult survivors of child sexual abuse were more likely to experience difficulties in the areas of intimate partner relationships and sexuality compared with adults without such abuse histories (Cleary & Hungerford, 2015; Colangelo & Keefe-Cooperman, 2012; Sigurdardottir & Halldorsdottir, 2013).

Supportive parental involvement following disclosure of the abuse, however, may ameliorate the effects of child sexual abuse on relationship functioning later in life (Godbout, Briere, Sabourin, & Lussier, 2014). In a sample of 348 adults who were engaged in long-term relationships, participants with child sexual abuse histories and supportive parents reported relationship quality that was similar to participants who had not been abused (Godbout et al., 2014). In contrast, participants who had child sexual abuse histories and nonsupportive or unaware parents reported higher levels of anxious attachment and poorer relationship quality (Godbout et al., 2014). It is notable, however, that only 14% of abuse survivors reported supportive parenting following disclosure (Godbout et al., 2014); the majority reported that their parents were unaware, possibly reflecting the delays in disclosure observed by other researchers (e.g., McElvaney, 2015). Colangelo and Keefe-Cooperman (2012) suggested that supportive parents might help the victimized child to develop a positive sense of self and adaptive coping skills, increasing the likelihood of positive psychological adjustment following the abuse. In a finding that was harmonious with this suggestion, King et al. (2015) found that feelings of personal mastery or control were predictive of better family relationship outcomes for women survivors of child sexual abuse.

Women with histories of child sexual abuse may develop negative self-schemas that include their beliefs related to sexuality; these negative self-schemas may be associated with aversions to sex and lower sexual responsiveness (Colangelo & Keefe-Cooperman, 2012). Women survivors of child sexual abuse who participated in interviews also explained that sexual encounters could trigger memories of abuse events,

causing them withdraw sexually from their intimate partners (Sigurdardottir & Halldorsdottir, 2013). The triggering of traumatic memories may also be associated with women survivors' higher likelihood of experiencing negative affect in response to sexual encounters (Stephenson, Pulverman, & Meston, 2014). Such emotional and cognitive difficulties with sexuality were likely reflected in the finding that both men and women with child sexual abuse histories reported a higher likelihood of sexual avoidance behaviors (Vaillancourt-Morel et al., 2015). This tendency toward sexual avoidance was further linked to poorer couples relationship adjustment in survivors (Vaillancourt-Morel et al., 2015), affirming previously discussed findings of adverse relationship outcomes for survivors of child sexual abuse (e.g., Colangelo & Keefe-Cooperman, 2012; Sigurdardottir & Halldorsdottir, 2013).

Although child sexual abuse has been associated with avoidant or aversive responses to sexual encounters, female survivors of child sexual abuse may also demonstrate lower inhibitions related to sex (Colangelo & Keefe-Cooperman, 2012; Fergusson et al., 2013). In both male and female child sexual abuse survivors who were unmarried, a tendency toward sexual compulsivity was also found (Vaillancourt-Morel et al., 2016). Sexual compulsivity refers to a heightened focus on sex and sexuality, which may involve intrusive thoughts about sex and impulsive sexual behavior (Vaillancourt-Morel et al., 2016). These factors may lead to risk-taking sexual behaviors including higher numbers of sexual partners and lower use of safe sex practices for both men and women, and higher frequencies of unplanned pregnancies for women (Colangelo & Keefe-Cooperman, 2012; Fergusson et al., 2013; Sigurdardottir et al., 2012).

Compounding these difficulties, women who were sexually abused as children are more likely to be sexually assaulted in adulthood compared with women without histories of child sexual abuse (Cleary & Hungerford, 2015). The repeated experience of sexual assault in adulthood may exacerbate psychological and sexual difficulties already experienced by survivors (Cleary & Hungerford, 2015).

Abuse characteristics and psychological effects. The relationship between the severity of child sexual abuse and adult psychological outcomes has been debated in the research literature, as researchers have found varied relationships between abuse characteristics and psychological outcomes in victims (Amado, Arce, & Herraiz, 2015; Gómez et al., 2014). For example, Bak-Klimek et al. (2014) conducted a study involving 149 Scottish participants between the ages of 16 and 55 years who were seeking mental health services to treat psychological symptoms resulting from sexual abuse experienced before the age of 16. Participants completed measures to evaluate a wide range of psychological symptoms, including obsessive-compulsive, anxiety, depression, somatization, and interpersonal difficulties (Bak-Klimek et al., 2014). Participants also completed measures to report characteristics of their abuse experiences, including age of abuse onset, frequency of abuse, number of perpetrators, and victim-perpetrator relationship (Bak-Klimek et al., 2014). No correlation was discovered between severity of psychological symptoms in participants and characteristics of abuse, but the researchers did note that they did not use a measure of PTSD, which is a common outcome of child sexual abuse (Bak-Klimek et al., 2014). The researchers also noted that their sample was comprised entirely of child sexual abuse survivors who were voluntarily

seeking treatment; it is possible, therefore, that these findings do not generalize to all child sexual abuse survivors (Bak-Klimek et al., 2014).

Other researchers obtained results that did indicate that abuse characteristics impacted risk or severity of subsequent dysfunction (Aaron, 2012; Amado et al., 2015). Gómez et al. (2014) investigated the role of betrayal levels in events of abuse, which referred to the level of closeness or trust the victim had for the perpetrator. They found that participants who experienced sexual abuse with higher degrees of betrayal were more likely to later experience dissociation compared with participants who experienced lower betrayal abuse (Gómez et al., 2014). Additionally, participants who reported sexual abuse during adolescence showed less vulnerability to developing hallucinations compared with participants who were abused as children, indicating that children under the age of 13 might be more severely affected by sexual abuse (Gómez et al., 2014). The combination of sexual abuse with other childhood adversities was also found to increase adult survivors' risk of developing two or more comorbid psychological disorders (Putnam, Harris, & Putnam, 2013). For example, children who experienced sexual abuse in combination with conditions such as exposure to domestic violence, parental drug or alcohol abuse, and economic hardship were more likely to develop complex psychopathology as adults (Putnam et al., 2013).

An association between abuse characteristics and severity of dysfunction in adult survivors was also indicated by Aaron's (2012) literature review. Both men and women survivors of child sexual abuse were at increased risk of sexual dysfunction as adults, and symptoms of dysfunction were more severe if the abuse involved physical force, was

chronic in course, involved penetration, or was perpetuated by a person whom the child trusted (Aaron, 2012). Penetration as a characteristic of child sexual abuse was also a predictive factor of psychological difficulties in Amado et al.'s (2015) meta-analysis of 78 studies in which researchers examined anxiety and depression in relation to child sexual abuse. Both male and female survivors of child sexual abuse were more likely to develop depression or an anxiety disorder if the abuse had involved penetration (Amado et al., 2015). Similarly, using an abuse severity scale that ranged from non-contact events to contact with penetration, Fergusson et al. (2013) found that the severity of child sexual abuse was associated with higher risk of psychological disorder in adulthood.

The research reviewed in this section illustrated a robust relationship between child sexual abuse and subsequent psychopathology such as PTSD and depression, with most of the studies reviewed indicating an association between severity of abuse and psychological outcomes in adulthood (Aaron, 2012; Amado et al., 2015; Maniglio, 2013; Pérez-Fuentes et al., 2013). Intense feelings of betrayal, fear, shame, and disgust have been reported by male and female victims of child sexual abuse (Foster & Hagedorn, 2014; Gómez et al., 2014; Sigurdardottir & Halldorsdottir, 2013), which may induce neurobiological changes that increase victims' risk of developing diagnosable psychological disorders in adulthood (Carrion et al., 2013; Maniglio, 2013). The effects of child sexual abuse on psychological functioning have been found to be pervasive, affecting adult survivors' self-esteem, life satisfaction, sexual functioning, and relationship quality (Cleary & Hungerford, 2015; Fergusson et al., 2013). Although parental support and personal resilience may bolster survivors against the adverse

psychological effects of child sexual abuse, many adult survivors require the support of therapeutic professionals to recover from the devastating effects of this trauma (Godbout et al., 2014; King et al., 2015).

Therapies for Psychological Effects of Child Sexual Abuse

Regardless of the specific characteristics of child sexual abuse, researchers have established that the experience of this trauma creates an increased risk of psychological disorder for victims into adulthood (Maniglio, 2013; Pérez-Fuentes et al., 2013). Identifying effective treatment for long-term psychological effects of child sexual abuse is therefore an important aim of research (Calvert et al., 2015; Cleary & Hungerford, 2015). Adult survivors of child sexual abuse who described their recovery experiences expressed that attaining psychological health had been possible, but that it required substantial effort and support from both professional and personal sources (Chouliara, Karatzias, & Gullone, 2014). Essential to recovery for these survivors was support to overcome continuing feelings of stigma, shame, and self-blame associated with being sexually abused (Chouliara et al., 2014). Recovery also required learning new ways of thinking and coping, such as managing resistance in their families to their disclosures of abuse, shifting blame for the abuse to the perpetrator, and overcoming tendencies toward avoidance-based coping and substance misuse (Chouliara et al., 2014).

Professional support to achieve recovery through therapy may greatly enhance child sexual abuse survivors' attainment of psychological health (Chouliara et al., 2014). Regardless of specific therapies chosen, however, Cleary and Hungerford (2015) emphasized that all care for women who are survivors of child sexual abuse should be

trauma-informed. Trauma-informed care is a paradigm of care that supports survivors by providing a safe treatment environment, by promoting recognition and understanding of the long-term effects of child sexual abuse, by support patient control and autonomy, and by supporting hope and recovery in patients (Cleary & Hungerford, 2015). However, trauma-informed care should not be confused with trauma-focused therapy, which refers to psychotherapeutic approaches that are primarily designed to assist the patient with processing the meanings of traumatic memories and related psychological functioning (Ehring et al., 2014). In conjunction with trauma-focused therapy, Orbke and Smith (2013) stressed the importance of using strengths-based approaches to support development of resilience in adult survivors of child sexual abuse. Building upon the patient's current strengths and capacities can support self-efficacy and development of positive self-concepts, which can be instrumental in enhancing post-traumatic growth in adult survivors (Orbke & Smith, 2013).

A concern with use of trauma-focused therapies with survivors of child sexual abuse has been that the exposure phase of therapy might be excessively difficult for participants, creating the risk of re-traumatization (Jongh et al., 2016). However, Jongh et al.'s (2016) review of research indicated little to no support for such concerns. Particularly, researchers have suggested that adults who experience complex PTSD may be too vulnerable to engage in trauma-focused therapy without a prior phase of treatment to support emotional stabilization (Jongh et al., 2016). In their review, however, Jongh et al. (2016) found that particularly vulnerable patients, such as survivors of child sexual

abuse or individuals with complex PTSD, seemed to tolerate and benefit from trauma-focused therapies.

Trauma-focused cognitive behavior therapy. Both trauma-focused cognitive behavior therapy and EMDR represent trauma-focused forms of therapy, which means that they are specifically targeted at assisting patients to manage the psychological effects of trauma exposure (Ehring et al., 2014). Trauma-focused therapies support patients through exposure to trauma-related thoughts and memories, with building adaptive coping skills, and with integration of traumatic memories into healthy emotional and cognitive schemas (Shapiro, 2014). Ehring et al. (2014) conducted a meta-analysis of 16 randomized control trials of treatments for adult survivors of child sexual and/or physical abuse, examining the effects of trauma-focused CBT, CBT without a trauma focus, EMDR, and other forms of psychotherapy. Although they did not specify results with regard to adult survivors of child sexual abuse specifically, they did report that all forms of treatment resulted in significant improvements in PTSD symptoms (Ehring et al., 2014). In particular, the treatments (including EMDR) that were designed with a trauma focus had superior effectiveness in reducing PTSD symptoms (Ehring et al., 2014). Another finding was that individual treatments were more effective than group-based treatment modalities (Ehring et al., 2014).

In keeping with Ehring et al. (2014), Resick et al. (2014) also found that trauma-focused CBT was the most effective treatment for women survivors of sexual assault in childhood or adulthood. To test the effects of different forms of therapy, Resick et al. (2014) randomly assigned 168 women with PTSD and histories of sexual assault to six-

week treatments using prolonged exposure therapy (PE), CBT, or a minimal attention condition. The PE treatment involved extended discussion and exposure to the details of survivors' assault or abuse experiences, which was aimed at extinguishing associated fear and anxiety (Resick et al., 2014). Although CBT was associated with greater reduction in PTSD symptoms overall, the researchers noted that women were more likely to drop out of treatment if they had experienced more frequent sexual abuse in childhood (Resick et al., 2014). They suggested that some survivors were not able to manage the emotional difficulties of confronting their abuse experiences in therapy, thus resulting in higher dropout rates when abuse had been more frequent or severe (Resick et al., 2014).

