Clinicians' experiences of using Eye Movement Desensitisation and Reprocessing (EMDR) with adolescents who have experienced trauma: a qualitative study in the UK

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Abstract

In the United Kingdom, there are growing pressures for adolescents' mental health support and post-trauma interventions. Eye movement desensitisation and reprocessing (EMDR) therapy is recommended in the UK by the National Institute for Health and Care Excellence (NICE, 2018) for treating post-traumatic distress in young people. Whilst quantitative research has offered promising findings on the outcomes of EMDR with young people, and limited qualitative research has examined clinicians' experiences of using EMDR in the UK with various populations, there is a lack of qualitative understanding of adolescent-specific EMDR practice in the UK. To address this gap, this research explored clinicians' experiences of delivering and adapting EMDR as a trauma intervention in a UK context. Semi-structured interviews were conducted with 15 accredited EMDR clinicians who use EMDR with adolescents across various UK contexts. Data was analysed using Braun and Clarke's (2006, 2019) six phases of reflexive thematic analysis. The analysis found five main themes and six associated subthemes. Findings underscore the importance of the therapeutic relationship and containment in adolescent EMDR. The findings also discuss how clinicians adapted EMDR to meet adolescents' developmental and relational needs. Clinicians perceived adolescent EMDR as a distinctive and transformational trauma intervention, but only when the conditions were right. Clinicians described adolescent EMDR as system-dependent, where UK and adolescent systems could either hold or hinder EMDR. Important implications for adolescent EMDR practice, workforce, training, and supervision recommendations in a UK context are highlighted.

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Frequently Used Acronyms

To aid the reader, the list below provides frequently used acronyms in this thesis.

Acronym	Phase Related to the Abbreviation
ACEs	Adverse Childhood Experiences
AF-EMDR	Attachment-Focused Eye Movement Desensitisation and Reprocessing
AIP	Adaptive Information Processing
BLS	Bilateral Simulation
CAMHS	Children and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
EMDR	Eye Movement Desensitisation and Reprocessing
G-TEP	Group Traumatic Episode Protocol
IFS	Internal Family Systems
IGTP	Integrative Group Treatment Programme
NC	Negative Cognitions
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PC	Positive Cognitions
PTSD	Post-Traumatic Stress Disorder
RTA	Reflexive Thematic Analysis
SUDs	Subjective Units of Disturbance scale
TF-CBT	Trauma-Focused Cognitive Behavioural Therapy
UK	United Kingdom
VOC	Validity of Cognition

Chapter 1: Introduction

Chapter Overview

This chapter discusses the context of adolescent mental health and trauma in the United Kingdom (UK), highlighting the increasing prevalence of adolescent psychological difficulties and the growing pressures on young people's mental health services. It outlines the impact of trauma on adolescents and how post-traumatic stress disorder (PTSD) presents in this population. This chapter then reviews evidence-based psychological interventions recommended by the National Institute for Health and Care Excellence (NICE, 2018) for adolescent PTSD, with a particular focus on Eye Movement Desensitisation and Reprocessing (EMDR) therapy. It considers the current theoretical understanding, eight-phase protocol, training, and supervision guidance for EMDR. This chapter considers the current evidence base for the use of EMDR with adolescents, as well as how it is practised in the UK. It concludes by outlining key gaps in the research, which provide the rationale for the present study, which explores clinicians' experiences of delivering EMDR to adolescents in UK clinical settings.

Adolescent Mental Health and Trauma in a UK Context

Prevalence and Service Demand

Adolescent mental health has become a significant public health priority in the UK. This is demonstrated by the 2023 Mental Health of Children and Young People Survey in England, which found that approximately one in five children and young people were likely to have a mental health difficulty, which is a significant increase from one in nine estimated in 2017 (NHS Digital, 2023).

In line with this increasing prevalence, there is an increasing demand for young people's mental health support in the UK. This is shown in 2024 data, which found that over

350,000 young people in the UK were awaiting an initial Children and Adolescent Mental Health Service (CAMHS) assessment, with young people and caregivers reporting deterioration in their mental and physical health whilst waiting for support (Han et al., 2026; Royal College of Psychiatrists, 2024; YoungMinds, 2024). Recent NHS data shows that nearly 849,000 under-18s had at least one contact with NHS-funded mental health services between July 2025 and September 2025, demonstrating the significant pressure on young people's mental health services in the UK (NHS England, 2025a).

The COVID-19 pandemic had a significant influence on these pressures, with prolonged social isolation, education disruptions, and increased family economic strain during this time associated with increases in adolescents' anxiety, depression, and trauma-related symptoms (Loades et al., 2020; Viner et al., 2022). This had a greater impact on young people with existing mental health difficulties, those from socio-economically disadvantaged backgrounds, and those affected by domestic violence (The Children's Society, 2022).

Adverse Childhood Experiences and Trauma Exposures

Adverse childhood experiences (ACEs), such as abuse, neglect, domestic violence, and parental mental illness, have a significant impact on adolescents' psychological distress (Felitti et al, 1998). Cumulative exposure to ACEs is strongly associated with an increased risk of depression, anxiety, behavioural difficulties, substance misuse, and post-traumatic symptoms across the lifespan (Hughes et al., 2017; Kessler et al., 2010).

Existing evidence highlights the high prevalence and impact of ACEs and trauma exposure during adolescence. Using a representative UK sample, Lewis et al. (2019) found that 31% of young people had experienced at least one traumatic event by the age of 18. They also found that trauma-exposed young people were twice as likely as their peers to experience

mental health difficulties; one in four trauma-exposed young people developed PTSD; and three in four of those with PTSD had a comorbid mental health condition by age 18 (Lewis et al., 2019). Despite this high level of need, Lewis et al. (2019) found that only 20% of young people with PTSD had received support from a psychologist, psychotherapist, or counsellor. These findings emphasise the importance of early and responsive psychological intervention to support adolescents' mental health post-trauma to reduce the risk of long-term psychological distress.

Developmental Impact of Trauma

Research has shown the impact that adolescent trauma exposure can have at various levels. On an intrapersonal level, trauma can disrupt adolescents' emotional regulation, impulsivity, and identity development (Perry & Szalavitz, 2017; van der Kolk, 2014). On an interpersonal level, trauma can destabilise adolescents' attachment security, trust, and peer relationships (Allen et al., 2007; McLaughlin et al., 2014). On a broader level, childhood trauma has been associated with increased engagement in risky behaviours, negatively impacting education, and increased conflict with authority amongst young people (Copeland et al., 2007; Jackson et al., 2023; Vaswani, 2018). Additionally, repeated activation of the body's stress-response systems because of trauma exposure can increase long-term physical health risks (Shonkoff & Garner, 2012). These developmental and biological aspects make adolescence a particularly important period for trauma-focused psychological interventions, whilst also highlighting that young people may require complex and individualised post-trauma intervention to meet their unique needs.

Post-Traumatic Stress in Adolescents

The persistence and severity of ongoing post-trauma distress symptoms determine whether there is a diagnosis of PTSD. PTSD is defined in both the Diagnostic and Statistical

Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) and the International Classification of Diseases (ICD-11; World Health Organisation [WHO], 2019). However, these diagnostic frameworks were developed mainly from adult samples, meaning they may not fully capture adolescents' specific neurodevelopmental, emotional, and social characteristics and how these impact post-trauma presentations. As discussed in the following paragraph, PTSD may present differently in adolescents compared to adults. Therefore, it has been argued that a developmentally sensitive understanding of post-trauma symptomatology is essential to young people's trauma-informed care (McLaughlin et al., 2013).

Although this research uses the diagnostic construct of PTSD to remain consistent with the wider evidence base, service structures, and NICE guidelines, the medical model has been criticised for medicalising understandable responses to trauma and overlooking the relational, developmental, and contextual factors that influence distress (Johnstone et al., 2018; Summerfield, 2001). From a clinical psychology perspective, a formulation-based approach provides a more individualised understanding of trauma-related distress. Nevertheless, the term PTSD is used in this research to maintain consistency with the existing literature and clinical practice guidelines. Adolescents' post-trauma symptoms are often expressed differently from adults (Pynoos et al., 2009). Research has indicated that adolescents may externalise psychological distress through aggression, risk-taking behaviours, or substance misuse, increasing the likelihood of misdiagnosis as conduct or attention-related difficulties, meaning young people may not access appropriate trauma-informed treatment (Copeland et al., 2007; Ford et al., 2009; Gerson & Rappaport, 2013). It has also been identified that dissociation, particularly following complex childhood and interpersonal trauma, may be more likely to present in adolescents (Dalenberg et al., 2012; Diseth, 2005). Somatic symptoms, such as recurrent pain or fatigue, have also been identified

as common symptoms of post-traumatic distress in young people, reflecting the embodied nature of such distress in this population (Danese & Baldwin, 2017; van der Kolk, 2014).

Evidence has shown that trauma-exposed adolescents are at increased risk of comorbid mental health difficulties, including depression, anxiety, substance misuse, self-harm, and suicidality (Lewis et al., 2019; McLaughlin et al., 2013). Given that adolescence is characterised by ongoing identity development, heightened social pressures, and continuing neural plasticity across emotional regulation networks, implementing trauma-focused psychological interventions during adolescence may be a significant developmental period characterised by both complex and transformative change (Blakemore & Mills, 2014; Steinberg, 2005).

From a systemic perspective, effectively identifying and treating adolescent PTSD often requires multi-agency collaboration across various agencies, including health, education, and social care sectors (Children and Young People's Mental Health Coalition, 2023; NICE, 2018). However, it has been shown that PTSD symptoms often go unrecognised and untreated for some populations, especially amongst marginalised groups. This is often due to cultural differences in how symptoms are expressed, as well as stigma and systemic inequities that further limit access to timely trauma-focused interventions (Eberle et al., 2024; McGorry et al., 2025; Tarasenko et al., 2025). The Children and Young People's Mental Health Coalition (2023) emphasised the need for integrated, trauma-informed, and equitable services to ensure that young people's mental health and post-trauma symptoms are accurately identified and appropriately treated.

Psychological Interventions for Adolescent PTSD

Historically, adolescents presenting with trauma-related symptoms were often offered non-directive or supportive therapies, including counselling and play-based approaches

(Wethington et al., 2008). While such interventions may foster emotional containment and therapeutic alliance, some have argued that these interventions may not adequately process the maladaptive memory networks or trauma-related cognitions characterising post-trauma distress (Silverman et al., 2008).

In recent decades, national and international guidelines have recommended evidence-based psychological interventions, including Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and EMDR, to treat adolescents presenting with PTSD (NICE, 2018; WHO, 2019). NHS implementation guidance has emphasised the need for early intervention, integrated care, and improved access to psychological therapies for young people in the UK presenting with complex, trauma-related distress (NHS England, 2024a, 2024b). This highlights the importance of understanding trauma intervention practices within UK-specific contexts.

Trauma-Focused Cognitive Behavioural Therapy

TF-CBT is the most extensively researched psychological intervention for treating post-traumatic distress symptoms in adolescents (Lenz & Hollenbaugh, 2015). TF-CBT combines cognitive, behavioural, relational, and trauma-informed practices to promote cognitive reappraisal of maladaptive trauma-related cognitions, reduce behavioural avoidance, and improve trusting caregiving relationships where appropriate (Cohen et al., 2017; Ehlers & Clark, 2000). Meta-analyses have found that TF-CBT is effective in reducing PTSD symptoms amongst adolescents, alongside comorbid anxiety and depression (Cary & McMillen, 2012; Thielemann et al., 2022, 2024).

Despite its strong evidence base, the exposure, verbal, and cognitive demands of TF-CBT may mean this intervention is not appropriate or effective for all adolescents, particularly those with complex or developmental trauma histories, dissociation, difficulties

with affect regulation, or problems with sustained cognitive engagement (Cohen et al., 2012; Ford & Courtois, 2013). These barriers of TF-CBT have contributed to growing interest in alternative trauma-focused psychological interventions, including EMDR. Some literature suggests that EMDR may be more suitable for certain adolescents compared to traditional talking therapies, as it places less emphasis on explicit trauma narration, meaning adolescents who find detailed verbal processing of trauma experiences difficult may particularly benefit from this approach (Gkintoni et al., 2024; Shapiro, 2014; WHO, 2013).

Eye Movement Desensitisation and Reprocessing Therapy

As previously discussed, EMDR therapy is recognised by NICE (2018) guidelines for treating PTSD in young people, particularly where TF-CBT has not been successful as a first-line intervention. However, the International Society for Traumatic Stress Studies (2018) identifies EMDR as a first-line intervention for PTSD in adolescents, alongside TF-CBT.

Theoretical Foundations and Mechanisms of Change. Developed by Shapiro in the late 1980s (Shapiro, 1989), EMDR's mechanisms of change are arguably explained by the Adaptive Information Processing (AIP) model (Shapiro, 2001, 2018). The AIP model proposes that the brain has an innate capacity to process and integrate experiences into adaptive memory networks. It argues that new, neutral experiences are connected to existing memory neural networks, allowing for learning and everyday functioning (Shapiro, 2018). However, when an experience is highly distressing, the AIP model argues that this processing system becomes overwhelmed, resulting in the experience being stored in a dysfunctional way in the memory network, meaning the memory remains unprocessed and isolated from adaptive memory networks. Consequently, these memories remain 'frozen in time', making them easily activated by triggers, leading to PTSD symptoms, including heightened psychological distress, intrusive images and thoughts, and negative self-beliefs (Solomon &

Shapiro, 2011). Therefore, according to the AIP model, post-trauma symptoms present due to the dysfunctional way the memory has been stored in the brain.