Other individual therapies. Individual therapies for survivors of child sexual abuse were also examined in the literature, including expressive writing therapy and treatment for feeling of contamination (Jung & Steil, 2013; Meston, Lorenz, & Stephenson, 2013). Expressive writing is a therapeutic approach that helps patients to self-reflect on their traumatic experiences and consider how these experiences may have affected their social, psychological, or sexual functioning (Meston et al., 2013). Meston et al. (2013) found that women survivors of child sexual abuse benefited from five sessions of expressive writing, which was followed by discussion of their written experiences with a therapist. Whether women wrote about their traumatic experiences in general or focused on how these experiences affected their sexual self-schemas, improvements were observed in both PTSD and depression symptoms (Meston et al., 2013).

Women who wrote about their sexual self-schemas, however, demonstrated greater improvements in sexual functioning following the treatment (Meston et al., 2013). Lorenz, Pulverman, and Meston (2013) also found additional benefits of writing specifically about sexual self-schemas in relation to child sexual abuse for women survivors. They found that, compared with participants who wrote about trauma in general, participants who wrote about sexual issues were more likely to experience sudden gains between treatment sessions (Lorenz et al., 2013). Sudden gains refer to rapid decreases in symptoms, and in this study were reflected by substantial reductions in depression symptoms in women who wrote about the effects of child sexual abuse on their current sexual functioning (Lorenz et al., 2013).

In addition to long-term effects on a survivor's sexual schema, another long-term effect of child sexual abuse for many survivors who experience PTSD is the feeling of contamination (Jung & Steil, 2013). Feelings of being contaminated may include survivors believing that they smell badly, feeling that they are dirty, or suspecting that the perpetrator's body fluids are still present; in response, they may shower repeatedly each day, use strong cleaners or disinfectants, and take measures to avoid contaminating other people (Jung & Steil, 2013). Jung and Steil (2013) suggested that this symptom is commonly overlooked, and conducted a study to evaluate a therapeutic approach that they developed specifically to address feelings of contamination. Their therapeutic method, Cognitive Restructuring and Imagery Modification (CRIM), uses two sessions to help survivors to build a new catalog of facts related to body processes (i.e., cellular life cycles and regrowth), and to create new mental images of these processes specifically in

relation to their abuse experiences and subsequent perceptions of contamination (Jung & Steil, 2013). In a randomized control trial that compared CRIM against a wait list condition for 34 women, the CRIM treatment yielded superior reductions in feelings of contamination (Jung & Steil, 2013).

Group therapies. Several forms of group therapy were examined as treatments for adult survivors of child sexual abuse. Although Ehring et al. (2014) found through a meta-analysis that individual therapies had higher effectiveness compared with group approaches, treatment gains were generally obtained through group therapies. Group cognitive analytic therapy is a commonly used form of treatment for adult survivors of child sexual abuse (Calvert et al., 2015; Elkjaer, Kristensen, Mortensen, Poulsen, & Lau, 2014). A variety of therapeutic approaches may be combined with a group therapy approach in the treatment of survivors of child sexual abuse, including trauma-focused and strengths-based approaches (Walker-Williams & Fouché, 2015). Cognitive analytic therapy for survivors of child sexual abuse is designed to help participants identify maladaptive social roles and self-concepts they adopted as a means of coping with early abusive situations (Elkjaer et al., 2014). Participants are also guided to recognize that these coping strategies (i.e., suppressing anger, adopting a servant role) are maladaptive in the long-term, and are then coached on developing new self-concepts and social roles that are more adaptive (Calvert et al., 2015). Calvert et al. (2015) found that this therapeutic approach, grounded in a group therapy environment, had positive effects on women survivors' anxiety, interpersonal functioning, and psychological wellbeing. These positive effects of therapy were significantly better than wait time changes, which

reflected changes in participants' psychological functioning while waiting to receive therapy (Calvert et al., 2015). A limitation of this study, however, was the lack of true comparison or control group (Calvert et al., 2015).

In contrast to Calvert et al. (2015), Elkjaer et al. (2014) evaluated the effects of cognitive analytic therapy using a comparison group that received systemic therapy, using a sample of 106 women survivors of child sexual abuse. Unlike cognitive analytic therapy, which is centered around participants' cognitions and social roles, systemic therapy centered on the women's specific life goals. Aims of systemic therapy are to help participants to revise their self-concepts more positively and to develop more optimistic senses of their possible future lives (Elkjaer et al., 2014). Following treatment, women who received systemic therapy showed greater improvement in psychosocial functioning and quality of life compared with women in the analytic group (Elkjaer et al., 2014). At a one-year follow-up assessment, however, symptoms and functioning had declined in the systemic group, such that no significant differences existed between treatment groups (Elkjaer et al., 2014). In spite of these gains, the researchers noted that approximately one-half of the women in both groups still displayed psychological symptoms that required further treatment (Elkjaer et al., 2014).

Illustrating the plethora of therapeutic approaches applied to group therapy for survivors of child sexual abuse, Sayın, Candansayar, and Welkin (2013) described the outcomes of an eclectic group psychotherapy trial conducted with 47 women who were sexually abused in childhood. Their approach included several methods (i.e., cognitive-behavior therapy) that are viewed as effective and appropriate for trauma-focused

therapeutic processes (Sayın et al., 2013). At six weeks, the researchers found significant decreases in participants' depression, anxiety, and PTSD symptoms; however, re-experiencing the trauma showed delayed improvement, possibly because of the effects of retelling of abuse events in group (Sayın et al., 2013). Women participants in a strengths-based group therapy program that was designed to promote post-traumatic growth similarly described the emotional difficulty of discussing their sexual abuse histories (Walker-Williams & Fouché, 2015). Although they felt that confronting their painful memories was ultimately instrumental to their growth and adjustment, women expressed that this part of the therapeutic process induced an intense level of emotional pain (Walker-Williams & Fouché, 2015).

Another form of group therapy that demonstrated positive effects with adult survivors of child sexual abuse was mindfulness-based stress reduction (MBSR; Earley et al., 2014). The MBSR format typically entails eight weekly group sessions in which participants receive education related to physiological and psychological functioning, and instruction and modeling on methods to increase mindfulness, which is a state of nonjudgmental awareness of oneself (Earley et al., 2014). Mindfulness activities often include stretching, body scanning, yoga, and meditation (Earley et al., 2014). Different MBSR therapeutic programs are often tailored to the needs of specific populations, as was the Mindfulness Intervention for Child Abuse Survivors project (Earley et al., 2014). The group of 19 adult survivors of child sexual abuse who participated in this program reported significant improvements across PTSD, anxiety, and depressive domains that were maintained through a 2.5-year follow-up assessment (Earley et al., 2014).

Researchers supporting the group therapy approach to treatment of child sexual abuse survivors suggested that this modality is helpful in addressing not just trauma, but also negative self-concept issues that often develop as the result of this form of abuse (Sayın et al., 2013; Walker-Williams & Fouché, 2015). Specifically, they suggested that having the opportunity to hear others' similar stories and to tell their own stories without fear of judgment is helpful in addressing feelings of stigma, a sense of being different, and feelings of isolation (Sayın et al., 2013). Women who participated in strengths-based group therapy reported similar transformations in their self-concepts, describing their progress from feeling like victims, to survivors, and finally to thrivers (Walker-Williams & Fouché, 2015). Feelings of shared experience and unconditional acceptance within their groups were described as highly important and therapeutic aspects of their treatment (Walker-Williams & Fouché, 2015). Some women even expressed that they had begun to perceive their sense of being "different" in a positive way, and as a reflection of their strength and determination to thrive in spite of their traumatic experiences (Walker-Williams & Fouché, 2015).

The research reviewed in this section reported generally positive outcomes for both individual and group forms of therapy, although differences between treatments in single studies were often not observed and many studies used no comparison or control groups (e.g., Calvert et al., 2015; Earley et al., 2014). However, trauma-focused CBT did show better results when tested against other therapeutic approaches (Ehring et al., 2014; Resick et al., 2014). Most of the therapeutic methods examined were trauma-focused, in that a primary focus of the therapy was confronting traumatic memories and processing

them in ways that would promote positive self-schemas, adaptive coping, and less emotional reactivity to their memories (Ehring et al., 2014). Concern over the vulnerability of survivors of child sexual abuse, particularly those with complex PTSD, has been debated in the literature (Jongh et al., 2016). Indeed, survivors themselves noted the painful experience of reliving traumatic memories through exposure segments of therapy (Sayın et al., 2013; Walker-Williams & Fouché, 2015). Although enduring such pain was ultimately considered worthwhile to achieve treatment gains, the comparatively shorter and less detailed exposure elements of EMDR might be an advantageous aspect of this form of therapy for severely traumatized persons (Shapiro, 2014). This will be the subject of the next and final section of this chapter.

In closing, an important potential limitation to child sexual abuse treatment studies should be acknowledged. Two groups of researchers noted that research regarding effective treatments for survivors of child sexual abuse may be limited by the routine exclusion of participants with complex PTSD (Corrigan & Hull, 2015; Dorrepaal et al., 2014). Complex PTSD is a multifaceted expression of this disorder that arises from repeated exposures to traumatic or highly stressful events, and often represents a more severe form of the disorder (Dorrepaal et al., 2014). Corrigan and Hull (2015) argued that findings from many treatment studies involving participants with PTSD and histories of child sexual abuse may not generalize to the most severely traumatized survivors. Dorrepaal et al. (2014) expressed the same caution about interpreting the findings of PTSD treatment studies, as those studies with the most exclusion criteria tended to obtain the greatest effect sizes when assessing treatment effectiveness. In their meta-analysis of

child abuse related PTSD, Dorrepaal et al. (2014) discovered only four studies that addressed complex PTSD, and none of these focused specifically on sexual abuse as the childhood trauma.

Effectiveness of Eye Movement Desensitization and Reprocessing Therapy

The EMDR approach was developed by Francine Shapiro in 1989, and utilizes eye movements that are guided by the therapist during therapy sessions (Shapiro, 2013). The EMDR International Association (EMDRIA) provides certification to practice this therapeutic approach to individuals who complete an accredited training program (EMDRIA, 2017). Basic training in EMDR is typically conducted over two, 2.5-day sessions that address core concepts and procedures of the treatment approach. In addition to completing this training, therapists must have been licensed in their current specialties for a minimum of two years and have received at least 20 hours of EMDR consultation with an approved consultant. Finally, therapists must complete a minimum of 50 EMDR sessions with at least 25 therapy clients to qualify as a certified provider of EMDR (EMDRIA, 2017).

The EMDR treatment is organized according to multiple stages that progress from history taking through memory integration and debriefing (Logie, 2014). Before beginning the desensitization and reprocessing phases of the therapy, it is necessary for the therapist to learn of the patient's history and current presentation, including traumatic past events and current maladaptive cognitions related to the trauma (Logie, 2014). Eye movements are induced in connection with exposure to the patient's traumatic memories,

which facilitates access to stored memories and desensitization to related anxiety (Chen et al., 2014; Shapiro, 2013).

Therapists using EMDR guide patients to retrieve their traumatic memories, and while patients are describing their traumatic or painful memories, the therapist cues them to engage in specific eye movements (Shapiro, 2013). Unlike CBT, patients need not recount their traumatic experiences in great detail, but instead may describe them only generally or simply imagine the events (Shapiro, 2014). Through this process, the therapist guides the patient to gradually integrate their traumatic memories into healthy cognitive and emotional schemas (Chen et al., 2014). Unprocessed traumatic memories may act as foundations to self-destructive cognitive or emotional patterns (i.e., believing "I am powerless" or "no one loves me"), and processing these associations allows for the development of healthier psychological functioning (Shapiro, 2013). Although both EMDR and trauma-focused CBT have been found effective in treating PTSD and related symptoms, EMDR often achieves positive results in shorter time periods and through use of less complex therapeutic procedures (Shapiro, 2014).

Patients who have undergone eye movement exercises reported that the vividness of memories evoked during eye movement was diminished in future recalls, which was affirmed through an experimental test of memory vividness (van den Hout, Bartelski, & Engelhard, 2013). Participants who engaged in eye movement while viewing an image later recalled the image significantly less vividly compared with participants who did not engage in eye movements (van den Hout et al., 2013). In a subsequent experiment, van den Hout, Eidhof, Verboom, Littel, and Engelhard (2014) found that the decrease in

memory vividness induced by lateral eye movements was more pronounced for negative memories. They posited that these results occurred because of the combined effects of taxing working memory during the recall of emotional memories, which are also taxing (van den Hout et al., 2014). The combination of taxing working memory while recalling emotionally demanding memories appeared to decrease their clarity when recalled in the future (van den Hout et al., 2014). These findings pointed to an unpinning mechanism of EMDR, as this decrease in negative memory vividness may support desensitization to aversive memories for patients with PTSD (van den Hout et al., 2013; van den Hout et al., 2014).

The effects of EMDR have been examined not just in terms of clinical outcomes, but also in relation to their neurophysiological effects. Use of fMRI scans with 22 participants revealed that exposure to emotionally disturbing images in combination with bilateral eye movements induced specific changes to functioning in the amygdala and prefrontal cortex (Herkt et al., 2014). These changes were consistent with researchers' expectations of brain activity that would facilitate retrieval and integration of emotionally disturbing memories (Herkt et al., 2014). Examinations of brain functioning through EEG and power spectra testing, along with measures of autonomic functioning (i.e., heart rate), have revealed neurophysiological effects that might correspond with the improvements observed following EMDR treatment (Farina et al., 2015). Using a sample of six participants with PTSD, Farina et al. (2015) found that brain and autonomic functioning changed noticeably following EMDR treatments, indicating a neurological basis for the treatment. Their findings indicated that EMDR induced cortical connectivity that might

support integration of traumatic memories (Farina et al., 2015). Also, EMDR led to increased parasympathetic function, which was associated with decreased hyperarousal symptoms (Farina et al., 2015). For purposes of this chapter, however, the focus will be on clinical outcomes associated with EMDR.

EMDR as a treatment for traumatized children and adolescents. Early treatment for children who have experienced traumatic events is important in promoting psychological health and recovery (Jarero, Roque-López, Gómez, & Givaudan, 2014). Jarero et al. (2014) reported the results of a camp-based treatment for severely traumatized children and adolescents that incorporated EMDR into its overall therapeutic approach. Participants were 16 children aged nine to 13 years, most of whom had experienced both sexual and physical abuse (Jarero et al., 2014). The children attended an eight-day trauma recovery camp that included mindfulness exercises, emotion regulation strategies, and a variety of recreational and artistic activities (Jarero et al., 2014). For all 16 camp attendees, significant improvement in PTSD symptoms was observed following EMDR treatment (Jarero et al., 2014). Another camp-based treatment for children and adolescents with PTSD related to sexual abuse resulted in similarly positive outcomes in terms of PTSD symptom reduction (Silverstone, Greenspan, Silverstone, Sawa, & Linder, 2014). As with Jarero et al. (2014), however, this treatment included several types of activities that in themselves have illustrated therapeutic effects for abused children (Silverstone et al., 2014). Silverstone et al. (2014) also included sessions of trauma-focused CBT, which further limits the conclusions that can be drawn about the overall effects of EMDR in symptom reduction. As part of a camp-based therapy program,

however, EMDR was associated with symptom improvement in both studies (Jarero et al., 2014; Silverstone et al., 2014).

In another study of children with PTSD, EMDR was compared with trauma-focused CBT, which is considered a leading therapeutic approach for traumatized patients (Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2015). A sample of 48 children between the ages of eight and 18 years were randomly assigned to one of the two treatments, and received eight weekly treatment sessions lasting 60 minutes each (Diehle et al., 2015). Post-treatment evaluations revealed that both forms of treatment resulted in substantial decreases in PTSD symptoms, but there was not a significant difference in effects between EMDR and trauma-focused CBT (Diehle et al., 2015). It was noted that some of the children were traumatized through single or multiple occurrences of sexual abuse, but their responses to treatment were not specifically discussed (Diehle et al., 2015).

A meta-analysis of studies that examined therapeutic treatment modalities for traumatized children also resulted in evidence to support EMDR as an effective treatment for children with PTSD (Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013). Leenarts et al. (2013) reported that EMDR had resulted in significant reductions in PTSD symptoms in children in three studies, but expressed caution in interpreting these findings due to methodological shortcomings such as small sample sizes. In another meta-analysis, Morina, Koerssen, and Pollett (2016) also found that EMDR was one of several successful forms of therapy for adolescents with PTSD. Although the higher number of studies supporting trauma-focused CBT was noted by both groups of researchers, EMDR

was still presented as a promising form of treatment for child and adolescent PTSD that would be worthy of further investigation (Leenarts et al., 2013; Morina et al., 2013).

EMDR as a treatment for PTSD in adults. A sizable body of research supports the effectiveness of EMDR in reducing the symptoms of PTSD, which often include anxiety and depression (Bilal, Rana, Khan, Safi, & Qayyum, 2015; Chen et al., 2014). Studies of EMDR included both child and adult participants who had been traumatized through a range of experiences, and overall reported positive findings related to its effectiveness in reducing symptoms of PTSD (Chen et al., 2014). Bilal et al. (2015) conducted a single case study with a man in Pakistan who reported severe PTSD symptoms resulting from multiple traumatic experiences related to his work as a judge in a terrorism hit area. The man's symptoms were severe enough to significantly disrupt his social and family relationships, and had impacted his ability to carry out the responsibilities of his job (Bilal et al., 2015). Further, he had undergone pharmacotherapeutic treatment with selective serotonin reuptake inhibitors (SSRIs), but his symptoms did not respond to this treatment (Bilal et al., 2015). After 17 sessions of EMDR, the participant exhibited substantial decreases in symptoms of PTSD including hyper-arousal, anxiety, flashbacks, and nightmares (Bilal et al., 2015). He reported that he was able to work effectively and was no longer contemplating quitting his job, and also that his social and family relationships had improved as a result of EMDR treatment (Bilal et al., 2015).

Because individuals may be diagnosed with PTSD along with comorbid disorders, it is important to evaluate EMDR as a treatment for such persons (de Bont, van Minnen,

& de Jongh, 2013; van den Berg & van der Gaag, 2012). In a study of 10 adults with PTSD and comorbid psychotic disorders (i.e., schizophrenia, schizoaffective disorder), EMDR was compared with prolonged exposure (PE) therapy (de Bont et al., 2013). The PE treatment consisted of detailed recounting of traumatic events by participants, which was audio recorded so that they could replay the recording subsequently (de Bont et al., 2013). The assumption underlying PE treatment is that continued exposure to the traumatic memories will eventually lead to extinction of associated fear (de Bont et al., 2013). After the 12-week treatment period, seven of the 10 participants no longer met criteria for PTSD diagnosis, although no significant differences were found between the treatments (de Bont et al., 2013). Another trial of EMDR with 27 adults with PTSD and comorbid psychotic disorders similarly resulted in positive outcomes for participants (van den Berg & van der Gaag, 2012). Although no control or comparison group was used, the researchers did find that EMDR was associated with improvements in symptoms of PTSD, anxiety, and depression (van den Berg & van der Gaag, 2012). Additional benefits to participants were increases in self-esteem and decreases in psychotic symptoms (van den Berg & van der Gaag, 2012).

The broad applicability for treatment of PTSD in multiple populations was indicated by the literature reviewed. For example, veterans who have served in combat conditions are known to be at risk of PTSD, and EMDR has been evaluated as a suitable treatment for this population. In a randomized control trial that compared EMDR against cognitive processing therapy (CPT) for veterans with PTSD, both treatments resulted in significant improvements to symptoms of PTSD and depression (Graca, Palmer, &

Occhietti, 2014). There were no significant differences in treatment response between the two groups (Graca et al., 2014). In another example illustrating the broad applicability of EMDR, researchers examined the effects of this therapy with a sexual offender with PTSD (Clark, Tyler, Gannon, & Kingham, 2014). Although PTSD often results from being victimized, it can also arise in individuals as the result of their own violent behavior toward others (Clark et al., 2014). Clark et al. (2014) reported the findings of a single case study in which EMDR was used to successfully treat a man who had been traumatized by his own perpetuation of sexual offenses against others. It was noted that EMDR was more successful than other forms of treatment this man had received (i.e., CBT), because his prior treatment had not addressed his underlying trauma (Clark et al., 2014).

These overall positive findings regarding EMDR as treatment for PTSD were supported by a meta-analysis that targeted this research. Chen et al. (2014) conducted a meta-analysis of 26 studies of EMDR for PTSD symptoms, all of which utilized a randomized control design. Their findings indicated that EMDR was an effective treatment for PTSD, resulting in significant decreases in symptoms of anxiety, depression, subjective distress, and trauma-related symptoms in participants with PTSD (Chen et al., 2014). Additionally, they found that treatment sessions lasting 60 minutes or more were associated with more robust improvements in PTSD symptoms, as was therapist experience in using EMDR methods with patients (Chen et al., 2014).

EMDR as a treatment for acute stress. One study was located in which EMDR was tested as a treatment for acute stress disorder (Brennstuhl et al., 2013). Brennstuhl et

al. (2013) examined the effects of immediate EMDR compared with eclectic therapy for individuals who had experienced aggression in the workplace, such as physical assault, verbal abuse, or threats. Of particular interest was the effect of immediate therapy for individuals who had experienced aggression that resulted in acute stress symptoms that were severe enough to prevent them from returning to work (Brennstuhl et al., 2013). Acute stress disorder includes symptoms such as anxiety and avoidance, and may present as a precursor to PTSD, making preventive treatment important (Brennstuhl et al., 2013). Using a sample of 34 victims of workplace aggression, Brennstuhl et al. (2013) assigned participants to receive either EMDR or eclectic therapy within 48 hours of the distressing event. Their findings indicated that EMDR was more effective in reducing acute stress symptoms than eclectic therapy, and that at three months after the aggressive event, no participants in the EMDR group had developed symptoms of PTSD (Brennstuhl et al., 2013). In contrast, symptoms of PTSD were detected in participants in the eclectic therapy group, indicating that EMDR was a more effective treatment for preventing PTSD development (Brennstuhl et al., 2013).

EMDR and women survivors of child sexual abuse. The research on EMDR as a treatment for adult women survivors of child sexual is scant (Paylor & Royal, 2016). Only two studies were located that specifically addressed the effects of EMDR as a therapy for this population within the last five years; these were a critical review and a single case study. Aranda, Ronquillo, and Calvillo (2015) conducted a single case quantitative study with an 18-year-old woman who had been sexually abused three years earlier. The women presented with significant depression and PTSD, and had engaged in

self-injury and multiple suicide attempts within the previous six years (Aranda et al., 2015). Aranda et al. (2015) were interested not just in the clinical progress associated with EMDR for this participant, but also in the neuropsychological effects of this therapy. After 11 sessions of EMDR, the participant exhibited substantial decreases in depressive symptomatology and no longer met diagnostic criteria for PTSD; importantly, these treatment effects were maintained through a one-year follow-up (Aranda et al., 2015). Of note, the researchers found improvements in neuropsychological indicators, such as decreased heart rate, increased attentional regulation, improved cognitive processing speed, and improved working memory (Aranda et al., 2015). These findings indicated that EMDR may be effective in alleviating underlying structural brain changes that are associated with PTSD (Aranda et al., 2015).

Although EMDR appeared to be an effective treatment for the young woman in Aranda et al.'s (2015) single case study, much remains to be examined related to this therapy for women survivors of child sexual abuse. Paylor and Royal (2016) sought to review the literature on EMDR for this population, and found very little focused inquiry on this subject. Only three studies were included in their critical review, which were published between 1999 and 2007; only one of these studies included women survivors, with one including adolescents and the other including a mixed sample of traumatized individuals (Paylor & Royal, 2016). Although all studies presented results that indicated positive effects of EMDR on PTSD symptoms, none found that EMDR resulted in superior results when compared with other treatments such as CBT (Paylor & Royal, 2016). The small sample size of 20 participants in the evaluation of EMDR for women

survivors of child sexual abuse was a significant limitation, especially given the random assignment of participants to multiple treatment groups (Paylor & Royal, 2016).

In summary, important questions exist pertaining to the effectiveness of EMDR for women whose abuse experiences occurred many years earlier. The research reviewed indicated generally positive effects of EMDR treatment for traumatized children and adolescents (Leenarts et al., 2013; Morina et al., 2013), and also pointed to effectiveness of EMDR for adults with PTSD (Chen et al., 2014; de Bont et al., 2013; van den Berg & van der Gaag, 2012). However, studies such as Aranda et al. (2015) involved participants whose trauma occurred relatively recently, and there was a lack of research focus on EMDR for adult women survivors who were sexually abused as children. Paylor and Royal (2016) suggested that women survivors who experienced child sexual abuse many years earlier may have trauma-induced maladaptive cognitive and emotional patterns that are more deeply engrained, which might make such women more difficult to treat (Paylor & Royal, 2016).