EMDR aims to facilitate the reprocessing of maladaptively stored memories by inducing a physiological state that supports dual-attention processing, often described as 'one foot in the present, one foot in the past', in which traumatic material is accessed whilst the individual remains grounded in the present-moment of safety. This dual-attention process is argued to reduce the vividness and emotional intensity of trauma memories, enabling new associations and adaptive meanings to emerge (van den Hout & Engelhard, 2012). In EMDR, individuals engage in dual-attention processing by recalling distressing material whilst simultaneously paying attention to bilateral stimulation (BLS), such as guided eye movements, tactile tapping, or auditory tones (Lee & Cuijpers, 2013).

Neurobiological research further supports the proposed neuroanatomical mechanisms of change in EMDR, with studies identifying BLS decreasing activation in fear-associated brain regions (the amygdala) and increased activation in emotion-regulation regions (the prefrontal cortex) (Baek et al., 2019; Pagani et al., 2017). Whilst several studies have proposed various cognitive and neurobiological explanations for how EMDR works, the evidence remains in its infancy. Current understanding suggests that several interacting mechanisms likely explain EMDR's effectiveness. These include competition for working memory resources, automatic attention-orienting processes, reductions in the vividness and emotional intensity of trauma memories, and processes similar to those in REM sleep and adaptive memory consolidation (Lee & Cuijpers, 2013; van de Hout & Engelhard, 2012; Wadji et al., 2022).

The Standard Eight-Phase EMDR Protocol. EMDR was developed as an eight-phase protocol, providing a structured framework for assessment, preparation, trauma

processing, and evaluation of therapeutic outcomes (Shapiro, 2001, 2018). There is no fixed time frame for each phase of EMDR; instead, progression through the phases is guided by the client's trauma presentation, stability, and comorbidities, which influence the pace of EMDR (Shapiro, 2001, 2018). The standard eight-phased EMDR protocol is as follows:

Phase 1: History Taking and Treatment Planning. This phase involves information gathering about the client's difficulties, history, resources, and functioning. It involves collaborative treatment planning to identify the sequencing of target memories, including past trauma events (often referred to as 'touchstone memories'), present triggers, and anticipated future challenges. Consideration is given to the complexity of the trauma (e.g., single incident versus complex trauma), dissociative symptoms, emotional regulation capacity, and readiness for engagement.

Phase 2: Preparation. In this phase, the focus is on establishing a therapeutic relationship and ensuring the client has sufficient stabilisation and resourcing strategies to tolerate trauma processing. Psychoeducation on the EMDR model, an introduction to the different mechanisms of BLS, and expectations for an EMDR session are discussed. Regulation strategies, such as grounding techniques, relaxation exercises, and imagery (e.g., calm/safe place exercise), are introduced and practised.

Phase 3: Assessment. During assessment, a target maladaptive memory network is accessed, with the client identifying the most distressing image representing that memory, the negative cognition (NC) about themselves linked to that memory (e.g., "I am powerless"), and a desired positive cognition (PC) (e.g., "I am in control now"). The client rates the validity of the positive cognition using the Validity of Cognition (VOC) scale and the level of emotional distress using the Subjective Units of Disturbance scale (SUDs). Associated emotions and bodily sensations are also assessed to establish a baseline for reprocessing.

Phase 4: Desensitisation. This phase involves the therapist guiding the client to focus simultaneously on fast sets of BLS and on emerging thoughts, images, emotions, or bodily sensations related to the target memory, to facilitate adaptive information processing. Desensitisation continues until the SUDs rating for the target memory is reduced to zero or to an ecologically appropriate level (for example, a SUDs rating of one if it is felt the client will not be able to get below this).

Phase 5: Installation. Once distress related to the target memory has reduced to an ecologically appropriate level, the installation phase focuses on strengthening the previously identified positive cognition. Installation involves using BLS whilst the client concentrates on integrating the positive belief with the target memory. The goal is to enhance the felt sense of adaptive cognition until it reaches a high level of perceived validity, as measured by the VOC scale.

Phase 6: Body Scan. This phase aims to process any residual material held in the body by asking the client to mentally scan their body while holding the target memory and positive cognition in mind. Any somatic tension, discomfort, or unusual sensations are identified and reprocessed using BLS until the body feels neutral or relaxed. This phase ensures that unresolved physiological components of the memory are processed.

Phase 7: Closure. Closure occurs at the end of each session. It aims to ensure that the client leaves feeling stable and emotionally regulated, regardless of whether reprocessing of a target memory is complete. A debrief is completed with the client, and stabilising is provided using relaxation or grounding techniques if needed.

Phase 8: Re-Evaluation. At the beginning of the next EMDR session, the previously processed targets are reviewed, and the SUDs and VOC ratings for that target are reassessed

to consider whether additional processing of the target memory is needed. New targets may be identified, and treatment planning is reviewed to guide ongoing intervention.

Developmental and Attachment-Informed Adaptations of EMDR. Using EMDR with adolescents often requires developmentally attuned adaptations. Examples include creative and playful methods such as visual metaphors, drawings, and storyboards, as well as extending the resourcing phase to support age-appropriate cognitive and emotional regulation (Alder-Tapia & Settle, 2023; Civilotti et al., 2021). Where appropriate, EMDR with adolescents may also incorporate caregiver involvement and attachment-informed modifications to enhance engagement, safety, and relational attunement during the intervention (Adler-Tapia & Settle, 2009; Greenwald, 2007; Rodenburg et al., 2009). Focusing on creativity, collaboration, and young people's agency has been shown to improve young people's engagement and retention in EMDR (Courtney, 2016; Little, 2023; van der Hoeven et al., 2023).

The standard EMDR protocol has evolved to incorporate attachment and relational frameworks to better meet the needs of clients with complex trauma and early relational disruptions. Attachment-Focused EMDR (AF-EMDR), developed by Parnell (2007, 2013), combines standard EMDR with attachment theory. This approach emphasises developing relational safety, strengthening emotional and imaginal safety, and extending resourcing to strengthen clients' adaptive internal working models prior to and during trauma reprocessing. AF-EMDR is considered particularly helpful for clients with insecure attachments and developmental trauma (Kemal Kaptan & Brayne, 2022; Knipe, 2015; Parnell, 2013). Emerging evidence has shown the perceived benefits of AF-EMDR in reducing adolescents' post-traumatic symptoms (Mahmood et al., 2025). However, the empirical evidence supporting AF-EMDR remains limited. Existing literature has primarily focused on theoretical development, clinical applications, and preliminary studies, with a lack of

randomised controlled trials evaluating AF-EMDR's efficacy or its benefits beyond standard EMDR (Kemal Kaptan & Brayne, 2022).

Evidence for EMDR with Adolescents. Although the evidence base for EMDR with adolescents remains in its infancy, current findings are encouraging. Research has indicated that EMDR significantly reduced symptoms of PTSD, anxiety, and depression amongst young people (de Haan et al., 2020; Moreno-Alcázar et al., 2017), with clinical outcomes of EMDR broadly comparable to TF-CBT (Gillies et al., 2016; Hoogsteder et al., 2022). These findings suggest that EMDR may represent a viable first-line trauma-focused intervention for young people.

Research suggests that EMDR may be a particularly developmentally and cognitively accessible intervention for adolescents, potentially producing faster symptom reduction than more cognitively demanding therapies such as TF-CBT (Karadag et al., 2020; Moreno-Alcázar et al., 2017). Unlike TF-CBT, EMDR does not rely as heavily on explicit cognitive restructuring or detailed verbal narration of traumatic experiences, which could make EMDR more accessible for adolescents who struggle with abstract reasoning, verbal reflection, or discussing traumatic experiences in detail (WHO, 2013).

Additional quantitative findings show EMDR's effectiveness across diverse adolescent populations. Karadag et al. (2020) reported significant and sustained reductions in PTSD and anxiety symptoms among young people following EMDR, with therapeutic gains maintained at six-week follow-up. Similarly, Ahmad et al. (2007) demonstrated improvements in post-trauma and depression symptoms in refugee adolescents, highlighting EMDR's applicability for adolescents with complex and cumulative trauma experiences. When compared to TF-CBT, EMDR with young people may achieve therapeutic gains in

fewer sessions for post-traumatic distress and co-morbid symptoms (de Roos et al., 2011; Rodenburg et al., 2009).

As well as research identifying the usefulness of EMDR in reducing young people's PTSD symptoms, evidence highlights its effectiveness in reducing comorbid depression, anxiety, and somatic distress (Meentken et al., 2020; Moreno-Alcázar et al., 2017). These findings align with EMDR's AIP model, which emphasises integration of affective, cognitive, and somatic components of trauma memories that need adaptive processing (Shapiro, 2018). This integrative focus may be particularly relevant for adolescents, whose trauma responses are often expressed through behavioural dysregulation and somatic symptoms rather than explicit verbal distress (Perry & Pollard, 1998; van der Kolk, 2014).

EMDR Training, Supervision, and Implementation in the UK. The EMDR Association UK, which is affiliated with EMDR Europe, is the professional body for EMDR for clinicians and researchers practising in the UK. It outlines the standards for EMDR training, accreditation, and clinical governance.

The highest standard of EMDR practice with young people is outlined in the EMDR UK Guidance for Good Practice for Children and Adolescents (EMDR Association UK, 2019, updated in 2025). This states that standard EMDR training (typically a seven-day programme divided into three or four parts provided by various accredited training providers in the UK) equips clinicians to use EMDR with client groups for whom they are already qualified to work. Once standard training is complete, these Good Practice EMDR guidelines suggest that clinicians can practice the standard EMDR protocol with those for "whom it is suitable and with whom they are qualified to work with" (EMDR Association UK, 2025, p. 2).

However, these current guidelines do not state a minimum chronological age for using the standard EMDR protocol. Rather than defining age-based guidance, it emphasises the suitability of the standard protocol in terms of developmental and emotional regulation capacity, alongside presenting difficulties, rather than age alone (EMDR Association UK, 2019, 2025). The current absence of clearly articulated age-based guidance places responsibility on clinician judgement, training, and supervision, contributing to variability in adolescent EMDR practice across services. The current guidelines also state that clinicians practising EMDR with adolescents should ideally receive supervision provided by a Child and Adolescent EMDR Europe Accredited Consultant. However, this guidance recognises that if this is not possible due to a lack of availability of such consultants, supervision should be provided by a generic EMDR accredited consultant with appropriate experience across age ranges (EMDR Association UK, 2025).

Although the Good Practice Guidelines (EMDR Association UK, 2025) suggest that standard protocol training can be used with adolescents if the clinician has prior clinical experience working with this population, they also advise that clinicians using EMDR with this population should complete additional specialist training. This specialist child and adolescent EMDR training is typically delivered in two parts over three to four days, provided by a small number (currently three) of accredited training providers in the UK. This training focuses on flexibly applying the standard EMDR protocol with developmental, attachment, relational, and systemic considerations. This specialist training emphasises that while the standard eight-phase protocol remains at the core of EMDR practice with young people, aspects of EMDR practice, such as language, pacing, target sequencing, and resourcing, may need adapting to meet young people’s needs (EMDR Association UK, 2019, 2025; Shapiro, 2018).

Despite established accreditation pathways, the use and implementation of EMDR with adolescents in the UK may be inconsistent, potentially reflecting broader challenges in young people's access to specialist psychological interventions (Care Quality Commission, 2020; NHS England, 2025b). The challenges are compounded by high service demand and long waiting times in the UK healthcare system (Children's Commissioner for England, 2024). Consequently, although EMDR is recommended and clinically useful for treating PTSD in young people (NICE, 2018), the specialist training and supervision requirements, alongside wider inequalities in access to psychological therapies (YoungMinds, 2024), may contribute to variability in the access and delivery of EMDR with adolescents in the UK.

Gaps and Limitations in the Current EMDR Evidence Base

While EMDR is widely recognised and evidenced as a clinically useful trauma intervention for various populations, there remain limitations and gaps in the current evidence base. Most research on this topic area is quantitative, relies on small, heterogeneous age-based samples, and focuses on EMDR treatment outcomes rather than the therapeutic process itself (Onofri & Hase, 2025). Additionally, there is relatively little qualitative research specifically examining the application of EMDR in UK clinical settings (Amey & Serrano, 2025). This limits the generalisability of current understanding of how EMDR is practised within the UK context, where organisational structures, referral pathways, and clinical complexity may differ from those represented in international research.

Likewise, relatively little attention has been paid to clinicians' perspectives on how EMDR is implemented, adapted, and sustained in UK healthcare settings. Further exploration of these perspectives could develop an understanding of how EMDR's theoretical and protocol-driven foundations translate into real-world practice, considering the organisational, practical, and relational factors that may influence its implementation. Understanding these

experiences may also help identify aids and to effective EMDR practice, considering training pathways, supervision structures, service constraints, and contextual demands within the UK clinical contexts.

The following chapter presents a critical review of the existing qualitative literature exploring clinicians' experiences of delivering EMDR therapy with various populations in the UK. This review establishes the empirical and conceptual foundation for the current study, which explores clinicians' experiences of delivering EMDR to adolescents in the UK. This present research seeks to provide novel insights into an underexplored area, with potential implications for clinical practice, training, service development, and the future implementation of adolescent EMDR.

Chapter 2: Literature Review

Chapter Overview

This chapter reviews qualitative research studies examining clinicians' experiences of delivering EMDR across various populations in the UK. It situates the current study within the existing literature, identifying what is known and where key gaps remain. The review uses thematic synthesis to integrate findings from multiple qualitative studies, offering a conceptual understanding of EMDR delivery within the UK. It concludes by critically evaluating the reviewed literature and presenting the rationale for the current study. The research aims and questions for the current study are then presented.

Rationale and Aims for this Review

Whilst international research has explored EMDR across diverse settings, including trauma centres and humanitarian contexts, much of this literature is quantitative and focused on efficacy outcomes, with comparatively little qualitative research examining clinicians' experiences of delivering EMDR in the UK. Although a small number of reviews have synthesised clinicians' (Morrison et al., 2023) and clients' experiences of EMDR (Whitehouse, 2021), these reviews have drawn on international studies; therefore, they do not fully reflect the specific context of trauma care and service delivery within the UK. To the researcher's knowledge, there is currently no systematic review that specifically synthesises qualitative studies exploring clinicians' experiences of using EMDR in the UK. This represents an important gap, as healthcare systems vary internationally in terms of service provision, training pathways, referral processes, and approaches to trauma treatment. Therefore, a UK-focused synthesis may provide a more contextually relevant understanding of the experiences of delivering EMDR within UK services, which this review aims to address.

Given that the NHS and other UK systems are likely to present unique organisational, cultural, and systemic factors that shape therapeutic practice, it is important to understand how these factors impact clinicians' perspectives on how they experience, adapt, and practice EMDR within a UK context. Understanding clinicians' perspectives is important for implementation research because it enables exploration of how interventions are delivered beyond controlled trial settings and provides insight into clinical decision-making and contextual factors that influence real-world practice (Hamilton & Finley, 2019).

Therefore, by synthesising the current, limited body of qualitative research on clinicians' experiences of delivering EMDR in UK clinical settings, this review aimed to deepen understanding of how EMDR is used in real-world UK practice and to identify future directions for qualitative research in this topic area. The guiding review question was: What are clinicians' experiences of using EMDR in clinical practice within the UK?

Method

Protocol and Registration

A protocol was developed and registered with the International Prospective Register of Systematic Reviews (PROSPERO; registration number CRD420251038135) in April 2025 (see Appendix A). The protocol outlined the review question, inclusion and exclusion criteria, search strategy, and meta-synthesis approach, ensuring that procedures remained systematic and replicable. It is argued that registering a systematic review protocol promotes methodological transparency and reduces bias (Drucker et al., 2016; Shamseer et al., 2015).

Article Selection

Search Strategy and Identification. The literature search was guided by the SPIDER framework (Sample, Phenomenon of Interest, Design, Evaluation, Research Type), which is designed to review qualitative and mixed-methods research by exploring interpretative

findings, which aligns with the aims of a meta-synthesis (Cooke et al., 2012). Applying this framework enabled a targeted literature search that captured rich, interpretive studies relevant to EMDR clinicians lived experiences.

Boolean search terms were constructed for each SPIDER category (shown in Table 1) and searched across five electronic databases (APA PsycArticles, APA PsycInfo, CINAHL Complete, MEDLINE Ultimate, Open Dissertations) via the EBSCOhost research platform using proximity, 'select a field' search. No limiters or expanders were applied. Hand searching of the reference sections of eligible studies was also conducted to identify any further relevant studies not returned by the database searches. Additionally, the first 10 pages of Google Scholar search results for the phrase "clinicians experiences of delivering EMDR in the UK" sorted by relevance, were reviewed to ensure that any relevant studies not captured by the database searches were identified and included in the review. No date limits were applied, allowing inclusion of all relevant research since the development of EMDR in 1989. The search was initially run in April 2025 and then rerun on 25th March 2026 to ensure methodological rigour and include any more recent relevant literature. It was decided that both peer-reviewed and grey literature would be included to provide a more comprehensive review and reduce publication bias.

Table 1

SPIDER Framework Applied and Search Terms Used.

SPIDER	Research Focus	Boolean Search Term
Sample	Clinicians practising EMDR in the UK.	"clinician*" OR "therapist*" OR "psychologist*" OR "psychiatrist*" OR "counsellor*" OR "mental health professional*" OR "healthcare provider*" OR "practitioner*" OR "doctor*" OR "physician*" OR "social worker*" OR "psychotherapist*" OR "nurse*" OR "psychiatric nurse*" OR "behavioural health provider*" OR "allied health professional*" OR "mental health worker*"

SPIDER	Research Focus	Boolean Search Term
		AND
Phenomenon of **I**nterest	EMDR	"EMDR" OR "eye movement desensitisation*" OR "eye movement desensitization*"
Design	Qualitative	
		AND
Evaluation	Experience, Views, Perspectives	"Experienc*" OR "perc*" OR "attitude*" OR "view*" OR "feel*" OR "perspective*" OR "meaning*" OR "opinion*" OR "belie*" OR "understand*"
		AND
Research Type	Qualitative or Mixed Methods	qualitative OR "mixed method*" OR "mixed-method*"OR “interview*” OR “focus group*” OR "semi-structure*" OR "open-ended" OR narrative OR “thematic” OR "grounded theory" OR "content analys*" OR "framework analys*" OR phenomenological OR "interpretative phenomenological analys*" OR IPA OR "discourse analys*" OR "descriptive stud*" OR "exploratory stud*"

Study Screening. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Page et al., 2021) flow diagram was used to document the search process and is shown in Figure 1.

From database searching, an initial total of 311 studies were identified. Once duplicates were removed, a total of 252 studies remained. Titles and abstracts were screened against the inclusion and exclusion criteria (shown in Table 2). This process identified 45 studies from the database search for full-text review. After full-text screening, 36 studies were excluded for failing to meet the inclusion criteria. Three studies identified through a Google Scholar search were screened and met the inclusion criteria. Of the 45 studies identified through database searches and three from the Google Scholar full-text screening, 12 studies met the inclusion criteria and were included in this review.

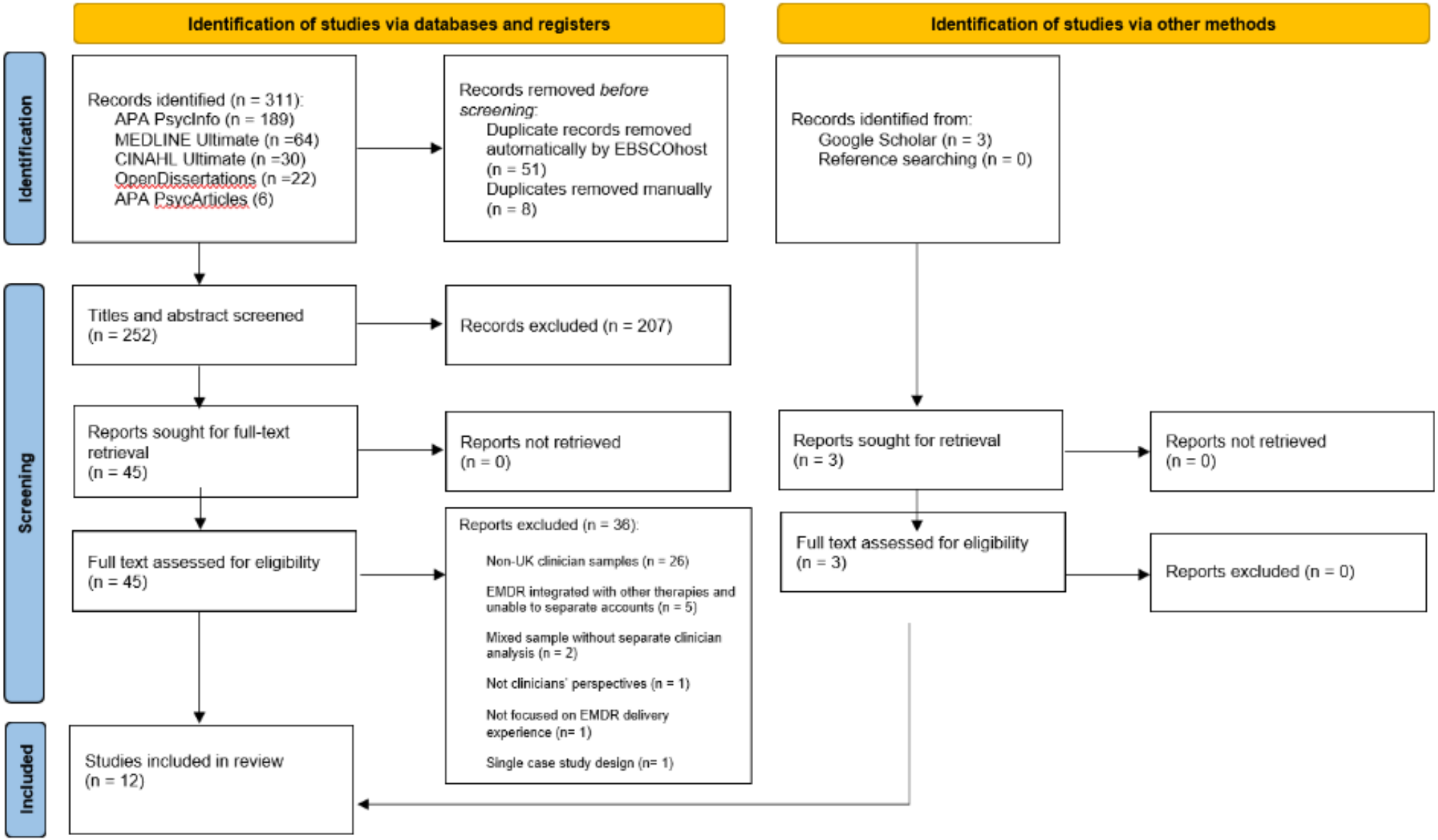
Table 2

Inclusion and Exclusion Criteria for Article Selection.

Inclusion	Exclusion
1. Qualitative methodology 2. Mixed-method research with rich qualitative data (e.g., themes with supporting quotes) 3. Focus on clinicians' experiences of delivering EMDR in UK clinical settings 4. Focus on EMDR as the primary therapeutic modality 5. Available in English 6. Peer-reviewed and non-peer-reviewed (grey literature such as doctoral theses or dissertations) studies	1. Not available in English 2. EMDR delivered as part of an integrated/blended intervention where EMDR-specific delivery experiences cannot be isolated 3. Does not primarily focus on clinicians' experiences of delivering EMDR 4. Non-UK setting, or UK clinician data/analysis not isolated 5. Client/carer-focused studies, or mixed samples where clinician experiences are not analysed separately 6. Quantitative studies (e.g., RCT/feasibility study) without qualitative data 7. Reviews, opinion pieces, single case study designs, or case reports

Figure 1

PRISMA Flowchart.



Quality Appraisal

Evaluating methodological quality in qualitative synthesis is debated, as qualitative research values contextual depth and interpretive richness over standardised validity measures (Lachal et al., 2017). However, consistent with best-practice recommendations (Hannes & Macaitis, 2012), this review undertook a systematic critical appraisal using the Critical Appraisal Skills Programme (CASP) checklist for qualitative research (CASP, 2018), as recommended by the Cochrane Collaboration (Noyes et al., 2019).

The CASP (2018) checklist evaluates the quality of research through 10 structured questions that consider the research aims, methodology, recruitment, data collection, analysis, ethics, and researcher reflexivity. Each study was appraised independently using this CASP checklist (2018), and responses were categorised as *Yes*, *No*, *Partly* (minimal discussion), or *Cannot Tell*. While studies were not excluded based on their appraisal ratings, consistent with qualitative synthesis recommendations (Majid & Vanstone, 2018), the quality appraisal process allowed methodological strengths and weaknesses to be identified, enhanced interpretive transparency, and informed recommendations for future research.

Meta-Synthesis Analysis

The meta-synthesis method used in this review was thematic synthesis (Thomas & Harden, 2008). Thematic synthesis was chosen for its clear and flexible framework, which enabled the synthesis of various qualitative study designs while preserving closeness to participants' accounts and interpretations (Barnett-Page & Thomas, 2009; Thomas & Harden, 2008). Unlike meta-ethnography, which aims to develop higher-order interpretations through the translation of concepts across studies (Atkins et al., 2008; Noblit & Hare, 1988), thematic synthesis was better aligned with the applied aim of this review to identify and synthesise themes relating to clinicians' experiences and contextual variation that may influence EMDR

practice across UK settings (Thomas & Harden, 2008). Thematic synthesis accommodated the range of qualitative methodologies, while allowing consideration of contextual variation that may influence EMDR practice in the UK. Unlike meta-aggregation approaches, which primarily seek to summarise findings (Hannes & Lockwood, 2011; Sandelowski et al., 1997), thematic synthesis supports the development of analytical themes that generate insights relevant to theoretical and clinical practice.