In a related discussion, Orbke and Smith (2013) explored the therapeutic needs of adult survivors whose developmental progress has been significantly deterred for many years due to unresolved trauma. They similarly suggested that such patients might have more deeply entrenched maladaptive self-schemas, which may require more intensive therapy (Orbke & Smith, 2013). Orbke and Smith (2013) suggested that EMDR might be combined with strengths-based therapy, which would build survivors' resilience while also processing their trauma histories. This approach was not empirically tested, however,

leaving continuing questions regarding the effectiveness of EMDR therapies for women survivors of child sexual abuse (Orbke & Smith, 2013; Paylor & Royal, 2016).

Summary and Conclusions

As the research reviewed in this chapter illustrated, child sexual abuse could have pervasive adverse effects on an individual's growth and development, creating a vulnerability to psychological, social, and sexual dysfunction into adulthood (Maniglio, 2013). Adult survivors of child sexual abuse may experience a lower quality of life, relationship difficulties, and problems coping in adaptive ways (Colangelo & Keefe-Cooperman, 2012; Coyle et al., 2014). The adverse effects of child sexual abuse can be severe enough to influence development of diagnosable psychological disorders of many types, with depression and PTSD reflecting the most common diagnoses (Fergusson et al., 2013; Pérez-Fuentes et al., 2013). Recovery is greatly enhanced by professional therapeutic assistance, and several trauma-focused individual and group therapies have shown promising effects on improving psychological symptoms, building positive self-schemas, and encouraging adaptive coping strategies in survivors of child sexual abuse (Ehring et al., 2014; Sayın et al., 2013; Walker-Williams & Fouché, 2015).

As EMDR was established as an effective first-line treatment for PTSD (Chen et al., 2014), and requires less time and detailed exposure to traumatic memories, its applicability in the treatment of women survivors of child sexual abuse was an important area of research (Aranda et al., 2015; Shapiro, 2014). The little research that existed on this topic indicated positive effects of EMDR on psychological symptoms of women survivors of child sexual abuse (Paylor & Royal, 2016); however, this research was scant

and characterized by small sample sizes. Understanding of the role of EMDR in the treatment of women survivors of child sexual abuse would be enhanced by further study, including exploration of the perspectives of therapists with experience in this area. It was the aim of the present study to address this gap; Chapter 3 will provide a detailed explanation of the methods that will be used to address this purpose.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological qualitative study was to explore the perceptions of therapists about EMDR as a tool to assist adult women survivors of child sexual abuse. The study focused on 10-12 therapists who provided therapeutic or counseling services (or both) through EMDR to women with a history of repeated sexual abuse as children. Therapists were interviewed instead of adult women victims to avoid retraumatizing them. The participants of the study were recruited from a local list of therapists, provided by EMDRIA, who provided services to sexually abused women and children. The EMDRIA was helpful in referring therapists who were knowledgeable about cases of women with sexually abusive childhood experiences.

This chapter includes an explanation of the research methods used to achieve this study's purpose, starting with discussion of research design and rationale for its selection, along with the role of the researcher. Following sections will outline the sampling plan, data collection instruments and procedures, data analysis plan, and methods to promote trustworthiness of findings. Finally, this chapter will include a discussion of ethical procedures used in this study to protect participants from harm.

Research Design and Rationale

I used a phenomenological qualitative approach to explore the following research questions:

RQ1: What are the perceptions and experiences of therapists about EMDR as a tool in assisting adult women clients through the healing process and regaining their abilities to function and behave appropriately?

RQ2: How have therapists perceived the effects of EMDR with women who had histories of child sexual abuse? What changes did they observe, and what did they like and/or dislike about EMDR?

RQ3: How did therapists perceive EMDR in comparison with other treatment approaches for this population? What were benefits or drawbacks observed?

RQ4: When is the right time to introduce client into EMDR treatment?

RQ5: How did therapists implement EMDR treatment with women survivors of child sexual abuse?

A qualitative approach was chosen for this study because it allowed for exploration of participants' perspectives and experiences in a flexible manner (Merriam & Tisdell, 2015). This freedom to explore participants' experiences is an attribute of qualitative methods that makes this approach useful in examining research topics that have not been widely studied (Merriam & Tisdell, 2015). Because therapists' experiences using EMDR with women survivors of child sexual abuse has not been extensively studied, a qualitative method was useful in this study. Conversely, quantitative methods involve numerical measurement of predetermined variables and determination of statistical relationships between variables (Maxwell, 2012). Although quantitative methods has strengths, these did not suit the purpose of this study, which was to explore

therapists' experiences and perspectives related to EMDR with women survivors of child sexual abuse.

A phenomenological design was most appropriate for this study because it allows researchers to gain insights about their phenomena of interest (Moustakas, 1994). Phenomenology has been defined as a research design used to comprehend different phenomena based on experiences of individuals who lived through the phenomena (Groenewald, 2004). Through systematic reflection on participants' experiences and perspectives, phenomenological inquiry can yield an understanding of the "essence of things" or essential meanings as experienced by participants (Moustakas, 1994).

For this study, the phenomenon was the therapists' perceptions of EMDR as a tool in assisting adult women survivors of child sexual abuse through the healing process. Because the central aim of this study was to understand this phenomenon from the perspectives of therapists, phenomenology was the most appropriate research design. Other designs were considered but not selected because of the comparative lack of fit with this study's aims. For example, grounded theory is a qualitative design through which researchers build theory based on the perspectives and insights shared by participants (Charmaz, 2014); however, this approach was not selected because it was not the aim of this study to derive theory from therapists' experiences with EMDR and women survivors of child sexual abuse.

Role of the Researcher

In the study, I conducted face-to-face interviews with each participant. When conducting qualitative research, the researcher has a close involvement with participants

while collecting data, which means that the researcher functions as a data collection instrument (Merriam & Tisdell, 2015). Because of the depth of involvement in collecting data through face-to-face interactions with participants, it was important to consider how my role as the researcher might affect data collection and interpretation (Merriam & Tisdell, 2015). A researcher could inadvertently introduce bias into data collection in qualitative research because of power differentials between the researcher and participants (Qu & Dumay, 2011). Additionally, a researchers' own beliefs and previous life experiences might create an unknown bias that affects data collection and analysis (Merriam & Tisdell, 2015). It was important, therefore, to acknowledge and address any potential sources of bias or power differentials in the study.

Methodology

This section includes an explanation of the methodology used in the study. This includes discussion of sample selection processes and rationale and a description of data collection instrumentation. This also includes description of processes of recruitment and data collection, along with the study's data analysis plan.

Participant Selection

For this study, a purposive sample of 10 therapists who treated women who survived childhood sexual abuse was asked to participate in semistructured interviews. Purposive sampling is a deliberate approach to participant selection that ensures sufficient experience and background in the sample to fully address the specific research questions of a study (Elo et al., 2014). To ensure that participants had sufficient experience to discuss the therapeutic progress associated with EMDR, therapists must

have had a minimum of 2 years of experience providing EMDR therapy to women survivors of child sexual abuse to qualify for participation. This level of experience was confirmed with therapists. The therapists were located in the Newark, NJ area and served women who have experienced childhood sexual trauma. I recruited therapists through the distribution of flyers via e-mail to all potential participants currently practicing EMDR. The therapists were volunteers provided that they were willing to cooperate in the data gathering of the study while maintaining therapist-patient confidentiality. Confidentiality procedures are described in detail in the ethical considerations section of this chapter.

Sample size determination for qualitative studies is not an exact process and requires judgment on the part of the researcher (Merriam & Tisdell, 2015). According to Mason (2010), sample sizes for qualitative studies, such as phenomenology, have ranged from 10 to 20 participants as being sufficient to achieve data saturation. Meanwhile, Beck (2009) noted in his guideline that a sample size ranging from six to 25 is more appropriate. A common method of evaluating adequacy of a qualitative study's sample is evaluation of data saturation (Mason, 2010). Data saturation refers to a point in data collection where there is no more significant new information to be added to the existing data pool with the addition of a new participant to the study (Marshall, Cardon, Poddar, & Fontenot, 2013). In this sense, I tested for data saturation by trying to add new data to existing ones and determining the amount of new data added regarding percentage of existing information. If the change was less than 5%, then data saturation was reached.

Instrumentation

Interviews with participants were guided by a semistructured interview protocol. The semistructured format created a consistent structure across all interviews, while also allowing for exploration of unique experiences or perspectives (Elo et al., 2014). The semistructured format refers to use of a set collection of questions in every interview as well as probe questions to elicit more specific information from each participant (Stuckey, 2013). Probe questions were used when participants expressed a perspective of interest that I wanted to hear elaborated; for example, probe questions might be, "Can you tell me more about that?" or "Describe that in a little more detail." The three core research questions provided a framework for development of more specific interview questions, and probe questions were also interspersed as needed throughout interviews to encourage participants to provide more detail on their experiences and viewpoints as these arise (Qu & Dumay, 2011). The interview protocol was developed by me (see Appendix A), and featured open-ended questions that drew out more textured and detailed responses from participants (Qu & Dumay, 2011). Following the interview protocol during data collection ensured that all key features were discussed with each participant, but the semistructured design provided flexibility to participants to share their individualized experiences and perspectives on EMDR with women survivors of child sexual abuse (Elo et al., 2014).

To provide relevant demographic context, quantitative data were obtained from participants. These data included age, gender, and number of clients seen each week who experienced sexual trauma (see Appendix B). Information was collected about EMDR.

This information included participants' training in EMDR, number of hours per week that they provided this form of therapy, and length of experience providing EMDR.

Procedures for Recruitment, Participation, and Data Collection

As data collection proceeded, an audit trail was kept to record any challenges or problems that developed, as well as decisions that were made to manage any of these issues (Merriam & Tisdell, 2015). The audit trail was kept in a word processing file in which I made notes and narratives regarding the research process. I conducted one face-to-face semistructured interview with each therapist who agreed to participate in the study. Once a therapist's qualifications to participate were confirmed with the clinic program director, an appointment was scheduled with the participant in a private location that was convenient for the participant. Actual locations varied depending on the needs of the participants; however, locations included private conference rooms in therapists' offices or libraries. Privacy was ensured by selecting rooms with doors that could be closed so that only the participant and I could hear what was being discussed during interviews. At this meeting, the purpose and procedures of the study were reviewed with participants, and they were allowed to ask any questions about participation. If they agreed to participate, they needed to sign an informed consent form before proceeding to the interview.

Depending on the participant's preferences, the interview was conducted directly following the above discussion or on a subsequent day. Interviews were expected to last about 1 hour each and were audio recorded with participants' written permission. I conducted the interviews and then provided participants the opportunity to ask additional

questions after the interviews. Because the participants were therapists and not themselves survivors of child sexual abuse, there were no concerns about secondary trauma; therefore, the need for additional debriefing did not seem necessary. Recordings were made using a digital device that would be stored in a locked cabinet when not in use. I transcribed the interviews and deleted the audio recordings afterward.

Data Analysis Plan

Audio recorded interviews were transcribed verbatim and imported to qualitative data analysis software for coding and analysis. The following data analysis procedures were used to examine meanings associated with each research question. In using Moustakas's (1994) method for analyzing phenomenology, the first phase for this study involved identification of relevant and initial grouping, wherein each relevant expression was listed through horizontalization, or developing a list of nonoverlapping important statements. The second phase consisted of reduction and elimination of each statement by evaluating whether the expression was (a) related to the experience being explored, and (b) could be labeled as a part of the spectrum of the whole experience. Those that could not satisfy these criteria were eliminated. The third phase involved clustering and thematizing the data. The fourth phase involved the final identification of themes. The fifth phase involved using the finalized themes and providing individual textural descriptions for each. The sixth phase involved the development of individual structural descriptions based on the individual textural description. The seventh and last phase consisted of development of meanings and essences for each textural-structural description (Moustakas, 1994).

Issues of Trustworthiness

In qualitative research, several methods can be used to promote trustworthiness of findings (Merriam & Tisdell, 2015). In this study, credibility of findings were supported through a peer debriefing process. Peer debriefing refers to inviting another person to review and evaluate coding and analysis of data as it emerges (Merriam & Tisdell, 2015). To conduct peer debriefing, I asked another person to review the coding midway through and at the end of analysis, and asked for that person's perspectives on how the ongoing analysis seemed to fit the content of the data. Credibility of resulting findings and conclusions was supported through peer debriefing because of the involvement of multiple perspectives on data interpretation (Merriam & Tisdell, 2015). Member checks were used to promote credibility and entailed verification of transcripts and emerging interpretations with participants to ensure these are accurate (Petty, Thompson, & Stew, 2012). Member checks were conducted by meeting individually with participants and reviewing their transcripts for verification.

Although generalization of findings is not a typical aim of qualitative research, it was desirable to disseminate findings that are transferable to other environments or settings (Petty et al., 2012). In this study, provision of thick description of the setting, participants, and data supported transferability of findings (Merriam & Tisdell, 2015). Providing this level of description of data allows readers to evaluate the findings in greater detail and assess the extent to which findings apply to their own conditions (Petty et al., 2012).

Another method for promoting trustworthiness was maintaining an audit trail during data collection and analysis (Merriam & Tisdell, 2015). As data collection proceeded, an audit trail was kept to record any challenges or problems that develop as well as decisions that were made to manage any of these issues. The audit trail was kept in a word processing file in which I made notes and narratives regarding the research process. An audit trail also supported trustworthiness because it documented my emerging interpretations and impressions while working with the data (Petty et al., 2012). Because the audit trail resulted in a record of decisions, impression, and interpretations as these occurred during the study, the audit trail supported dependability and confirmability of the study's findings (Merriam & Tisdell, 2015).

Ethical Procedures

Before any recruitment or data collection began, institutional review board (IRB) approval was obtained for this study 10-06-17-0167676. Because participants were not sharing sensitive or controversial information about themselves, it was not anticipated that participation would pose risk of psychological harm to participants themselves. However, there was a risk that they might divulge sensitive and confidential information about their patients, and clinic program directors emphasized the importance of protecting patient confidentiality in this study. At the time of informed consent procedures, this need for patient confidentiality was reviewed with participants. Informed consent information was explained to participants in a face-to-face meeting, and it was clearly stated that their participation was voluntary and could be withdrawn as they chose. This discussion included a review of the subject matter and aims of the study, as

well as description of data collection and storage procedures. The need to audio record interviews was explained and permission for this, and all other research procedures were documented on a signed informed consent form.

Data collected through interviews with participants was treated in specific ways to avoid concerns related to confidentiality and anonymity. Participants were not identified by name on transcripts, but were instead be denoted simply by a participant number. In written descriptions of this study's findings, caution was taken to ensure that the therapists who participated are not identifiable. In addition, the same caution was taken to ensure that patient identity was not inadvertently disclosed or suggested through presentation of the data and related interpretations. Confidentiality was supported by keeping transcripts in password-protected files, and by locking all hard copy materials for this study (i.e., printed interview transcripts) in locked files when not being used by the researcher. Audio recordings will be deleted after transcription.

Summary

This chapter explained the methods used to explore therapists' perspectives and experiences related to EMDR as a therapy for women survivors of child sexual abuse. A phenomenological qualitative approach was selected because of its usefulness in eliciting rich insights related to lived experiences of participants (Moustakas, 1994). A purposive sample of 10-12 therapists with at least two years of experience providing EMDR therapy to women survivors of child sexual abuse participated in semi-structured interviews to share their perspectives. Data were analyzed according to Moustakas' (1994) guidelines, which provided insight into essential meanings related to participants' experiences with

EMDR with this population. Trustworthiness of findings was supported through completing peer debriefing, conducting member checks, maintaining an audit trail, and providing thick description (Merriam & Tisdell, 2015; Petty et al., 2012). Ethical practices were considered and were implemented to safeguard participants and their patients from harm to ensure anonymity and confidentiality.

Chapter 4: Results

Introduction

The purpose of this phenomenological qualitative study was to explore therapists' perceptions of therapists about EMDR as a tool to assist adult women survivors of child sexual abuse through the healing process and to regain their abilities to function and behave appropriately. Five research questions were used to guide the study, including:

RQ1: What are the perceptions and experiences of therapists about EMDR as a tool in assisting adult women clients through the healing process and regaining their abilities to function and behave appropriately?

RQ2: How have therapists perceived the effects of EMDR with women who had histories of child sexual abuse? What changes did they observe, and what did they like and/or dislike about EMDR?

RQ3: How did therapists perceive EMDR in comparison with other treatment approaches for this population? What were benefits or drawbacks observed?

RQ4: When is the right time to introduce client into EMDR treatment?

RQ5: How did therapists implement EMDR treatment with women survivors of child sexual abuse?

Chapter 4 includes a description of the setting of data collection, followed by a presentation of the relevant demographic characteristics of the study participants. Next, Chapter 4 includes descriptions of the implementation of the data collection and data analysis procedures described in Chapter 3, followed by a discussion of the evidence of the trustworthiness of the study's results. The discussion of trustworthiness is followed

by a presentation of the results of the data analysis, organized by theme. The chapter concludes with a summary of the results.

Setting

I conducted one semistructured interview with each participant either face-to-face or through Skype or Facetime. Once a therapist's qualifications to participate had been confirmed by the director of EMDRIA, participants scheduled interview appointments for a time and location that was convenient for them to ensure that participants would be as comfortable as possible during the interview and therefore more likely to offer rich and complete responses to the interview questions. Face-to-face interviews were conducted in private conference rooms in therapists' offices or libraries. Privacy was ensured by selecting rooms with doors that could be closed so that only the participant and I could hear what was being discussed during interviews. This precaution was taken in order to help participants feel comfortable in giving candid and complete responses.

Demographics

Participants were 10 therapists in the State of New Jersey who treat women who have survived childhood sexual abuse. All participants had a minimum of 2 years of experience providing EMDR therapy to women survivors of child sexual abuse. Table 1 includes relevant demographic information for the study participants.

Table 1

Participant Demographics

Gender	Ethnicity	# years in practice	# of years trained and utilizing EMDR	Location	Type of work setting or practice
W	White	15 +	9	Maplewood, NJ	Private
W	Italian	15 +	10	Montclair, NJ	Private
W	White	10	5	Montclair, NJ	Private
W	Russian	18	11	Highland Park, NJ	Private
M	Puerto Rican	6	3	Jersey City, NJ	Clinic
W	African American	29	13	East Orange, NJ	Private
W	African American	20 +	11	Montclair, NJ	Private
M	African American	5	3	Newark, NJ	Clinic
W	White	9	5	South Orange, NJ	Private
W	White	7	3	Montclair, NJ	Private

Data Collection

One-on-one interview were conducted with participants, and the average duration of the interviews was approximately 1 hour. All interviews were audio recorded, using a digital recording device, with the participants' written permission. There were no deviations from the data collection plan presented in Chapter 3, and no unusual circumstances were encountered during data collection.

Data Analysis

Audio-recorded interviews were transcribed verbatim, yielding approximately 90 pages of single-spaced transcriptions. All transcriptions were uploaded into NVivo 11

software for analysis. Data were analyzed using the 7-step method described by Moustakas (1994). The first phase involved listing the data in a process of horizontalization to assess relevance and identify initial groupings. The second phase consisted of data reduction and elimination. In this phase, I evaluated every expression in the dataset to determine whether (a) it related to the experience being explored, and (b) it could be labeled as a part of the spectrum of the whole experience. Expressions that did not satisfy these criteria were eliminated. The third phase involved clustering and thematizing the data, and the fourth phase involved the final identification of themes. The fifth phase consisted of providing individual textural descriptions for each of the finalized themes. The sixth phase involved the development of individual structural descriptions based on the individual textural descriptions, and the seventh and last phase consisted of developing meanings for each textural-structural description.

Themes that emerged during data analysis and the codes that contributed to the themes, as well as representative quotations from each theme, are indicated in the table in Appendix C. The table in Appendix D depicts the themes that emerged during data analysis, the number of data elements that were included under each theme (i.e., frequency), and the percentage of the total number of data elements that were included in each theme (i.e., % coverage). In Appendix E, a table includes the textural and structural descriptions that emerged from the finalized themes during the fifth and sixth phases of data analysis (Moustakas, 1994).

Results

This presentation of the results of the data analysis is organized by theme.

Theme 1: Perceived Effects of EMDR

Perceived effects of EMDR on women child sexual abuse survivors included initial resistance to the treatment, short-term and long-term relief from shame and anxiety, enhanced ability to function and behave appropriately, and empowerment. Participant 1 had perceived that an initial effect of EMDR on women who had histories of child sexual abuse was a resurgence of feelings associated with the trauma, and that this difficult experience caused some patients to resist the treatment. In Participant 1's experience, this resistance could usually be overcome. Participant 1 described a case in which initial resistance to EMDR had been encountered, but in which the therapist's experience indicated that a resolution would soon be found. Notable in Participant 1's response was the perception that EMDR activated negative experiences stored in the neural network, and that this activation could cause physical and psychological distress, including dizziness and anxiety. Also notable was Participant 1's perception that patients needed to experience this activation of stored negative experiences to resolve the trauma (i.e., the patient must "feel it to heal it"). Thus, the effects of EMDR that Participant 1 had perceived included initial resistance accompanied by distress, followed by a change toward lessening of resistance as the treatment progressed.

Five out of 10 participants had perceived that EMDR, when used to treat women child sexual abuse survivors, had the effect of giving the patient marked relief from anxiety. In Participant 4's experience, patients' relief during EMDR was associated with a realization that the traumatic event was safely in the past and that the patient was finally *moving forward* and leaving the trauma behind. Another aspect of Participant 4's

experience with EMDR was that the role of facilitator was passive. Participant 4 liked this characteristic of EMDR because it allowed the patient to take the lead in the healing process, thus ensuring that the patient's needs were met.

In Participant 6's experience, EMDR was difficult for women child sexual abuse survivors ("It's a long road"), but observed changes in clients over the course of treatment included noticeable relief from symptoms associated with anxiety. Notable in Participant 6's response was the perception that the effects of EMDR on women child sexual abuse survivors included the clients' increasing acceptance that they were not "strange" or "crazy," and a corresponding reduction in clients' sense of shame associated with the abuse. Although Participant 6's perceptions of the effects of EMDR included long-term changes such as an overall reduction in anxiety and shame, Participant 8 described the perception of EMDR causing a change during the course of a single therapeutic session, with the client experiencing observable relief as the EMDR proceeded

In the perceptions of seven out of 10 participants, women child sexual abuse survivors who underwent EMDR experienced the change of being able to function and behave more appropriately. Participant 1 described a case in which a woman CSA survivor was unable to deal effectively with her husband's alcoholism in part because of the ongoing effects of child sexual abuse trauma; Participant 1 described this client as "bogged down," and in this respondent's perception EMDR had the effect of helping the client to move forward and cope more effectively with present stressors. Participant 1 went on to contrast the case of the client with the experience of patients who had suffered

child sexual abuse repeatedly, indicating that the rapidity with which the course of treatment resulted in positive changes for the client depended to some extent on the emotional significance of the abuser, as well as on the number of occurrences of abuse.

Participants 8 and 10 agreed with Participant 1 in perceiving that the effects of EMDR on women child sexual abuse survivors included a change toward more effective coping with current circumstances. Participant 2 described women child sexual abuse survivors who underwent EMDR as experiencing positive changes related to behavior and functioning, attributing these effects to a reduction in anxiety and shame. In Participant 4's perception, the empowering effects of EMDR helped patients to function and behave more appropriately by removing impediments to self-actualization such as anxiety and depression, so that the patient was able to move forward. In Participant 5's experience, EMDR affected different patients in different ways, but common effects included an enhanced ability to function and behave appropriately and empowerment, which was described by this participant as the ability to escape from bad relationships. Table 2 includes representative quotations from participants.

Table 2

Descriptions of the Effects of EMDR

Participant	Description
1	[The patient] feels her emotions physically, she feels like she's tipping over, that she thinks it's a sign that she's got MS or a brain tumor. She starts to get anxious . . . She was already feeling like that and [we] took some history, made a plan, did the EMDR and one of the things it does first is it accesses the material, it finds where all those negative information is stored in your neural networks and it brings it up. You've got to feel it to heal it as they say. First it activates it so she's not in love with the idea of continuing because I would prefer it never to be activated like that again. I think she'll get through that and we will do it but ideally if you have a long enough session, maybe you can get to a better place before ending the session. It doesn't always happen. (Participant 1)
4	[Specific changes observed in clients who were exposed to EMDR are] just so amazing. I've heard descriptions of "I felt like I had bricks in my chest and they've moved one by one. I felt my . . . My head is not foggy." The physical sensations that people get just from processing, when it's a completed process and we're at the validity, the number, the range that we need to be and everything like that and it's just like when they express that and then afterward, it's like, "Okay, so let's talk about the event." . . . I don't want to say it's a good moment but sometimes it is because they associate these positive feelings they're having or this like a relief, that oh yeah. It doesn't seem like it happened yesterday, it doesn't feel like I'm on edge all the time. I feel that it did happen but now this is going to happen. Now I am this, now I am moving forward. And everybody's different but yet everybody kind of says the same thing or is in the same theme. I feel relief. (Participant 4)
2	[child sexual abuse survivors who underwent EMDR] have a better life. They have better relationships. They sleep better. The world feels safer and they're not walking around in a cloud of shame that I'm defective or this is my fault." They sleep better. That's one for sure. They're able to reach out for help, get the kind of, their trauma may not be gone and the weight may not be 100% gone but they have a lot more choices how they handle stuff when it comes up. They don't blame themselves in the same way. Their lives just get better and easier. They feel entitled to more.