The analytical process of thematic synthesis involved three iterative stages: familiarisation and coding, development of descriptive themes, and generation of higher-order analytical themes. In the first stage, each study was read multiple times to ensure deep familiarity with its context, findings, and interpretations. Line-by-line coding of the relevant results and discussion sections of each study was then completed, focusing on clinicians' experiences, perceived challenges, and adaptations when using EMDR with adolescents. Each study was coded using both an inductive (emerging from the data) and deductive (informed by the review question) approach, allowing the translation of concepts and the identification of recurrent patterns.

Secondly, codes were organised to develop initial descriptive themes. Initial codes were collated in a Microsoft Excel spreadsheet to facilitate systematic comparison and consolidation (see Appendix B for an example). Related codes were grouped into broader descriptive categories that remained close to the original study findings and interpretations, capturing key elements of clinicians' experiences of using EMDR in a UK context.

Finally, the descriptive categories were further refined to construct analytical themes and subthemes, thereby synthesising and interpreting the data to answer the review question.

Results

Characteristics of Included Studies

In total, 12 studies met the inclusion criteria (Blackford-Jones, 2025; Fisher et al., 2023; Folland, 2017; Kemal Kaptan & Brayne, 2022; McKillop et al., 2024; Phillips et al., 2021; Shaw, 2024; Shipley, 2022; Smith-Lee Chong, 2016; Strelchuk et al., 2023; Strelchuk et al.,2024; Unwin et al., 2023). Table 3 summarises the characteristics of the included studies. The included studies examined clinicians' experiences across varied UK contexts, including CAMHS, adult mental health, older adult mental health, learning disability, local authority, psychosis, and private practice. Sample sizes ranged from three to 23 participants, and data collection methods included semi-structured interviews, online surveys, and mixed-methods designs incorporating qualitative components.

Data collection across the included studies was predominantly through semi-structured interviews, conducted either face-to-face or online, allowing for a flexible yet focused exploration of clinicians' experiences and perceptions. One study (Unwin et al., 2023) utilised an online survey incorporating open-ended questions to capture perspectives of remote EMDR delivery. Two included studies (Strelchuk et al., 2023; Strelchuk et al., 2024) used a mixed-methods design, integrating qualitative interviews within broader evaluation designs. These methodologies collected rich data while accommodating participants' diverse work environments and practical considerations.

As shown in Table 3, the analytical approaches used in the studies varied. These included interpretative phenomenological analysis (IPA); framework analysis; reflexive thematic analysis (RTA); and conventional thematic analysis, which was applied in studies with broader aims or mixed methods designs.

Table 3

Summary of Characteristics of Included Studies.

Study Citation	Sample	Aim	Data Collection Method	Analysis Method	Main Themes
Blackford-Jones (2025)	12 therapists using EMDR with older adults in 2 NHS North West England Community Services	Explore clinicians' experiences of delivering EMDR to older adults (60+)	Semi-structured interviews	Applied thematic analysis	1) Adapting EMDR to meet older adult needs 2) Agency & emotional safety in EMDR 3) EMDR is distinctly valuable 4) System & cultural barriers to EMDR access
Fisher et al. (2023)	23 UK-based EMDR therapists with experience working with autistic individuals across different contexts	Explore EMDR therapists' experiences of working with autistic individuals across the lifespan	Semi-structured interviews	Reflexive thematic analysis	1)The experience of being autistic 2) Accessing EMDR 3) Adapting EMDR 4) Supervision and Support for EMDR therapists
Folland (2017)	9 UK EMDR therapists	Explore how TF-CBT and EMDR therapists engage and experience, and protect themselves in trauma work	Semi-structured interviews	Interpretative phenomenological analysis	1) Nature of trauma 2) Managing trauma narratives 3) Delivering trauma models 4) Protecting the therapist's sense of self
Kemal Kaptan & Brayne (2022)	8 UK EMDR therapists	Explore UK EMDR clinicians' experiences of using Attachment-Focused EMDR	Semi-structured interviews	Reflexive thematic analysis	1) Perceptions of AF-EMDR 2) It is not versus, it is with 3) The spirit of EMDR is innovation
McKillop et al. (2024)	6 clinical psychologists trained in EMDR from 1 NHS learning disability service in South England	Explore clinicians' experiences of using and adapting EMDR for adults with learning disabilities	Semi-structured interviews	Reflexive thematic analysis	1) Learning EMDR 2) Conducting EMDR 3) External factors

Study Citation	Sample	Aim	Data Collection Method	Analysis Method	Main Themes
Phillips et al. (2021)	20 EMDR therapists from UK outpatient settings with experience using EMDR with clients who have experienced psychosis	Explore therapists' experiences of using EMDR with psychosis, and compare it to other therapies	Semi-structured interviews	Thematic analysis	1) Familiarity with psychosis and EMDR 2) Acceptability of EMDR 3) Systemic factors 4) Keeping key therapy principles in mind
Shaw (2024)	4 education psychologists using EMDR with young people in UK local authorities	Explore the use and outcomes of EMDR by educational psychologists with children and young people	Semi-structured interviews	Thematic analysis	1) Flexible use 2) Integrative approach 3) Support from parents & schools 4) Pre-assessment and evaluation measures
Shipley (2022)	7 EMDR therapists in outpatient UK settings	Explore how EMDR therapists adapt and deliver EMDR to children and young people.	Semi-structured interviews	Reflexive thematic analysis	1) Putting EMDR into practice 2) Working systematically
Smith-Lee Chong (2016)	6 EMDR-accredited therapists in the UK NHS/private settings	Explore EMDR therapists' experiences of the standard protocol and 'vicarious growth' when working with clients with PTSD symptoms	Semi-structured interviews	Interpretative phenomenological analysis	1) Initial struggles 2) "Hearing journey" 3) Growth through connection 4) Impact of growth on self
Strelchuk et al. (2023)	5 EMDR therapists, Cardiff and Vale University Health Board Traumatic Stress Service	Explore therapists' views and experiences of online EMDR for PTSD.	Mixed methods: semi-structured interviews for qualitative methodology	Thematic analysis	1) Differences between online and in-person EMDR 2) Benefits and challenges 3) Safety and effectiveness 4) Improvements to online EMDR
Strelchuk et al. (2024)	3 EMDR therapists NHS Early Intervention Services, Northwest England	Explore therapists' views of delivering EMDR with At Risk of Mental State patients	Mixed methods: semi-structured interviews	Thematic analysis	1) Trauma work & EMDR effectiveness for ARMS 2) Suggestions for EMDR protocol modifications

Study Citation	Sample	Aim	Data Collection Method	Analysis Method	Main Themes
Unwin et al. (2023)	13 therapists from 6 UK NHS intellectual disability services	Explore therapists' perspectives on remote delivery of EMDR for people with intellectual disabilities	Online survey with open-ended questions	Framework analysis	1) Acceptability of EMDR 2) Feasibility of remote working

Quality Appraisal Findings

The quality appraisal of the included studies, conducted using the Critical Appraisal Skills Programme checklist (CASP, 2018), is summarised in Table 4. Overall, the 12 included studies demonstrated strong methodological integrity, particularly in the clarity of their research aims, the coherence between their aims and methodology, and the appropriateness of qualitative designs for exploring clinicians' subjective experiences. Across the studies, the analysis approach aligned with epistemological stance and research questions, indicating an overall strong qualitative orientation.

A consistent strength across the included papers was the robustness of recruitment strategies and data collection methods, which were well aligned with each study's stated aims and target population. Participants were appropriately selected for their clinical experience with EMDR, and semi-structured interviews and open-ended surveys facilitated the collection of rich, reflective data. This methodological congruence increases confidence that the findings captured clinicians lived experiences of EMDR practice in a UK context.

However, the quality appraisal also identified several methodological limitations. Some studies lacked discussion of the researchers' positioning, assumptions, and potential biases that may have influenced the research process. While some studies (e.g., Folland, 2017; Kemal Kaptan & Brayne, 2022; Smith-Lee Chong, 2016) demonstrated strong researcher reflection through explicit acknowledgement of the researcher's stance and the use of reflexive journaling or supervision, others did not. For example, Strelchuk et al. (2023; 2024) and Unwin et al. (2023) made little to no reference to research reflexivity. This lack of transparency raises concerns regarding potential interpretive bias, particularly given the subjective and sensitive nature of this research topic.

A further limitation relates to ethical transparency. Although most studies reported appropriate ethical considerations such as informed consent, confidentiality, and institutional ethical approval, some studies lacked detail in their descriptions of these procedures. For example, McKillop et al. (2024) did not report whether ethical approval had been obtained or how consent was managed. Similarly, whilst Fisher et al. (2023) stated that ethical approval and consent had been obtained, other ethical considerations (e.g., participant wellbeing, data storage) were not discussed.

In terms of analytical rigour, most studies demonstrated thorough and transparent data analysis procedures; however, the depth of reporting varied among studies. For example, Unwin et al. (2023) provided limited details about their analytical process, making it difficult to evaluate the transparency and credibility of their interpretation. In contrast, studies using RTA (e.g., Kemal Kaptan & Brayne, 2022; Shipley, 2022) and IPA (e.g., Folland, 2017; Smith-Lee Chong, 2016) demonstrated stronger discussion of analytical procedures and used sufficient participant quotations to support their findings. This variability highlights a broader limitation in current UK EMDR clinician research, where inconsistent reporting of analytical procedures may reduce confidence in the findings.

Additionally, several studies relied on small, homogeneous samples drawn from single NHS Trusts or specific UK service contexts (e.g., McKillop et al., 2024; Strelchuk et al., 2024), which limits the transferability of findings across wider UK clinical settings. Whilst Fisher et al. (2023) included a larger and more diverse sample of clinicians working with autistic individuals across the lifespan, the study did not account for age-specific differences in EMDR practice. In addition, some accounts were clinicians who had not used all the stages of EMDR with clients, which may limit the transferability and interpretation of these findings (e.g., McKillop et al., 2024).

Although two studies explored EMDR practice with young people in the UK (Shaw, 2024; Shipley, 2022), both were limited by small, context-specific samples (outpatients and local authority). These studies also combined age ranges, meaning isolated experiences of using EMDR with adolescent-specific populations were not explicitly explored. Moreover, the absence of useful demographic and professional information (e.g., years of experience, core profession) in these studies limits the contextual interpretation of their findings. Consequently, there remains a limited understanding of how clinicians with diverse professional backgrounds experience and adapt EMDR to meet adolescents' developmental and relational needs within a UK context.

A further critique of the current literature is the limited exploration of clinicians' perspectives on the challenges and barriers encountered during EMDR sessions. Whilst some studies (e.g. Fisher et al., 2023; McKillop et al., 2024) have acknowledged the influence of professional training, supervision, and therapist competence on EMDR, there remains limited in-depth exploration of the challenges that may arise within the therapeutic encounter of EMDR, including those related to client-specific needs during EMDR in UK healthcare settings.

Despite these limitations, the reviewed studies share several strengths. All studies showed conceptual clarity in linking EMDR theory to practice and reflected a commitment to improving clinical outcomes. The inclusion of therapists from both NHS and private practice contexts in some studies enhanced the diversity of perspectives. Additionally, most studies explicitly discussed implications for clinical practice, training, or policy, reinforcing their applied relevance.

In summary, the reviewed studies contribute to the growing body of qualitative evidence exploring clinicians' experiences of using EMDR in the UK. However, several

methodological critiques in the current literature were identified, highlighting the need for further research in this area to be transparent about its analytical processes, ethical details, and researcher reflexivity. Notably, a significant gap remains in understanding adolescent-specific EMDR practice within UK contexts, outlining the need for further research in this area.

Table 4

CASP Critical Appraisal Results.

		Study											
Section	Question	Blackford-Jones (2025)	Fisher et al. (2023)	Folland (2017)	Kemal Kaptan & Brayne (2022)	McKillop et al. (2024)	Phillips et al. (2021)	Shaw (2024)	Shipley (2022)	Smith-Lee Chong (2016)	Strelchuk et al. (2023)	Strelchuk et al. (2024)	Unwin et al. (2023)
Section A: Are the results of the study valid?	Q1: Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Q2: Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Q3: Was the research design appropriate to address the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Q4: Was the recruitment strategy appropriate to the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Q5: Was the data collected in a way that addressed the research issue?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Q6: Has the relationship between the researcher and participants been adequately considered?	Y	Y	Y	Y	Y	Y	Y	Y	Y	?	P	N
Section B: What are the results?	Q7: Have ethical issues been taken into consideration?	Y	Y	Y	Y	P	Y	Y	Y	Y	Y	Y	Y
	Q8: Was the data analysis sufficiently rigorous?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	P
	Q9: Is there a clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Section C: Will the results help locally?	Q10: How valuable is the research? (Did the researcher/s consider this?)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total CASP Score (out of 10):		10	10	10	10	9.5	10	10	10	10	9	9.5	8.5

Note. Y= Yes (CASP Score = 1), N = No (CASP Score = 0), P = Partly (CASP Score = 0.5), ? = Cannot Tell (CASP Score = 0)

Thematic Synthesis Findings

The findings from 12 qualitative studies were synthesised to generate five analytical themes and 11 subthemes (Table 5). Table 6 presents a cross-comparison table, illustrating how each subtheme was represented across the included studies.