Theme 2: Therapists Perceived EMDR As More Effective in Treating Child Sexual Abuse Trauma Than Other Treatment Options.

Therapists perceived EMDR as more effective in treating child sexual abuse trauma than other treatment options because it involved the body and worked rapidly, although it may involve a danger of dysregulating the patient. Six out of eight participants indicated that EMDR was always their preferred treatment for women child sexual abuse survivors because it was more effective than other treatment options. Participants 1 and 8 were the discrepant cases, as they indicated that under at least some circumstances other treatment options were either preferable or equivalent to EMDR. Participant 1 indicated a preference for EMDR when treating this patient population, but suggested that EMDR was not universally effective or always safe and other treatment options occasionally had to be explored. Participant 8 indicated that acupressure desensitization was preferable to EMDR because it did not cause the patient to relive the trauma.

Eight out of 10 participants indicated that EMDR was a more effective treatment for women child sexual abuse survivors than talk therapy was. No participants indicated that talk therapy was more effective than EMDR. For Participants 8 and 9, EMDR was the preferred treatment option because it was perceived as activating and discharging emotions, whereas talk therapy merely activated negative emotions without discharging them. In addition, Participants 7 and 8 compared EMDR favorably to talk therapy because EMDR worked more quickly. Four participants (2, 5, 6, and 10) attributed the perceived superiority of EMDR over talk therapy methods such as CBT was attributed to

the holistic and somatic nature of EMDR, emphasizing that EMDR involved the patient's body. Participant 4 preferred EMDR over talk therapy and other methods because it allowed the patient to relive the trauma and thereby process it. Table 3 includes representative quotations from participants in support of Theme 2.

Table 3

Descriptions of EMDR as More Effective than Other Treatment Options

Participant	Description
8	I think that [EMDR] is an excellent, excellent tool to help people because, especially with people suffering with post-traumatic stress disorder, which is what many trauma victims have… talk therapy can intensify the trauma without giving the client any tools to make the distress go down. Because when you talk about a trauma with someone that has been traumatized it re-triggers it. Over five years talking about the same trauma because every time you talk with them about it, it didn't really seem to get better over time. In contrast, when you do EMDR you not only have the ability to talk them through the trauma a lot more quickly, but it helps the body get rid of or discharge a lot of emotional over-activity or neurological hyperactivity . . . talk therapy is not going to get it with trauma victims. (Participant 8)
6	I think [EMDR is] more holistic [than other treatment options]. It treats the mind, body and the spirit all together compared to more traditional ones where you're talking about a lot of talk therapy. While some of those approaches may have been effective, like I was speaking of cognitive behavioral and things like that. They may have had some effectiveness but it's also a slow progress with that. This one, it's a little bit more quicker [sic]. Like I said, it deals with the whole total body, head to toe, follicle to nail, if I could say. (Participant 6)
4	I know [EMDR is] an evidence-based technique but in a way, it's kind of magical too because it can really take you back . . . I don't know any other technique that can take you back to that moment and in addition to remembering it but then the physical sensations and then being able to kind of relive it . . . For processing the sexual traumas, no. (Participant 4)

Theme 3: Perceived role of EMDR in a treatment program.

The perceived role of EMDR in a treatment program was to allow patients to remember traumatic events without reliving them, in order to free patients from shame and prepare them to learn more effective coping skills. All participants indicated that the role of EMDR in a treatment program was to allow patients to remember traumatic events

without reliving them. Participant 2 described the perceived contrast between patients' tendency to relive traumatic events before EMDR and their ability to remember those events without acute distress after a course of EMDR treatment. Participant 4 described the way in which EMDR was perceived to allow patients to cope with triggering sensations without reliving traumatic events. Participant 1 described the further perception that traumatic memories were stored incorrectly in the brain, such that they remained vivid and present, and that EMDR allowed those memories to recede from immediacy to a more appropriate remoteness.

Five out of 10 participants indicated that allowing patients to remember traumatic events rather than reliving them helped to free the patient from feelings of shame associated with CSA. No participants expressed the perception that helping patients to remember rather than relive traumatic events did not help to free patients from feelings of shame. Participant 2 described the perception that EMDR freed patients from shame, and that this freedom allowed patients to react more appropriately to their memories of trauma by grieving. Participant 6 added the perception that helping patients to stop reliving traumatic events prepared those patients to learn to cope more effectively with their current circumstances. Table 4 includes representative quotations indicating the perceived role of EMDR in a treatment program.

Table 4

Perceived Role of EMDR in a Treatment Program

Participant	Description
2	Let's say someone has abuse memories and prior to treatment they think about the abuse and they want to throw up, their heart rate is going, they feel really unsafe. They feel like they're back there. By the end of treatment, that memory is pretty distant. It's not, it doesn't hijack them. They don't go back there. They think, "That thing happened to me and that was really awful. I wish it didn't happen." They're able to think about it as a memory as opposed to re-experiencing it. Part of what of EMDR does is it moves memories into long term memory. Where they're kind of stuck in the amygdala and so as soon as a person thinks about it, it's like it's happening again, which is a really difficult way to live. (Participant 2)
1	When somebody is sexually assaulted, not only does it inspire fear and a sense of not having a right to one's boundaries, you don't know how to protect yourself, it sets them up to be violated over and over again and just not have good personal boundaries and a good sense of how to protect their children . . . The perpetrator was not using their sense of shame as a guidance system and detached from their shame and allowed themselves to therefore behave without the guidance of their own shame and the victim picks that shame up but it doesn't just feel like a guidance system, it makes the child feel overwhelmed, feel overwhelmingly shameful about herself. That's why victims feel dirty and worthless because they picked up the perpetrator's shame . . . Then you take too much shit off of people because you don't think you're worth anything. (Participant 1)

Theme 4: The right time to introduce a client into EMDR.

The right time to introduce a client into EMDR treatment was perceived to be when the client is not suicidal or excessively dissociative, when the client's current circumstances are stable and safe, and when the client can be trusted to report distress. Seven out of ten participants indicated the perception that the right time to introduce EMDR was when the patient was not suicidal or excessively dissociative. Participant 9 explained why it was perceived as important to ensure that the patient was not suicidal or excessively dissociative before implementing EMDR, indicating that EMDR might make the patient's condition worse by overwhelming them with memories and sensations related to the trauma. Five out of ten participants indicated the perception that EMDR

should be implemented only when the client's circumstances were stable and safe. Participant 2 discussed why it was perceived as necessary for patients to be in stable, safe circumstances before implementing EMDR, indicating that patients who were already under stress as a result of their present circumstances could more easily be overwhelmed by the negative emotions that occasionally arose during the treatment. Participant 7 added the perception that the patient needed to be in stable circumstances when EMDR was implemented because otherwise the necessity of dealing with present stressors might not leave time for EMDR. One out of ten participants described the perception that it was necessary for a therapist to trust a client to report distress before EMDR could be implemented. Table 5 includes representative quotations indicating participant perceptions of the right time to introduce EMDR.

Table 5

Perceptions of the Right Time to Introduce EMDR

Participant	Descriptions
9	You wouldn't do it with somebody that's suicidal. You wouldn't do it with somebody that's cutting. You wouldn't do it with somebody that's psychotic because you don't want to make them worse or overwhelm them emotionally. You want to try to make it as safe as possible for the person who is agreeing to face the very thing that probably is the worst thing that has happened to them in their life. It can be very scary and very frightening for the client. But you try to reassure them that if they stay with the procedure eventually your distress level will go down. (Participant 9)
2	If someone also is in the middle of a divorce or has very sick child, we're not gonna open up their childhood trauma at that time. Then really trying to just resource and help somebody contain and ground because your life should be relatively stable to open this stuff up. If you're in the middle of a crisis, that's not a good idea. (Participant 2)
1	For me, my number one factor is if I trust the person to tell me what's going on. I need them to not be pleasing to me. I need to know the real truth. I need to trust that they'll let me know if they're in trouble. (Participant 1)

Theme 5: Strategies for implementing EMDR.

Therapists implemented EMDR by building rapport, conducting a thorough assessment, focusing treatment on the most distressing elements of past traumas and present triggers, and teaching the client skills for coping with distress. Eight out of ten participants reported that they worked on building a rapport with the patient before implementing EMDR. No participants indicated that they did not build rapport with the patient prior to the introduction of EMDR. Participant 6 described the practice of rapport-building as taking place gradually, over a number of sessions, and involving the therapist's becoming acquainted with all aspects of the patient's life. Ten out of 10 participants discussed the importance of conducting a thorough assessment of the patient before beginning EMDR, and the eight participants who discussed rapport-building

reported that building rapport and taking a thorough assessment were different aspects of the same process of acquainting themselves with the patient's condition. Participant 8 described why a thorough case history was a necessary prerequisite of safe EMDR, indicating that the assessment process enabled therapists to better predict the severity and causes of the patient's distress (if any) during treatment. Participants 1, 2, and 10 discussed the importance of the therapist's becoming acquainted with the patient's triggers, while Participant 5 indicated that it was also necessary for therapists to assess the patient's willingness to undertake EMDR. Participant 4 stated that the final part of the assessment and rapport-building process involved helping the patient to identify the most upsetting aspect of a traumatic memory.

Participant 1 described the implementation of EMDR as a process of addressing past traumas, present triggers, and future concerns. Participant 8 explained that if a patient continued to be triggered after EMDR, this was an indication that the trauma had not been completely reprocessed. When this occurred, Participant 8 would assist the patient with further reprocessing of the target memory. Participant 4 expressed that the implementation of EMDR involved teaching the patient skills to help her deal with stress associated with the treatment, including visualization and breathing exercises. Table 6 includes representative quotations indicating strategies for implementing EMDR.

Table 6

Strategies for Implementing EMDR

Participant	Descriptions
8	EMDR actually has a fairly structured format in terms in how you're supposed to introduce it to people. You're supposed to spend a lot of time doing your regular intake and getting all the clinical information about the client. And the reason why this is important is because once you start doing the EMDR, the EMDR has the ability to bring up other traumas that may or may not be in the awareness of the client. Some traumas the client may know all related to what's going on and sometimes things may come up that the client did not know were considered traumas but they may remember them. So you try to take a good history first so that you can have a good idea as to what might pop up. (Participant 8)
1	With EMDR we talk about it being a protocol past, present and future. We do the past, the original event, the things that got the river running, we go to the source. We do the past and we do the present triggers, the reminders, the implications, how's this affecting you today. (Participant 1)
4	So it's like even when use EMDR afterwards, when we're in reviewing, because it's not like they do, then they process it there and they're in and then out of the office. I usually at that time, it's like, "Okay, now you need to practice." Because with EMDR there's actually, when we practice safe, or calm place, that's a relaxation technique, basically, because you're working on your breathing and your visualization and that can be implemented through it. And other meditation and body scans. It's also the CBT of it. What's rational. Or irrational versus rational thought. (Participant 4)

Summary

The purpose of this phenomenological qualitative study was to explore the perceptions of therapists about EMDR as a tool to assist adult women survivors of child sexual abuse through the healing process and to regain their abilities to function and behave appropriately. To achieve this, one-on-one, semi-structured interviews were conducted with ten therapists in the northeastern United States who treat women who have survived childhood sexual abuse. All participants had a minimum of two years of experience providing EMDR therapy to women survivors of child sexual abuse. Two primary research questions and three sub-questions were used to guide the study.

The first research question was: What are the perceptions and experiences of therapists about EMDR as a tool in assisting adult women clients through the healing process and regaining their abilities to function and behave appropriately? The second and third research questions helped to answer Research Question 1 fully. Therefore, the second research question asked the following: How have therapists perceived the effects of EMDR with women who had histories of child sexual abuse? What changes did they observe? What do you like and/or dislike about EMDR? Results indicated that the perceived role of EMDR in a treatment program is to allow patients to remember traumatic events without reliving them, in order to free patients from shame and prepare them to learn more effective coping skills. Research Question 3 asked the following: How did therapists perceive EMDR in comparison with other treatment approaches for this population? What were benefits or drawbacks observed? Results indicated that perceived effects of EMDR on women CSA survivors included initial resistance to the treatment, short-term and long-term relief from shame and anxiety, enhanced ability to function and behave appropriately, and empowerment.