Together, these themes describe how UK clinicians experience EMDR as an initially unfamiliar and sometimes contested intervention, negotiate tensions between protocol fidelity and flexibility, manage the relational demands of EMDR, develop personally and professionally through using EMDR, and deliver EMDR within wider systemic contexts.

Table 5

Summary of Themes and Subthemes.

Main theme	Subthemes
Making Sense of EMDR	Experiencing EMDR as Different
	Negotiating Doubt and Legitimacy
	Integrating EMDR into Practice
Balancing Protocol and Flexibility	Tensions around Fidelity
	Adapting in Practice
Therapeutic Relationship	Relational Strain
	Relational Support
Developing as an EMDR Therapist	Emotional Burden
	Growth and Meaning
EMDR Within Systems	Systemic Barriers or Helpers
	Access Inequities

Table 6

Translated Themes.

Studies (in order of CASP score)	**Total CASP Score**	**Making sense of EMDR**			**Balancing Protocol and Flexibility**		**Therapeutic Relationship**		**Developing as an EMDR Therapist**		**EMDR Within Systems**	
		Experiencing EMDR as Different	Negotiating Doubt and Legitimacy	Integrating EMDR into Practice	Tensions around Fidelity	Adapting in Practice	Relational Strain	Relational Support	Emotional Burden	Growth and Meaning	Systemic Barriers or Helpers	Access Inequities
Blackford-Jones (2025)	10	*	*		*	*		*	*	*	*	*
Fisher et al. (2023)	10	*	*	*	*	*	*	*		*	*	*
Folland (2017)	10	*	*						*	*	*	
Kemal Kaptan & Brayne (2022)	10	*	*	*	*	*		*		*	*	
Phillips et al. (2021)	10	*	*	*	*	*	*	*	*	*	*	*
Shaw (2024)	10	*		*	*	*		*		*	*	
Shipley (2022)	10	*	*	*	*	*	*	*		*	*	*
Smith-Lee Chong (2016)	10	*	*	*	*	*		*	*	*	*	
McKillop et al. (2024)	9.5	*	*	*	*	*		*		*	*	*
Strelchuk et al. (2024)	9.5	*		*		*		*		*	*	*
Strelchuk et al. (2023)	9		*	*	*	*	*	*		*	*	*
Unwin et al. (2023)	8.5		*	*		*	*	*		*	*	*

Theme 1: Making Sense of EMDR. Across studies, clinicians described EMDR as a distinctive approach that was initially unfamiliar and sometimes difficult to legitimise, but with experience and support, it became integrated into their practice and professional identity over time.

Experiencing EMDR as Different. Clinicians described EMDR's unfamiliarity compared to traditional talking therapies. Its use of BLS reduces reliance on verbal disclosure and procedural structure, often challenging expectations of what therapy "should" look like. Clinicians valued EMDR compared to other trauma-focused therapies (e.g., CBT) because it reduced the pressure on clients to "talk about thoughts and feelings" (Fisher et al., 2023, p. 1079) and allowed clients to process experiences "in a way that makes specific sense to them" (p. 1080).

Similarly, clinicians described EMDR as feeling unusual or difficult to explain because it differed from familiar therapeutic models. Shipley (2022) described clinicians initially experiencing EMDR as an "odd therapy" (p. 65), while newly trained EMDR therapists in McKillop et al. (2024) reported anxiety because EMDR initially felt "difficult to grasp" and "tricky to explain" (p. 4). Clinicians described having to adopt a different therapeutic stance, becoming less active once reprocessing began and allowing clients to guide the process more independently - something that felt unfamiliar for some (e.g., Phillips et al., 2021).

However, clinicians generally viewed the differences of EMDR as positive. Compared with CBT and other trauma-focused therapies, EMDR was often perceived as less demanding, less invasive, and more accessible because of its reduced demand for 'homework', detailed disclosure, and repeated retelling of traumatic experiences (e.g., Folland, 2017; Phillips et al., 2021; Strelchuk et al., 2024). EMDR was also described as

well-suited to older adults because of its lower verbal demands and ability to accommodate cognitive changes and generational differences in emotional expression (Blackford-Jones, 2025). Similarly, Shaw (2024) described how EMDR helped children process trauma and shame without disclosing significant details, with one clinician commenting that “they don’t have to tell you, and I think that’s the most powerful thing about EMDR” (p. 168).

Clinicians often expressed surprise at the speed and outcome of change associated with EMDR. Folland (2017) found that therapists described EMDR as “profound", “incredible”, and “magical” (p. 177), while Smith-Lee Chong (2016) also described clinicians witnessing rapid and unexpected transformations.

Negotiating Doubt and Legitimacy. Feelings of doubt were common among clinicians during their earlier experiences of using EMDR, often stemming from uncertainty about how EMDR works, where the process might lead, and whether clinicians could confidently manage clients’ intense emotional reactions. Several therapists described feeling “lost” in sessions or unsure whether they were “doing EMDR properly” (Shipley, 2022; Smith-Lee Chong, 2016).

Concerns about managing clients’ safety and destabilisation were particularly evident in studies applying EMDR across different contexts, including working with psychosis, learning disabilities, or remote delivery of EMDR. In Phillips et al. (2021), one clinician described: “What happens if EMDR goes wrong? What would wrong look like?” (p. 147). Similarly, Unwin et al. (2023) found that clinicians delivering EMDR to people with learning disabilities evoked some clinicians’ feelings of anxiety about clients’ readiness for trauma processing work, their ability to identify specific trauma targets, and concerns about causing distress for clients.

Several studies also highlighted that therapists' uncertainty was linked to feeling unable to explain EMDR clearly to clients or colleagues. Shipley (2022, p. 65) found that clinicians felt EMDR "looked weird anyway" and could be "hard to sell" unless therapists felt confident in explaining it. Similarly, some found that clinicians worry that EMDR sounded vague or "mystical", which could undermine their professional credibility or discourage client engagement (e.g., Blackford-Jones, 2025; Folland, 2017).

Professional and cultural scepticism also shaped clinicians' experiences of using EMDR in different formats and contexts. Kemal Kaptan and Brayne (2022) described clinicians' initial doubts about AF-EMDR linked to the preconceptions and limited published research in the EMDR field. Likewise, Phillips et al. (2021) found that some professional networks doubted the appropriateness of using EMDR with psychosis.

Online EMDR was initially doubted by some, with Fisher et al. (2023) outlining that some therapists initially described EMDR with autistic clients as "the most ridiculous notion" (p. 1080). However, this scepticism often reduced once clinicians experienced its effectiveness. Strelchuk et al. (2023) similarly reported that therapists were "blown away" (p. 8) by how well EMDR worked online. This highlights how initial scepticism extended not only to the EMDR approach itself, but also its mode of delivery.

Despite initial doubts, clinicians often described confidence growing through experience with EMDR and the importance of "trusting the process" (Folland, 2017; Smith-Lee Chong, 2016). Unwin et al. (2023) described "light bulb moments" (p. 209) when clinicians saw dramatic changes in clients and became more confident in using EMDR online with clients with learning disabilities.

Integrating EMDR into Practice. Despite early uncertainty about the intervention, repeated use of EMDR, supervision, and observation of its positive outcomes helped

therapists confidently integrate EMDR into their practice. Over time, EMDR shifted from feeling unfamiliar to becoming part of the clinician's wider therapeutic repertoire and their 'toolbox' (e.g., McKillop et al., 2024; Unwin et al., 2023; Shaw, 2024).

Some clinicians describe integrating EMDR to fit their existing therapeutic style. An example was clinicians being trained to use EMDR in a more relational form, such as AF-EMDR, which reassured clinicians that EMDR is practised in the way "they think it should be done" (Kemal Kaptan & Brayne, 2022, p. 600). Strelchuk et al. (2023) described that therapists valued the convenience of online EMDR, including reduced travel, easier rescheduling, and greater flexibility, with many supporting blended models that combined online and face-to-face EMDR sessions.

Integrating EMDR into practice was therefore not simply about gaining competence in using EMDR, but about reframing EMDR as sitting alongside therapists' existing therapeutic skills and practical considerations, and as client-led, particularly for populations with diverse and complex needs (Fisher et al., 2023; Strelchuk et al., 2024).

Theme 2: Balancing Protocol and Flexibility. Therapists consistently described the tension between adhering to EMDR's standard protocol and adapting to the client, context, and service realities.

Tensions Around Fidelity. For some clinicians, the standard EMDR protocol was a helpful scaffold that offered containment (e.g., Fisher et al., 2023; Kemal Kaptan & Brayne, 2022) and a "safe allowing structure" for the client and therapist (Smith-Lee Chong, 2016, p. 84), particularly when working with complex trauma.

However, therapists also highlighted that strict adherence to EMDR practice could be experienced as restrictive and uncomfortable for some, particularly when there were expectations that EMDR should be used instrumentally (Fisher et al., 2023; Kemal Kaptan &

Brayne, 2022; Shaw, 2024). When practising EMDR with young people, some described that the protocol could feel overly formal or "school-like" and created an added pressure for therapists to do it "right" (Shipley, 2022).

Therapists' early EMDR practice often relied heavily on a more manualised approach, but with experience, clinicians described becoming more confident in working "loosely with the protocol" while retaining its core principles (Shipley, 2022; Smith-Lee Chong, 2016). These findings suggest that fidelity to the EMDR standard protocol was experienced as both supportive and constraining, where the protocol offered clinicians a sense of safety in their practice, but rigid adherence risked reducing attunement and responsiveness to diverse client needs and UK contexts.

Adapting in Practice. Despite these tensions, therapists described adaptation as routine and often essential in effective EMDR practice. Across studies, therapists prioritised understanding clients' unique needs rather than making assumptions about how EMDR should be practised based on diagnosis, age, or certain presentations (Fisher et al., 2023; Phillips et al., 2021; Shaw, 2024). Various adaptations in EMDR practice were described, including extending preparation, simplifying language, modifying cognitive elements, widening targets beyond imagery, and tailoring BLS to clients' sensory preferences, physical abilities, and tolerance (Blackford-Jones, 2025; Fisher et al., 2023; McKillop et al., 2024; Strelchuk et al., 2023; Unwin et al., 2023).

When adapting EMDR to meet the developmental needs of young people, therapists often incorporated various creative and playful techniques and involved parents or caregivers where appropriate (Shaw, 2024; Shipley, 2022). With complex trauma presentations, AF-EMDR were used to pace EMDR practice more carefully and strengthen relational safety during the process (Kemal Kaptan & Brayne, 2022; Smith-Lee Chong, 2016).

Online EMDR practice also required adaptation. These included using different BLS formats (e.g., tapping), longer preparation, and more stabilisation techniques to make the online environment feel more contained for both the therapist and client (Fisher et al., 2023; Strelchuk et al., 2023; Unwin et al., 2023). Some also described online EMDR as potentially more accessible to clients, as it improves their sense of safety and comfort (Strelchuk et al., 2023).

Theme 3: Therapeutic Relationship. Clinicians discussed the therapeutic relationship characterised by safety, trust, attunement, and client agency as central to effective EMDR. However, some aspects of the approach could place strain on rapport and relational attunement if not carefully managed.

Relational Strain. Several therapists noted that some aspects of EMDR's procedural nature could disrupt therapeutic attunement, particularly when clients were overwhelmed, struggled to communicate distress, or found EMDR too formal or procedural. Some described finding it difficult to interpret when EMDR sessions had become too intense, particularly when working with clients with autism with minimal facial expressions (Fisher et al., 2023). In remote EMDR, therapists described reduced non-verbal cues and a loss of "in the room" attunement, which could make rapport-building and relational safety more difficult (Strelchuk et al., 2023; Unwin et al., 2023). Some also described certain presentations, such as paranoia (Phillips et al., 2021), making it harder to establish a robust therapeutic relationship, raising concerns about the appropriateness of EMDR when clients were acutely unwell. When practising EMDR with young people, Shipley (2022) also explained that a strong therapeutic relationship could increase social desirability, whereby children overstate improvement because they want to validate the therapist.

Relational Support. Despite these considerations, therapists more often described the therapeutic relationship as essential to effective EMDR. Across studies, trust, safety, rapport, and relational support were viewed as essential for trauma processing, particularly when working with more complex contexts or needs, including psychosis, learning disabilities, autism, and online EMDR (e.g., McKillop et al., 2024; Phillips et al., 2021; Shipley, 2022; Unwin et al., 2023). Therapists emphasised being warm, curious, open, and clear about what EMDR involved, which helped clients feel heard, safe, and prepared (Fisher et al., 2023).

Some therapists described becoming the "safe figure" (p. 74) for children when parents or carers did not represent this or could not be involved in EMDR (Shipley, 2022). Others highlighted the importance of giving clients control over the choice, pacing, and flexibility of EMDR (Blackford-Jones, 2025; Shaw, 2024). EMDR was also experienced as strengthening wider relationships by helping clients trust supportive adults, reconnect with their own strengths, and experience EMDR as a corrective relational experience (Blackford-Jones, 2025; Kemal Kaptan & Brayne, 2022; Shaw, 2024).

Theme 4: Developing as an EMDR Therapist. Delivering EMDR reshaped therapists' professional identities in complex ways, at times involving emotional burden and, at other times, experiences of professional growth and meaning.

Emotional Burden. Several therapists described EMDR as sometimes being emotionally demanding, particularly during early EMDR practice or when working with complex trauma. Some felt overwhelmed, emotionally drained, or disturbed by the client's distress, and some described interrelated somatic or embodied responses when delivering EMDR, potentially reflecting vicarious trauma (Folland, 2017; Smith-Lee Chong, 2016).

On the contrary, many clinicians considered EMDR to be less emotionally intrusive for the therapist compared to trauma-focused CBT because it reduces their exposure to

detailed trauma narratives. In this sense, this 'distancing' in EMDR was framed by some as protective, and the blind to therapist EMDR protocol was often viewed as helpful in reducing clinicians' vicarious exposure (Folland, 2017; Phillips et al., 2021). These findings suggest that EMDR could feel both emotionally impactful and protective for clinicians, depending on the clinician's experience, the client group, and how EMDR was delivered.

Growth and Meaning. Despite the potential emotional impacts of delivering EMDR, this intervention was often described as providing professional growth and meaning for some clinicians, particularly as they observed meaningful change in clients and became more able to trust their clinical judgement in EMDR practice (McKillop et al., 2024; Phillips et al., 2021; Unwin et al., 2023). Some described EMDR as especially rewarding because of the speed or depth of outcomes they witnessed, including reductions in trauma-related and psychotic symptoms (Blackford-Jones, 2025; Phillips et al., 2021; Strelchuk et al., 2024). For some, this interdependent and reciprocal growth extended beyond therapists' EMDR competencies to changes in their empathy, creativity, and sense of professional identity (Smith-Lee Chong, 2016).

Supervision and peer support were repeatedly identified as central to this professional growth and meaning. Appropriate clinical supervision was described as "integral to practice" (Fisher et al., 2023, p. 1084), while peer groups and the wider EMDR community offered reassurance, reflection, and containment (McKillop et al., 2024; Smith-Lee Chong, 2016). Across studies, appropriate EMDR supervision supported clinicians' technical development in practising EMDR and their emotional well-being, particularly when population-specific expertise was lacking (Blackford-Jones, 2025; Phillips et al., 2021; Shipley, 2022).

Theme 5: EMDR Within Systems. Finally, therapists situated their EMDR practice within the broader realities of UK service, training, and care systems, describing how these could either enable or constrain access to EMDR.

Systems as Helpers or Barriers. Clinicians frequently described organisational and structural barriers impacting EMDR practice in the UK, including unclear referral pathways, gatekeeping, fixed number of sessions, and pressure to demonstrate rapid therapeutic outcomes (Blackford-Jones, 2025; Fisher et al., 2023). These systemic constraints were often experienced as disadvantaging clinical populations with complex or diverse needs, who often required greater flexibility or broader systemic approaches when applying EMDR in practice (Fisher et al., 2023; Shipley, 2022).

Therapists also described limited UK training and supervision provision for using EMDR with complex presentations, including autism, psychosis, older adults, and attachment-related difficulties, which reduced therapists' confidence in using EMDR in some cases (Blackford-Jones, 2025; Fisher et al., 2023; Phillips et al., 2021; Shipley, 2022). In some contexts, EMDR was further constrained by wider professional cultures that favoured other interventions like CBT or medical-model approaches, as well as practical barriers such as technology problems, unsuitable therapy environments, and lack of service capacity (Folland, 2017; McKillop et al., 2024; Phillips et al., 2021; Strelchuk et al., 2023; Unwin et al., 2023).

The lack of family/carer support and stability was also discussed as a factor that could undermine clients' engagement and retention in EMDR (McKillop et al., 2024; Shaw, 2024). Therapists discussed the need to address social and environmental stressors to support EMDR implementation in the UK (Phillips et al., 2021).

At the same time, systems were also shown to support EMDR delivery at times. For example, MDT support, team awareness, informed referrals, and appropriate support from parents, carers, schools, and wider networks helped therapists assess readiness, manage risk, and maintain clients' engagement in EMDR (McKillop et al., 2024; Phillips et al., 2021; Shaw, 2024). Clinicians emphasised that effective EMDR practice often depended on support beyond the therapy room, and that systemic work was sometimes needed alongside, or before, direct EMDR.

Access Inequities. Therapists also described inequities in who could access EMDR in the UK. Diagnostic assumptions, limited evidence bases, and limited understanding about EMDR's suitability for more diverse and complex presentations (such as autistic clients, people with psychosis, individuals with intellectual disabilities, those with complex trauma, and older adults) were at times described as constraining structural and clinical decision-making processes, which impact accessibility to EMDR (Blackford-Jones, 2025; Fisher et al., 2023; McKillop et al., 2024; Phillips et al., 2021; Strelchuk et al., 2024).

Disparities in EMDR training and supervision were also reported across studies, leading to variations in EMDR provision in the UK. For example, Shipley (2022) described the shortages of accredited child EMDR supervisors in the UK, limiting therapists' ability to practice EMDR in children's and adolescent mental health services, whilst Phillips et al. (2021) also highlighted difficulties in accessing EMDR supervision within UK psychosis services.

Whilst remote EMDR widened access for some clients, particularly those facing childcare, mobility, or geographical barriers, it was described as restrictive for others. For example, clients without access to privacy, technological equipment or confidence, or

adequate support to manage distress safely at home, made remote EMDR inaccessible (Blackford-Jones, 2025; Fisher et al., 2023; Strelchuk et al., 2023; Unwin et al., 2023).

Discussion

This thematic synthesis of 12 qualitative studies is, to the researcher's knowledge, the first to synthesise clinicians' experiences of delivering EMDR in UK contexts. The findings show that clinicians experienced EMDR not simply as a manualised intervention. Rather, it was experienced as a distinctive, therapeutic approach that required clinicians to make sense of its unfamiliarity, negotiate fidelity and flexibility, carefully attend to relational safety, develop professionally through their EMDR practice, and deliver EMDR within systems that could either enable or constrain its use. Taken together, the synthesis highlights EMDR delivery in the UK as a dynamic clinical process shaped by therapist experience, client needs, and wider service considerations.

A prominent finding is that clinicians often experienced EMDR as initially unfamiliar, unusual, or difficult to explain. Compared with more traditional talking therapies like CBT, EMDR's reduced reliance on verbal disclosure, use of BLS, and more procedural structure challenged assumptions about what therapy should look like. This initial uncertainty reflects Mezirow's (1991) transformative learning theory, in which professionals reshape their beliefs about practising therapy with clients when they encounter EMDR, which can initially feel disorienting or inconsistent with their previous learning. In the synthesised studies, initial uncertainty about EMDR was often followed by increased confidence as clinicians observed positive outcomes, received appropriate supervision, and became familiar with practising the intervention. This finding echoes Bandura's (1977) concept of self-efficacy, in which confidence develops through mastery experiences and modelling, as well as with Schön's (1983) reflective practitioner model, where clinicians learn through reflection-in-action -

experimenting, adapting, and internalising new ways of working within uncertain practice environments.

A central theme across the synthesis was the tension between adherence to EMDR's standard protocol and the need for flexibility in real-world practice. For many clinicians, the standard EMDR protocol (Shapiro, 2018) offered a sense of structure, containment, and safety, especially early in their EMDR career or when working with complex trauma. At the same time, strict adherence could be experienced as restrictive when working with clients with complex or additional needs, where EMDR protocol elements such as imagery, cognition, pacing, communication style, sensory preferences, or readiness for trauma processing needed further consideration. With practice and confidence, therapists moved from viewing the EMDR protocol as something to be strictly followed to understanding it as a flexible framework to be adapted whilst preserving EMDR's core therapeutic principles. This is consistent with the concept of adaptive expertise, where skilled clinicians move beyond manualised therapy competence towards flexible, context-sensitive, and clinically judged use of evidence-based therapeutic practice (Hatano & Inagaki, 1986). Adaptation was not framed as poor fidelity to EMDR principles, but as a necessary responsiveness to diverse client needs and service contexts. This interpretation aligns with broader psychotherapy research, which suggests that therapist responsiveness - the capacity to flexibly attune to client needs - is central to effective EMDR practice (Norcross & Wampold, 2018).

This synthesis also highlighted the importance of the therapeutic relationship in EMDR. Clinicians consistently described safety, trust, relational attunement, and client agency as central to effective EMDR practice. These findings correspond with attachment-informed and relational models of psychotherapy, which position the therapeutic relationship as central to therapeutic regulation and positive outcomes (Bowlby, 1988; Safran & Muran, 2000). Clinicians described preparation and stabilisation phases of EMDR as especially

important for building trust and containment before trauma processing began, with some suggesting that EMDR could itself strengthen relational security by helping clients reconnect with their own strengths and experience supportive adult relationships as safer and more trustworthy.

At the same time, the therapeutic relationship could also be strained during EMDR if the client's distress was harder to read or escalated quickly, or if the structure of EMDR felt distancing or overly formal for the client. This is understood through the alliance rupture theory (Safran & Muran, 1996), in which clinicians may need to notice or repair ruptures or misunderstandings before effective trauma processing in EMDR can occur, a process that depends on sufficient trust, containment, and responsiveness in the therapeutic relationship.

Delivering EMDR also appeared to shape clinicians' professional development in complex ways. Some clinicians described the emotional burden of delivering EMDR, including feeling overwhelmed or affected somatically, particularly in clinicians' early EMDR careers or when working with severe or complex trauma. These findings align with the literature of empathic strain, vicarious trauma, and the emotional demands of delivering trauma therapy (Figley, 2002; Killian, 2008). However, some clinicians experienced EMDR as less emotionally intrusive compared to delivering other trauma-focused interventions like CBT, particularly because it reduced their exposure to detailed trauma narratives. The blind to therapist EMDR protocol (Blore et al., 2013) was sometimes described as a way of practising EMDR which protected clinicians' emotional burden. This suggests that delivering EMDR may be experienced as emotionally containing for some therapists, whilst emotionally demanding for others.

Alongside this emotional burden, the synthesis also showed that clinicians' experiences of EMDR were professionally meaningful and transformative. Some therapists

experience reciprocal or shared growth when practising EMDR by witnessing clients' positive outcomes after engaging in the intervention. These findings overlap with ideas of vicarious post-traumatic growth (Tedeschi & Calhoun, 2004), where exposure to the client's recovery also promoted therapists' professional and personal development. Throughout the synthesis, supervision and peer support were repeatedly discussed as central to the development of clinicians' EMDR competencies. Appropriate supervision offered clinicians emotional containment, a reflective space, and support for the flexible practice of EMDR, reinforcing the view that reflective supervision is especially important for sustained trauma-focused work and clinician wellbeing (Bion, 1962).

The final theme of this synthesis showed how UK systems influence EMDR practice. Clinicians described various organisational and structural factors influencing whether EMDR could be delivered, adapted, and sustained in practice. These included referral pathways, gatekeeping, service time constraints, pressure for quick outcomes, insufficient managerial or MDT support, lack of suitable environments for delivering EMDR, practical barriers to remote EMDR, and limited access to population-specific EMDR training and supervision. Likewise, inequities in access to EMDR in the UK were also apparent across the literature. Diagnostic assumptions, limited understanding of suitability for EMDR, limited EMDR evidence bases for certain populations, and the delivery model appeared to restrict some from accessing appropriate EMDR therapy. On the contrary, the finding also showed that systems could both help and hinder EMDR. For example, parent/carer support, informed referrals, and collaboration with other systems, such as schools, often made it more feasible and safer to practice EMDR. These findings suggest that broader systemic influences and contexts shape EMDR implementation and access, consistent with implementation and ecological frameworks, which emphasise that evidence-based intervention practice depends on various

clinician-, organisational-, and system-level factors (Bronfenbrenner, 1979; Fixsen et al., 2005).

Strengths and Limitations of the Review

A strength of this review is its exclusive focus on UK-based EMDR studies, which provide contextual insights into how EMDR is understood, adapted, and implemented within UK mental health practice, thereby enhancing the synthesis's relevance to EMDR clinical practice, training, and supervision in the UK. An additional strength was the use of thematic synthesis, which offered a rigorous and transparent meta-synthesis approach to interpret qualitative findings, enabling the generation of higher-order analytical themes into how clinicians learn, adapt, and sustain EMDR across diverse settings while remaining grounded in the study's findings (Thomas & Harden, 2008). The inclusion of grey literature, such as doctoral theses and service evaluations, alongside peer-reviewed publications was viewed as a strength, as it reduced the risk of publication bias and provided a broader account of the evidence base (Adams et al., 2017; Paez, 2017).

Despite these strengths, several limitations should also be considered. First, the included studies varied in their reporting of methodological quality, particularly regarding reflexivity, ethical detail, and transparency in analytical procedures. Although most studies were methodologically sound overall, inconsistent reporting of procedures may reduce the interpretive depth of the findings. Second, several studies involved small, context-specific samples, which may limit transferability across UK settings. Third, while thematic synthesis allowed for interpretive exploration, it cannot fully capture how clinicians' experiences of EMDR may develop over time. Ethnographic or longitudinal meta-synthesis designs may have yielded additional insights into how EMDR practice evolves through training, supervision, and professional experience (Greenhalgh & Wieringa, 2011).