Research Question 4 asked the following: When is the right time to introduce client into EMDR treatment? The answer was that the right time to introduce a client into EMDR treatment was perceived to be when the client was not suicidal or excessively dissociative, when the client's current circumstances are stable and safe, and when the client can be trusted to report distress. Research Question 5 asked the following: How did therapists implement EMDR treatment with women survivors of child sexual abuse? Results indicated that therapists implemented EMDR by building rapport, conducting a

thorough assessment, focusing treatment on the most distressing elements of past traumas and present triggers, and teaching the client skills for coping with distress. Chapter 5 includes interpretation and implications of these results.

Chapter 5: Discussion

Introduction

Several therapies have been introduced to cater to the needs of patients with history of abuses and traumatic experiences. EMDR, which is classified as a trauma-focused treatment (Chen et al., 2014; van den Berg & van der Gaag, 2012), is one of the available therapies. Several researchers also stated that the EMDR approach is effective in treating PTSD, depression, and anxiety (Fergusson et al., 2013; Pérez-Fuentes et al., 2013).

There is a lack of consensus on the most effective treatment for adults who have adult onset trauma due to psychological difficulties resulting from childhood trauma (Ehring et al., 2014). Even though EMDR may be applicable in the treatment of adults who are survivors of child sexual abuse, uncertainty or lack of familiarity with EMDR may reduce therapists' use of the modality with victims of sexual abuse or assault (Edmond, Lawrence, & Schrag, 2016). Previous researchers have provided evidence to support the efficacy of EMDR in treating patients suffering from psychological trauma (de Bont, van Minnen & de Jongh, 2013; Ehring et al., 2014; Shapiro, 2014). Ricci and Clayton (2016) stated that EMDR is an effective method for patients who suffered childhood maltreatment or different physical abuses. There is also limited information about perceptions of therapists about EMDR as a tool in assisting adult women clients. In line with this, the purpose of this phenomenological qualitative study was to explore the perceptions of therapists about EMDR as a tool to assist adult women survivors of child

sexual abuse through the healing process and to regain their abilities to function and behave appropriately.

This study needed to be conducted to add more information about the use of EMDR for treating cases of adult women with childhood history of chronic sexual abuse. The perceptions of therapists about the use of EMDR to help adult women victims of childhood sexual abuse will be helpful in developing a broader range of proven strategies for clinical interventions to help these individuals heal and regain their abilities needed to function and behave appropriately. Women survivors of child sexual abuse will also benefit from this study. This study will add more information so that women survivors of child sexual abuse know how to handle and quickly recover from current difficult interpersonal and social situations.

There were five themes that emerged in this study. The first theme is the perceived effects of EMDR on women child sexual abuse survivors included initial resistance to the treatment, short-term and long-term relief from shame and anxiety, enhanced ability to function and behave appropriately, and empowerment. The second theme is that therapists perceived EMDR as more effective in treating child sexual abuse trauma than other treatment options because it involved the body and worked rapidly, although it may involve a danger of dysregulating the patient. The third theme is the perceived role of EMDR in a treatment program is to allow patients to remember traumatic events without reliving them, in order to free patients from shame and prepare them to learn more effective coping skills. The fourth theme is that the right time to introduce a client into EMDR treatment was perceived to be when the client is not

suicidal or excessively dissociative, when the client's current circumstances are stable and safe, and when the client can be trusted to report distress. The fifth theme is that therapists implemented EMDR by building rapport, conducting a thorough assessment, focusing treatment on the most distressing elements of past traumas and present triggers, and teaching the client skills for coping with distress. These are all new knowledge, as there is limited information about the perceptions of therapists about the use of EMDR as a treatment to women survivors of child sexual abuse.

Interpretation of the Findings

Research Question 1

RQ1: What are the perceptions and experiences of therapists about EMDR as a tool in assisting adult women clients through the healing process and regaining their abilities to function and behave appropriately? The therapists have perceived positive effects of EDMR with women who had histories of child sexual abuse. Moreover, the therapists also experience EDMR as being more effective compared to other treatment options with women child sexual abuse survivors.

The findings to the first research question extended knowledge in the discipline. Only a few researchers have explored the perceptions and experiences regarding EMDR as a tool in assisting adult women clients through the healing process and regaining their abilities to function and behave appropriately. The findings of the study contributed to understanding the role of EMDR in the treatment of women survivors of child sexual abuse. The findings of this study extended the findings of previous studies through

adding the perspective of the therapists about the effectiveness of EMDR as a treatment to women who had histories of child sexual abuse.

Research Question 2

ReQ2: How have therapists perceived the effects of EMDR with women who had histories of child sexual abuse? What changes did they observe, and what did they like and/or dislike about EMDR? The perceived effects of EMDR on women child sexual abuse survivors included initial resistance to the treatment, short-term and long-term relief from shame and anxiety, enhanced ability to function and behave appropriately, and empowerment. This finding extends the knowledge in the discipline about the application of EMDR on women who are survivors of sexual abuse when they were children. Previous researchers have explored the use of EMDR as a treatment to this population. Jarero et al. (2014) used a camp-based treatment for severely traumatized children and adolescents that incorporated EMDR into its overall therapeutic approach. Participants were 16 children aged nine to 13 years, most of whom had experienced both sexual and physical abuse (Jarero et al., 2014). These participants attended an 8-day trauma recovery camp. There was significant improvement in PTSD symptoms observed following EMDR treatment among the participants (Jarero et al., 2014).

Several researchers have confirmed that EMDR reduces symptoms of PTSD, which often include anxiety and depression (Bilal et al., 2015; Chen et al., 2014). In a single case study, a man has exhibited substantial decreases in symptoms of PTSD including hyper-arousal, anxiety, flashbacks, and nightmares after 17 sessions of EMDR

(Bilal et al., 2015). Van den Berg and van der Gaag (2012) also found that EMDR was associated with improvements in symptoms of PTSD, anxiety, and depression.

This finding aligned with the theory of Lazarus (1993). In the context of this study, the victim assessed the act of sexual abuse as a child and as an adult through the two forms of appraisal: primary and secondary. It might also be the same environment that may help in coping with such stress (Lazarus, 1993). EMDR was perceived by the therapists as an effective treatment approach in women who had histories of child sexual abuse as it reduced their shame and anxiety, enhanced ability to function and behave appropriately, and made them feel empowered about their situation. EDMR might help individuals suffering from trauma to face their situation and to help them cope.

Research Question 3

RQ3: How did therapists perceive EMDR in comparison with other treatment approaches for this population? What were benefits or drawbacks observed? Therapists perceived EMDR as more effective in treating child sexual abuse trauma than other treatment options because it involved the body and worked rapidly, although the treatment may involve a danger of dysregulating the patient. This finding confirms the results of previous studies about the use of EMDR in comparison with other treatment approaches. However, previous researchers reported no significant difference in the results of comparing EMDR with other treatment approach. It seems that therapists perceive EMDR as more effective as the patients no longer need to be exposed to the trauma repeatedly.

Previous researchers compared EMDR with other treatment approaches. Diehle et al. (2015) compared EMDR with trauma-focused CBT, which is considered a leading therapeutic approach for traumatized patients. Forty-eight children between the ages of eight and 18 years were randomly assigned to one of the two treatments. There were significant changes in the PTSD symptoms of the children in the two groups. There was no significant difference in the effects between EMDR and trauma-focused CBT (Diehle et al., 2015). In a meta-analysis, Leenarts et al. (2013) concluded that EMDR had resulted in significant reductions in PTSD symptoms in children in three studies, but expressed caution in interpreting these findings due to methodological limitations such as small sample sizes. In another meta-analysis, Morina, Koerssen, and Pollett (2016) also found that EMDR was one of several successful forms of therapy for adolescents with PTSD.

De Bont et al. (2013) conducted a study about 10 adults PTSD and comorbid psychotic disorders (i.e., schizophrenia, schizoaffective disorder), comparing EMDR and prolonged exposure therapy. The prolonged exposure treatment consisted of detailed recounting of traumatic events by participants, which was audio recorded so that they could replay the recording subsequently (de Bont et al., 2013). One of the assumptions of prolonged exposure treatment is that continued exposure to the traumatic memories will eventually lead to extinction of associated fear (de Bont et al., 2013). After the treatment period of 12 weeks, seven of the 10 participants no longer met criteria for PTSD diagnosis (de Bont et al., 2013). However, there were no significant differences found between EMDR and prolonged exposure treatment approaches.

In another study, immediate EMDR was compared with eclectic therapy for individuals who had experienced aggression in the workplace, such as physical assault, verbal abuse, or threats (Brennstuhl et al., 2013). Acute stress disorder includes symptoms such as anxiety and avoidance as well as a precursor to PTSD (Brennstuhl et al., 2013). In a sample of 34 victims of workplace aggression, Brennstuhl et al. (2013) assigned participants to receive either EMDR or eclectic therapy within 48 hours of the event. Brennstuhl et al. concluded that EMDR was more effective in the reduction of acute stress symptoms than eclectic therapy. Three months after the event, Brennstuhl et al. conducted a follow-up on whether the participants developed PTSD. The participants in the EMDR group had not developed PTSD (Brennstuhl et al., 2013), whereas PTSD symptoms were detected in the participants of the eclectic therapy group.

These studies included comparisons of EMDR with other treatments. Most of the researchers did not find any significant difference between EDMR and the other treatments. EDMR was found to be more effective in reducing the PTSD symptoms of the participants. Additionally, Orbke and Smith (2013) suggested that EMDR might be combined with strengths-based therapy, which would build survivors' resilience while also processing their trauma histories.

This finding extended the conclusion of previous researchers through the addition of the perceptions of therapists. These therapists are the most experienced in providing treatment to this population. The perspectives of these therapists are important, especially in determining the most effective approach in treating women who had histories of child sexual abuse.

In the transactional theory of stress and coping, the relationship of the person with the environment is important in understanding the stress and coping processes of an individual (Lazarus & Folkman, 1987). Another core proposition of the theory is that psychological stress has two aspects or phases that may occur consecutively or simultaneously: (a) primary appraisal or evaluation of the stressor, which involves the determination of the significance or meaning of an event for a person, and (b) secondary appraisal, which is used to explore coping or the individuals' perceptions of whether they are capable and have the tools to address the stressor (Lazarus, 1993). Depending on the appraisal of the individual, coping methods will then be employed accordingly (Lazarus & Folkman, 1987). There are two types of coping methods: emotion-focused coping and problem-focused coping (Lazarus, 1993). The finding that EMDR was perceived by therapists are more effective compared to other treatment approaches is consistent with the transactional theory of stress and coping. The EMDR helps the patient in her primary and secondary appraisal and determines the appropriate coping method to use to be able to overcoming the trauma or becoming desensitize to the negative memories.

Research Question 4

RQ4: When is the right time to introduce clients into EMDR treatment? The fourth research question was about determining the right time to introduce client into EMDR treatment. The perceived role of EMDR in a treatment program is to allow patients to remember traumatic events without reliving them, in order to free patients from shame and prepare them to learn more effective coping skills. This finding provides clarification on the perceptions of therapists about the role of EMDR in assisting adult

women clients in their healing process. This is consistent with previous studies about EMDR and how it helps patients. In EMDR, eye movements are induced in connection with exposure to the patient's traumatic memories, which facilitates access to stored memories and desensitization to related anxiety (Chen et al., 2014). Patients only need to describe the traumatic experience in general or simply imagine the events (Shapiro, 2014). Moreover, therapists using EMDR guide patients to retrieve their traumatic memories and gradually integrate them into healthy cognitive and emotional schemas (Chen et al., 2014).

There were only two studies on using EMDR with women who have been sexually abused. Aranda, Ronquillo, and Calvillo (2015) conducted a single case quantitative study with an 18-year-old woman who had been sexually abused as a child. The woman presented with significant depression and PTSD as well as engaged in self-injury and multiple suicide attempts within the previous 6 years (Aranda et al., 2015). Aranda et al. wanted to determine the clinical progress associated with EMDR and the neuropsychological effects of this therapy. After 11 sessions of EMDR, the woman exhibited substantial decreases in depressive symptomatology and no longer met diagnostic criteria for PTSD. After a 1-year follow-up, these treatment effects were maintained (Aranda et al., 2015). There were also improvements in neuropsychological indicators, such as decreased heart rate, increased attentional regulation, improved cognitive processing speed, and improved working memory (Aranda et al., 2015). These improvements helped the woman through her healing process and to be able to function and behave appropriately. In another study, Paylor and Royal (2016) sought to review the

literature on EMDR for this population. Paylor and Royal only found one study that included women survivors, with one including adolescents and the other including a mixed sample of traumatized individuals. This study also presented positive effects of EMDR as a treatment. Paylor and Royal noted that the limited sample size of participants in previous studies served a significant limitation, especially given the random assignment of participants to multiple treatment groups.