Despite these limitations, the methodology employed was appropriate for the review's interpretive and integrative aims. The thematic synthesis provided recommendations for future research by highlighting the interplay between clinical expertise, service context, and adaptation in EMDR practice. This understanding directly informs the design of the current study, which seeks to address the identified methodological and conceptual gaps by focusing on EMDR delivery with adolescents across various UK mental health contexts.

Implications and Recommendations for Future Research

A key implication of this synthesis is the need for future research that focuses specifically on clinicians' experiences of delivering EMDR to adolescents in UK mental health settings. Although two studies included clinicians using EMDR with children and young people in UK contexts (Shaw, 2024; Shipley, 2022), neither explored adolescent-specific populations and were limited by small, context-bound samples. As a result, clinicians' experiences of delivering EMDR specifically to adolescents in the UK are absent. This is despite adolescents representing a distinct developmental period and features (Pynoos et al., 2009) that are likely to shape how EMDR is explained, paced, adapted, and experienced in practice.

The current synthesis suggests that flexibility, relational safety, and systemic influences are central to EMDR delivery more broadly. However, it remains unclear how clinicians use EMDR with adolescents in various UK contexts. Developmentally informed EMDR approaches, such as attachment-based EMDR and creative or flexible applications of EMDR described in these synthesis findings, further suggest that adolescent EMDR may require responsiveness to developmental, relational, and contextual needs, which warrant further exploration.

Therefore, future qualitative research is needed to explore clinicians' experiences of delivering EMDR to adolescents and how they make sense of its benefits, challenges, and fit relative to other trauma-focused interventions. Such research could also examine how service context, organisational culture, supervision, and professional training shape clinicians' confidence when working with complex adolescent presentations in the UK.

Finally, greater methodological consistency and transparency are recommended in future EMDR research. Research that provides clearer reflective accounts, more ethical detail, and more transparent analysis would strengthen the credibility and transferability of the current EMDR evidence base (Braun & Clarke, 2021a).

Rationale for the Current Study

Taken together, this synthesis identified a significant gap in understanding clinicians' experiences of delivering EMDR to adolescents in UK mental health settings. Although quantitative research supports the efficacy of EMDR with adolescents, little is known about how clinicians adapt EMDR to meet adolescent-specific developmental needs, manage engagement, and deliver it with this population within the realities of the NHS and other UK systems. Existing qualitative research has also given limited attention to how clinicians' professional backgrounds, supervision arrangements, and comparisons with other trauma-focused interventions shape their use of EMDR with adolescents across different clinical contexts in the UK.

Given the rising adolescent mental health needs in the UK, the increasing use of EMDR, and the importance of clinician perspective for implementation science, there is a clear need for adolescent-specific qualitative research in this area. This understanding would support informed EMDR practice, training, supervision, service development, and trauma-informed care for adolescents across UK contexts.

Current Research Aim and Question

This current research aims to explore clinicians' subjective experiences of delivering and adapting EMDR as a trauma intervention with adolescents aged 13–17 years in UK mental health settings.

The research questions are:

1. What are clinicians' experiences and perceptions of the benefits and challenges of using EMDR with adolescents in the UK?
2. How do clinicians adapt EMDR to meet the developmental and contextual needs of adolescent clients?
3. What are clinicians' experiences of EMDR with adolescents in relation to other therapeutic interventions?

Chapter Summary

This chapter has reviewed the current literature on clinicians' experiences of delivering EMDR in the UK and concluded with a rationale and aims for the present study. The following chapter outlines the methodological approach for exploring clinicians' experiences of practising EMDR with adolescents in the UK.

Chapter 3: Methods

Chapter Overview

This chapter sets out the methodological approach used in this study. It first situates the research within a qualitative paradigm, outlines the study's critical realist ontological and epistemological positioning, before justifying the use of reflexive thematic analysis (RTA) and its conceptual fit with critical realism. The chapter then presents the researcher's positioning and the reflexive practices used across data collection and analysis. Ethical considerations are subsequently discussed, including approval, informed consent, withdrawal procedures, confidentiality, data management, and well-being considerations. The chapter then describes the study design and methodological details, including sampling and eligibility criteria, recruitment procedures, participant characteristics and considerations of transferability, and the data collection process (pilot interview, interview materials, and interview procedure). Finally, it outlines the analytic process that follows Braun and Clarke's six phases of RTA, alongside strategies to support methodological coherence and quality. It concludes with the dissemination plan for clinical, academic, and professional audiences.

Methodological Framework

Rationale for a Qualitative Methodology

A qualitative methodology was chosen to enable an in-depth exploration of clinicians' experiences of delivering EMDR to adolescents in the UK. This study sought to examine professional meaning-making, clinical judgement, and the complexities of everyday practice rather than to test hypotheses or quantify relationships between variables. Qualitative approaches are well-suited to exploring lived experience, professional sense-making, and the interplay among individual, relational, and organisational influences in clinical contexts

(Carter & Little, 2007; Hammarberg et al., 2016), and align closely with the aims of this research.

Delivering trauma-focused interventions with adolescents involves complex clinical decision-making, developmental adaptations, and navigation of contextual and organisational factors, which are processes not easily captured through quantitative designs alone. Therefore, a qualitative approach enabled exploration of how clinicians understand, adapt to, and evaluate the use of EMDR with adolescents in everyday practice in the UK. This included investigating clinicians' perceived benefits and challenges of EMDR practice with adolescents, protocol adaptations, experiences of adolescent-specific EMDR training and supervision, and comparisons with and integration of other trauma-informed interventions. Semi-structured interviews were selected because they provide both flexibility and focus, enabling participants to articulate what they consider clinically relevant, aligning with the research questions, and facilitating analysis of shared and divergent experiences.

Philosophical Positioning

This study makes it's philosophical positioning explicit to promote transparency and ensure theoretical coherence between ontological assumptions, epistemological commitments, and analytic practice. In qualitative research, philosophical foundations shape the formulation of research questions, the generation and analysis of data, and the nature of the knowledge claims that can be made (Silverman, 2013; Willig, 2013). Articulating these positions acknowledges that researchers' views of reality inevitably influence research design, interpretation, and analytical decisions (Braun & Clarke, 2021b).

Research paradigms differ in their assumptions about reality and knowledge. A positivist stance assumes that knowledge can be objectively measured and that causal relationships can be identified through hypothesis testing and examination of relationships

between variables (Park et al., 2020). This position aligns most closely with quantitative methodologies, which have traditionally been prioritised on the assumptions of rigour, replicability, and generalisability through statistical analysis (Millsap & Maydeu-Olivares, 2009; Park et al., 2020).

In contrast, qualitative methodologies are gaining increasing legitimacy and recognition, particularly in health and social care research. By treating participants' accounts, meanings, and language as data, qualitative approaches enable in-depth exploration of complex, contextualised, and subjective experiences that may not be accessible through quantitative methods alone (Al-Busaidi, 2008; Braun & Clarke, 2013). Often grounded in interpretivist philosophy, qualitative research challenges the notion of a single objective reality and instead emphasises multiple, socially constructed realities and the co-construction of knowledge (Willig & Rogers, 2017).

Ontological Stance. Ontology concerns assumptions about the nature of reality and what can be said to exist (Guarino et al., 2009). Ontological positions are often conceptualised along a continuum ranging from realism, which assumes a reality exists independently of human perception, to relativism, which views reality as socially constructed and contextually contingent (Guba & Lincoln, 1994; House, 1991).

This study adopts a critical realist ontology, which occupies a middle ground between positivism and relativism. From a critical realist perspective, reality exists independently of both the researcher and the participants; however, our understanding of reality is shaped through interpretation, language, and social context (Sayer, 2004). Reality is therefore understood as shaped by both observable experiences and practices and the underlying mechanisms and structural conditions that influence them.

This ontological stance is particularly useful for the present study because clinicians' accounts of delivering EMDR were treated as meaningful descriptions of real-world practice, while recognising that such accounts are shaped by wider organisational, professional, and systemic contexts, as well as the research context itself. Therefore, this positioning was particularly suited to examining clinicians' experiences of delivering EMDR to adolescents, as both individual-level factors and broader structural conditions within UK mental health services likely influence practice.

Epistemology Stance. Epistemology concerns the nature of knowledge and its generation, interpretation, and evaluation (Willig, 2013). It addresses the relationship between the knower and what is known. In this study, the 'knowers' are clinicians who share their experiences of practice, and the researcher interprets those accounts. The 'known' is clinicians' situated accounts of delivering EMDR to adolescents in UK contexts.

A critical realist epistemology (Bhaskar, 2008) underpins this study. From this perspective, participants' narratives are not treated as direct reflections of objective truth, but as interpretative accounts of lived and professional experience. Knowledge is understood as partial and situated, yet capable of offering meaningful insight into the real practices and the conditions that shape them (Danermark et al., 2002). This epistemological stance supported an analysis grounded in participants' accounts while considering the influence of service context, professional norms, and power dynamics that are likely to shape those accounts.

Methodological Fit: Critical Realism and Reflexive Thematic Analysis

Reflexive thematic analysis (RTA) is a methodological approach that can be situated within various philosophical frameworks, including critical realism (Braun & Clarke, 2006, 2022). Within RTA, meaning is not treated as something that exists within the data waiting to

be discovered. Instead, themes are developed through the researcher's active and reflexive engagement with participants' accounts.

This aligns with a critical realism approach, which maintains that reality exists independently of both the researcher and participants, while recognising that our understanding of this reality is shaped through interpretation and influenced by contextual factors (Sayer, 2004). RTA was therefore well suited to the aims of this study, as it enabled the identification of meaning within clinicians' accounts while also acknowledging that these interpretations are situated within complex, diverse, and context-informed experiences (Braun & Clarke, 2006, 2022).

Researcher Positioning and Reflexivity

Researcher Position Statement

In line with a critical realist framework and reflexive thematic analysis (RTA), explicit consideration of the researcher's positioning was integral to the research process (Braun & Clarke, 2022). RTA conceptualises the researcher as an active and interpretive agent whose assumptions, experiences, values, and social positioning shape all stages of the research, including the questions asked, data collection, and the interpretations developed (Braun & Clarke, 2022). The purpose of this positionality statement is therefore not only descriptive but also methodological, providing transparency into the standpoint from which this research was conducted and how reflexivity was practised across data collection and analysis.

I am a White British female and a trainee clinical psychologist working within the UK NHS mental health services. My early academic training in psychology was predominantly grounded in quantitative methodologies aligned with positivist traditions, with limited opportunities for qualitative exploration. Over time, my clinical work within the NHS highlighted the value of qualitative approaches for understanding lived experience,

professional practice, and the contextual influences shaping mental health service delivery. This shift reflects my professional commitments to trauma-informed care, service accessibility, and the inclusion of practitioner and service-user perspectives in service development.

Before doctoral training, I worked as an assistant psychologist across several NHS inpatient and community mental health settings. While working in an adolescent inpatient unit supporting young people experiencing complex post-trauma distress, suicidality, self-harm, and a range of other mental health difficulties, I developed a sustained interest in trauma-focused interventions for adolescents. Observing clinicians using EMDR both therapeutically and as a staff support intervention following critical incidents further shaped my curiosity about EMDR and its implementation.

My interest in adolescent mental health is also informed by longstanding experience working with young people, including volunteering in a school counselling service during my undergraduate studies. I value the creativity and developmental significance of adolescent therapeutic work, as well as the potential for timely intervention to interrupt trajectories of distress, strengthen emotional resilience, and support future well-being. At the same time, I recognise that my values could shape what feels salient to me during data collection and analysis. Therefore, reflexive practice throughout this research involved monitoring where my passion might draw me towards certain interpretations (e.g., privileging narratives of therapeutic effectiveness or innovation) and deliberately attending to ambivalence, constraint, and critique within the dataset.

While I would have valued directly incorporating adolescents' perspectives, ethical and procedural constraints in doctoral research made this infeasible. The study is therefore positioned as a foundational exploration of clinicians' experiences, intended to inform future

work that more directly includes adolescents' voices. This absence was held in mind during interpretation, particularly when participants spoke about acceptability, engagement, or outcomes, and it informed a cautious approach to claims regarding adolescents' experiences.

At the outset of the study, my direct experience with EMDR was limited as I had not undertaken formal EMDR training. This placed me as an outsider to specialist EMDR practice while also being an insider to UK mental health service structures and professional cultures. I began standard EMDR training with a UK provider after data collection for this research had concluded, thereby reducing the likelihood that training-specific EMDR knowledge would shape the interview encounters, whilst also enhancing my understanding of EMDR during later analytic stages. This evolving insider-outsider position was treated as a reflexive resource rather than a methodological problem, supporting both curiosity during the interviews and interpretation during analysis. Reflexive notes were used to track shifts in my understanding of EMDR over time and to consider how these shifts might shape theme development (Braun & Clarke, 2022).