The findings from these studies are consistent with the transactional theory of stress and coping (Lazarus & Folkman, 1987). The use of guided eye movements to support desensitization to anxiety was beneficial. This therapy would be expected to reduce the patient's tendency to become overwhelmed in response to stressors and support adaptive appraisal and coping (Shapiro, 2013). This is helpful in addressing the stressful condition of the individual and to determine the best way to cope with the stress.

The right time to introduce a client into EMDR treatment was perceived to be when the client is not suicidal or excessively dissociative, when the client's current circumstances are stable and safe, and when the client can be trusted to report distress. This finding contributes new knowledge to the discipline. There are only a few studies about the use of EMDR in treating women survivors of child sexual abuse. There was no information on the right time to introduce EMDR to the client.

Research Question 5

RQ5: How did therapists implement EMDR treatment with women survivors of child sexual abuse? Therapists implemented EMDR by building rapport, conducting a thorough assessment, focusing treatment on the most distressing elements of past traumas

and present triggers, and teaching the client skills for coping with distress. This finding contributes new knowledge to the discipline. The previous studies about EDMR were focused on the effects of the treatment or a combination of EMDR with other treatments. There was no study that focused on the implementation of the therapists of EMDR treatment with women survivors of child sexual abuse. There are limited studies about the use of EMDR in women survivors of child sexual abuse. There is also limited knowledge on the perceptions of therapists about EMDR as a treatment for this population. This finding provides new information about how EMDR is administered to patients.

Limitations of the Study

The sample served as a limitation for this study. It is a small and homogenous sample of ten therapists working in the state of New Jersey. The small sample size resulted in the findings not being generalizable to the whole population of therapists. The results of the study may only accurately represent the experiences of therapists who treat women survivors of child sexual abuse in this locality, and yet fail to fully represent the experiences of therapists working in other regions of the United States or globally. The location of the therapists was also focused in the state of New Jersey. The findings might not be transferable to other locations.

The focus of the current study was also female survivors. The experience of therapists who use EMDR with women may not be fully reflective of those who treat male survivors of child sexual abuse. The results of the study might only be applicable to women survivors of child sexual abuse.

The instrument might also serve as a limitation. There was limited information about the perceptions of therapists about the use of EMDR. The interview protocol was developed by the researcher. The interview questions were not pilot tested to determine whether they would generate the information needed for the study.

Another limitation of this work is that the sample was biased. The sample only included therapists who belonged to an EMDR organization, and who are actively practicing EMDR, increasing the chances that they already have a positive view of using EMDR.

Recommendations for Future Research

Future researchers could increase the sample size and ensure a heterogeneous sample. The increase in sample size to at least 15 could make a significant impact to the richness of the data. Moreover, a heterogeneous sample would make the results more credible. An expansion of the geographic location of the study could improve the validity of the results. Recruiting therapists from different states might ensure transferability of the results of the study to the whole country. The findings might be applicable even in other countries.

Therapists who treat male survivors of child sexual abuse and use EMDR as a treatment could also provide a new direction to the discipline. This will provide more information about the use of EMDR as a treatment for this population but focuses on the male survivors. There might be similarities between the use of EMDR in both male and female survivors of child sexual abuse. Moreover, future researchers could also conduct a

study with both the perceptions of the therapists and the patients in the effectiveness of EMDR.

The instrument protocol used in this study could be used in future studies to determine its validity. Moreover, future researchers could also improve the interview questions to better collect data. More qualitative studies are needed to obtain in-depth information about EDMR as a treatment. Future researchers could also use quantitative methodology once there is enough information about EMDR as a treatment. The quantitative studies could lead to generalizations about EMDR as a treatment to survivors of child sexual abuse.

Implications of the Findings

The findings of this study are consistent with the selected theoretical framework. In the context of this study, psychological stress was felt from (a) the interaction between the victim (woman) during childhood and the perpetrator of sexual abuse at that time, and (b) the interaction between the victim (woman) as an adult and the people that surround her. In relation to the theory of Lazarus (1993), the victim in this study (e.g., adult woman with history of childhood sexual abuse) assesses the act of sexual abuse as a child and as an adult through the two forms of appraisal. It is also the same environment that may help in coping with such stress (Lazarus, 1993). Therefore, if the proper treatment of coping mechanism is placed in the environment of the victim, then coping will be made easier. One way of improving the ability to cope through trauma is by undergoing therapy, which, for the case of this study is EMDR.

The findings of this study also help advanced the research methodology in this discipline. The previous researchers about this topic focused on experimental designs about the effectiveness of EMDR and other treatment approaches. The use of qualitative methodology provided a rich and detailed account of the perception of therapists about the use of EMDR in treating women survivors of child sexual abuse.

Academic researchers, clinical psychologists and psychotherapists, and abused women might be interested in knowing the findings. Academic researchers could use the findings to address the gap in literature on the use of EMDR for treating cases of adult women with childhood history of chronic sexual abuse. The findings of the study extended and contributed new knowledge in the discipline about the perceptions of therapists about EDMR. The findings of the study could serve as a foundation for future studies about the topic.

Clinical psychologists and psychotherapists might also be interested in the findings of the current study to develop a broader range of proven strategies for clinical interventions for long-term symptoms related to chronic childhood sexual abuse. Clinical psychologists and psychotherapists are experts in treating long-term and short-term implications of childhood sexual abuse. The findings of this study could be used to develop or modify existing treatment procedures and concepts to improve the potential outcomes for patients with experiences of childhood sexual abuse. They could use EMDR in combination with other treatment approaches to women survivors of child sexual abuse. Clinical psychologists and psychotherapists could undergo training for

EDMR to be able to provide this treatment as an option to women survivors of child sexual abuse.

Women survivors of child sexual abuse might also be interested in the findings of the study. EDMR was perceived as an effective treatment and useful in the healing process of women survivors of child sexual abuse. Women who were sexually abused might have hope that their traumatic experiences can be treated and they can regain their abilities to function and behave appropriately. Women survivors of child sexual abuse could use the findings from this study directly for themselves by implementing new strategies for the self- healing process. Positive social change can occur with more knowledge and awareness about women survivors of child sexual abuse and the various available treatments. Informing and educating the public about the long-term impact of women's health with histories of childhood sexual abuse could also help increase the reporting of such incidences More individuals could be more understanding toward other women who are having a hard time.

Conclusion

The purpose of this phenomenological qualitative study was to explore the perceptions of therapists about EMDR as a tool to assist adult women survivors of child sexual abuse through the healing process and to regain their abilities to function and behave appropriately. In Lazarus' (1993) psychological stress theory, it was concluded that if the proper treatment of coping mechanism is placed in the environment of the victim, then coping will be made easier. The transactional theory of stress and coping is

expected to provide a useful framework for exploring therapists' perspectives on EMDR as a treatment for women who are survivors of child sexual abuse.

Based from the literature review, EMDR has been considered an effective first-line treatment for PTSD (Chen et al., 2014). EMDR also requires less time and detailed exposure to traumatic memories (Chen et al., 2014). From the findings of previous studies, EMDR could be applied in the treatment of women survivors of child sexual abuse. Previous researchers have concluded that its application to this context is an important area of research (Aranda et al., 2015; Shapiro, 2014). There is little research on the positive effects of EMDR on psychological symptoms of women survivors of child sexual abuse (Paylor & Royal, 2016). However, previous studies on the application of EMDR on women who are survivors of child sexual abuse is limited and characterized by small sample sizes.

There were five themes that emerged in this study. The first theme is the perceived effects of EMDR on women child sexual abuse survivors included initial resistance to the treatment, short-term and long-term relief from shame and anxiety, enhanced ability to function and behave appropriately, and empowerment. The second theme is that therapists perceived EMDR as more effective in treating child sexual abuse trauma than other treatment options because it involved the body and worked rapidly, although it may involve a danger of dysregulating the patient. The third theme is the perceived role of EMDR in a treatment program is to allow patients to remember traumatic events without reliving them, in order to free patients from shame and prepare them to learn more effective coping skills. The fourth theme is that the right time to

introduce a client into EMDR treatment was perceived to be when the client is not suicidal or excessively dissociative, when the client's current circumstances are stable and safe, and when the client can be trusted to report distress. The fifth theme is that therapists implemented EMDR by building rapport, conducting a thorough assessment, focusing treatment on the most distressing elements of past traumas and present triggers, and teaching the client skills for coping with distress.

The findings of the study provided a deeper understanding of the role in the treatment of women survivors of child sexual abuse. It was expected that therapists would find EMDR as an effective treatment approach to women survivors. The findings provided evidence that EMDR is supported in the literature as well as therapists with experience in this area. Chapter 5 concludes this study.

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Appendix A: Semistructured Interview Protocol

RQ1. What are the perceptions and experiences of therapists about EMDR as a tool in assisting adult women clients through the healing process and regaining their abilities to function and behave appropriately?

-What are your general thoughts about EMDR for this population?

-How do you feel about EMDR as a treatment modality for this population?

RQ2. How have therapists perceived the effects of EMDR with women who had histories of child sexual abuse? What changes did they observe? What do you like and/or dislike about EMDR?

-Were there any positive changes? If so, what were they?

-Were there any adverse changes? If so, what were they?

RQ3. How did therapists perceive EMDR in comparison with other treatment approaches for this population? What were benefits or drawbacks observed?

-What were the benefits of EMDR compared to other methods? What other methods were these?

-What were the drawbacks of EMDR compared to other methods? What other methods were these?

RQ4. When is the right time to introduce client into EMDR treatment?

RQ5. How did therapists implement EMDR treatment with women survivors of child sexual abuse?

Appendix B: Demographic Survey

Age:

Gender:

Number of clients seen each week who have experienced sexual trauma:

Training in EMDR:

Number of hours per week providing EMDR:

Length of experience providing EMDR:

Appendix C: Emergent Themes, Codes Contributing to Themes, and Representative Quotations from Themes

Theme	Codes contributing to theme	Representative quotation from theme
Theme 1: Perceived effects of EMDR	Bogged down/moving forward; experiencing relief; initial distress/resistance; more stabilizing than distressing; overall empowerment; seeing themes;	"[EMDR is] so amazing because it is just [the patient]. It's however they want to heal, it's what's best for them." (Participant 4)
Theme 2: Therapists perceived EMDR as more effective than other treatment options	Acupressure desensitization; EMDR as somatic/holistic; nothing better for PTSD; on par with other approaches; primary approach used; talk therapy not enough; thematic approach	"There's nothing else like [EMDR] for the removal of PTSD symptoms. Nothing. That shaking like a leaf thing, that fear, it needs tweaking for this usually but it can be great at removing the sexual shame." (Participant 1)
Theme 3: The perceived role of EMDR	Address core negative beliefs; building resource capacity; changing memory storage; discharge of stress; freeing from shame; perspective changing; remembered but not relived	"[The traumatic event] will be remembered, not relived. It will be farther away, not vivid and throbbing. It won't make your heart pound and it won't, you will remember that you were afraid but you won't feel it now." (Participant 1)
Theme 4: The right time to introduce a client into EMDR	Dissociative or suicidal; safety/stability of present environment; stability and ability to self-regulate; trust in client telling truth	"You really have to be sure the client has good ego strength and a good support system and is not extremely fragile. You don't want to do EMDR with somebody that's already very fragile. The client has to be doing fairly well overall emotionally." (Participant 8)
Theme 5: Strategies for implementing EMDR	Adding to skill set; assessment and rapport; explaining how EMDR works; importance of a thorough case history; learning/dealing with present triggers; screening for dissociation	"With EMDR we talk about it being a protocol: past, present and future. We do the past, the original event, the things that got the river running, we go to the source. We do the past and we do the present triggers, the reminders, the implications, how's this affecting you today." (Participant 1)

Appendix D: Theme Frequencies and Percentages

Theme	Frequency (*n*)	% coverage
Theme 1: Perceived effects of EMDR	26	21%
Theme 2: Therapists perceived EMDR as more effective than other treatment options	24	19%
Theme 3: The perceived role of EMDR	41	32%
Theme 4: The right time to introduce a client into EMDR	15	12%
Theme 5: Strategies for implementing EMDR	20	16%