I was also mindful of how my role as a trainee clinician-researcher interviewing experienced, accredited EMDR clinicians could shape the interview encounter. Power dynamics were considered as potentially operating in complex ways. For example, participants may have experienced the interview as an opportunity to advocate for EMDR or perceived it as an evaluation by a trainee psychologist. However, my trainee status may also have facilitated openness, particularly where clinicians framed their accounts as mentoring, reflective teaching, or professional sharing. During the interviews, I used open prompts, clarification questions, and asked for examples to invite participants to elaborate rather than agree, based on my experience working in complex UK healthcare systems. I also attended reflexively to moments of resonance, uncertainty, or shared professional assumptions that risked narrowing participants' discussion. I remained mindful of potential social desirability

and professional consensus, particularly in relation to descriptions of good practice, safeguarding, and organisational pressures, and used gentle probing to invite complexity (e.g., “What made that difficult?”, “Were there times it did not work as hoped?”, “How did the service context shape that decision?”).

Reflexive Practices Throughout The Study

Reflexive engagement was supported through maintaining a reflexive diary, regular research supervision, and considering how positioning influenced data collection and analysis (Braun & Clarke, 2022). Reflexive notes documented emotional responses, assumptions, interview dynamics, analytic decisions, and shifts in interpretive thinking over time. In keeping with RTA, reflexivity was treated as a quality practice and an analytic tool, enabling critical engagement with how meanings were co-produced and how final thematic interpretations were constructed, rather than as a mechanism for eliminating researcher subjectivity.

Ethical Considerations

Ethical approval was granted by the University of Essex Science and Health Faculty Ethics Committee on 28th May 2024 (Approval ID: ETH2324-1052; see Appendix C). During this research project, all processes adhered to the British Psychological Society’s (BPS) Codes of Ethics and Conduct (BPS, 2021).

Informed Consent

Before gaining consent, interested clinicians and potential participants were provided with the participant information sheet via email (See Appendix D), which outlined an overview of the research project. Participants’ informed consent was obtained via an electronic consent form (See Appendix E) sent by email before the interview. The researcher securely stored the signed consent forms on a password-protected computer. Consent

procedures emphasised voluntariness, confidentiality, and the right to withdraw. At the start of the interview, participants gave verbal consent for the interview to be recorded.

Right to Withdrawal

Participants were informed of their right to withdraw at any time during the interview and to request deletion of their data up to 21 days after the interview by emailing the researcher with their allocated participant identification number (ID). No participant withdrew during or following the interviews.

Confidentiality, Anonymity, and Data Management

Participants were assigned an ID number for consent, data management, and analysis. Participants were assigned pseudonyms throughout the research write-up to ensure confidentiality and anonymity.

All distinguishable information, such as localities, service names, and distinctive role descriptions, was removed from transcripts and the report write-up. Given the specialist nature of EMDR practice with adolescents in the UK and the potential for deductive disclosure within professional communities, care was taken to avoid presenting combinations of details that could identify clinicians or services, particularly when discussing specific service models or professional roles (Kaiser, 2009).

Virtual interviews were audio-recorded via Zoom's recording function, and the audio was transcribed using Microsoft Word's automatic transcription feature, then manually checked against the audio recording for accuracy. Audio recordings and transcripts were stored on a password-protected device accessible only to the researcher. Audio files were deleted once transcription and accuracy checking were complete. Anonymised transcripts will be stored on a University of Essex-secured drive for up to three years to facilitate publication.

Wellbeing Considerations

Although no distress was anticipated, it was acknowledged that participants discussing trauma-focused clinical work could evoke discomfort. To minimise this, participants were reminded that they could terminate the interview or take a break at any time. The researcher monitored for signs of distress or discomfort during the interview and checked in with participants at the end of the interview. The participant information sheet provided signposting to support channels, and participants were encouraged to access their workplace support services if needed. No participants reported distress or a negative impact from participation.

Given that the researcher is a trainee clinical psychologist trained in managing potential emotive discussions, it was not anticipated that data collection or analysis would adversely affect the researcher's well-being. Researcher support was available through research supervision and programme structures.

Participants and Recruitment

Sampling Strategy and Eligibility Criteria

Criterion purposive sampling was used to recruit clinicians with direct experience relevant to the research aims (Patton, 2015). This non-random sampling method involved selecting participants who are competent and informed about the phenomenon of interest (Etikan et al., 2016) and willing to participate (Creswell & Plano Clark, 2011). Additionally, snowball sampling was used to supplement a criterion-based purposive sample, in which participants were asked to share the research information with other potential participants who met the eligibility criteria.

Various guidelines discuss what is an appropriate 'sample size' for qualitative research. Sandelowski (1995) argues that for qualitative research, the sample size should be

small enough to manage the dataset and large enough to provide "a new and richly textured understanding of experience" (p. 183) and maintain focus on the participants' experiences relative to the analytic purpose (Braun & Clarke, 2013). These guidelines suggest that sample size should be determined by the type of data collection and the size of the research project, with medium-sized projects (e.g., professional doctorate research) aiming to collect 10 to 20 interviews (Braun & Clarke, 2013). In line with these guidelines, the current study aimed to recruit and individually interview 10-20 participants. In keeping with RTA, the aim was not data saturation, but the generation of a sufficiently information-rich dataset, meaning recruitment was ceased when the dataset was judged to contain sufficient depth to address the research aims (Braun & Clarke, 2021; Malterud et al., 2016).

Participants were eligible if they were an EMDR Europe-accredited practitioner and had delivered full EMDR therapy at least once (i.e. completed all EMDR protocol phases) with adolescents aged 13–17 in UK mental health contexts within the past five years. EMDR Europe accreditation was considered at the practitioner level rather than as separate child and adolescent EMDR accreditation, as EMDR practitioners can practice EMDR to adolescents without holding children and adolescent-specific accreditation (EMDR Association UK, 2025). This criterion ensured that participants had recognised EMDR training, accreditation, and experience, while allowing the inclusion of clinicians with relevant experience in delivering EMDR to adolescents within UK mental health settings. The age range of 13-17 was chosen because this developmental stage is associated with distinct cognitive, emotional, and relational processes that may influence EMDR practice differently from younger children or adults. This age range also aligns with UK service structures, including adolescent inpatient and community services, supporting inclusion of clinicians working across a range of settings where adolescent EMDR is delivered in practice. The five-year timeframe was selected to ensure that participants reflected on relatively recent adolescent EMDR practice

and contemporary service contexts and delivery. Participants were required to be fluent in English for interviewing purposes. Clinicians who did not meet these criteria were excluded. Table 7 presents the full inclusion and exclusion criteria.

Table 7

Participant Inclusion and Exclusion Criteria.

Inclusion Criteria	Exclusion Criteria
• EMDR Europe-accredited practitioner • Delivered ≥ 1 full EMDR treatment with an adolescent (13–17) in a UK mental health setting within the past five years • Fluent in English	• Not an EMDR Europe-accredited practitioner • < 1 full EMDR treatment with an adolescent (13–17) in a UK mental health setting within the past five years • Not fluent in English

Recruitment Process

Recruitment occurred between April and October 2025. Recruitment materials included a research poster (Appendix F) circulated via LinkedIn and an EMDR-focused professional Facebook group. Targeted email invitations (Appendix G) were also sent to clinicians listed on the EMDR Association UK public directory as accredited adolescent EMDR clinicians. Snowball sampling was supported by inviting EMDR clinicians known to the researcher to forward information about the study to potentially eligible colleagues.

Interested clinicians were emailed the participant information sheet, which outlined the study's aims, what was involved, ethical considerations, and data management. If the potential participants were still interested after reading the participant information sheet, they

were sent some basic questions to screen for eligibility. They were invited to ask any questions before participating and to arrange a date for the interview. Those who agreed to take part and met the eligibility criteria returned a signed electronic consent form before the interview. All interviews were conducted online via Zoom in a private, confidential space for the researcher and the participant.

Participant Characteristics, Representativeness and Transferability

In total, 15 participants took part in this study. All participants met the inclusion criteria. The results chapter presents further details of participant characteristics.

In qualitative research, the aim is not statistical representativeness or generalisability, but the generation of an information-rich sample which addresses the research aims. Instead, transferability is considered a more appropriate quality marker in qualitative research, referring to the extent to which findings can be meaningful or applicable to other similar contexts and characteristics (Lincoln & Guba, 1985). The present sample included clinicians from multiple professional backgrounds and service contexts, supporting the exploration of how EMDR practice with adolescents is experienced and adapted across diverse UK settings.

However, the demographic homogeneity of the sample in relation to ethnicity (all participants were White) may limit the transferability of findings to clinicians from minoritised ethnic backgrounds and to service contexts where cultural and structural factors may shape trauma presentations, access, and delivery of EMDR differently. This limitation is revisited in the Discussion chapter.

Data Collection

Materials

Demographic Questionnaire. A brief demographic questionnaire (Appendix H) was used to describe the sample and contextualise clinicians' accounts. Items on this demographic questionnaire asked about participants' core professional role, EMDR accreditation status, years of clinical experience, years of EMDR experience, the setting in which they have practised adolescent EMDR (e.g., public and/or private practice, community and/or inpatient), and their current use of adolescent EMDR. This demographic information was used descriptively rather than analytically, supporting contextual interpretation and transparency.

Semi-Structured Interview Schedule. The primary data-gathering tool was the semi-structured interview schedule (Appendix I), which was co-developed by the researcher and supervisor. The interview schedule was informed by the study aims, gaps in the literature regarding EMDR implementation and adaptation with adolescents in UK contexts, and pilot interview feedback. Semi-structured interviewing provides sufficient structure for comparability across participants while allowing flexible exploration of clinically meaningful topics and areas of interest (Adams, 2015; Rubin & Rubin, 2011).

Individual interviews were selected rather than focus groups to minimise peer influence and social desirability effects (Hennink, 2007), particularly given that participants discussed professional practice, supervision, and organisational barriers. Fully unstructured interviews were considered inappropriate due to the risk of producing excessive variability across interviews, potentially limiting coherence with the research aim.

The final interview schedule (Appendix I) explored clinicians' experiences of delivering EMDR to adolescents in the UK. The topic areas included: clinicians' perceived

benefits and challenges; adaptations to the EMDR protocol (including developmental and attachment-informed modifications); clinical decision-making processes in EMDR; comparison and integration of EMDR with other modalities (including TF-CBT); UK adolescent EMDR supervision, training, and professional support; systemic influences on adolescent EMDR practice; and recommendations for improving EMDR provision for adolescents in the UK. Prompts within core questions were used to elicit further detail and reflection (e.g., "Can you describe a time when…?", "What do you think shaped that?", "Can you tell me more about…?"). The schedule was used flexibly to allow participants to emphasise their own experiences while aligning with the research aim and questions.

Pilot Interview

Before formal data collection began, a pilot interview was conducted in April 2025 with a clinician experienced in delivering EMDR interventions to adolescents in a UK CAMHS context, but who did not meet the accreditation requirements for participation in the main study. The pilot evaluated the clarity, relevance, and sequencing of questions; assessed whether the questions were suitably framed to elicit rich, reflective, and experience-near accounts; and enabled the researcher to practise interview delivery, refine their interviewing style, and evaluate the practicalities of interviewing online.

Following the pilot interview, several refinements were made to the interview schedule, including reordering questions to improve narrative flow, clarifying wording, adding prompts to support elaboration, and rephrasing questions that risked constraining or leading responses. For example, more general questions about clinicians' training motivations and emotional reactions to delivering EMDR to adolescents were removed. Broad questions about "good" or "bad" EMDR sessions were replaced with more focused exploration of barriers, benefits, and adaptations. Additional prompts were also added to explore differences

across settings, supervision, and the integration of EMDR with other therapeutic approaches when working with adolescents. These revisions supported the development of the final interview schedule, which was intended to provide the depth and nuance required to meet the research aim.

Interview Procedure

Interviews were conducted online via Zoom between April and October 2025, with an average duration of 61 minutes. Online interviewing enhanced accessibility for participants located across the UK, reduced travel requirements, and supported scheduling around clinicians' work demands. It also enabled participation by clinicians working in various geographic locations and service contexts that might have been difficult to reach through in-person interviews. Arguably, virtual qualitative interviews can produce rich and meaningful data when compared to face-to-face interviews, particularly when exploring professional experiences (Archibald et al., 2019). One participant chose to turn their video off during the interview due to technical difficulties. Interviews were audio-recorded using Zoom's automatic audio recording feature.

At the start of the interview, participants were reminded of their voluntary participation, their right to withdraw, and the confidentiality processes in place. Participants gave verbal consent for their interview to be recorded via Zoom for transcription. Zoom's recording and automated transcription via Microsoft Word were used to support accurate capture of content. Transcripts were checked against audio recordings for accuracy and anonymised by removing identifying information (e.g., localities, service names, potentially identifying clinical details). Pseudonyms and participant IDs were used throughout the analysis and write-up.

Data Analysis

Whilst interpretative phenomenological analysis (IPA) (Smith et al., 1999) and grounded theory (Glaser, 1992) were considered as data analysis methods, these were not selected because this research aimed to identify patterned meaning across diverse clinicians and contexts, rather than aiming for idiographic depth or generating a formal theory. Instead, thematic analysis allows the researcher to describe the data and interpret aspects of the topic area based on participants' accounts and experiences (Boyatzis, 1998). Reflexive thematic analysis (RTA) (Braun & Clarke, 2019, 2021b), a form of thematic analysis, was chosen for this current research because it offered a flexible, yet theoretically coherent, analytical approach that could capture both shared patterns of meaning and important areas of diverse accounts across participants' accounts (Braun & Clarke, 2021b). RTA was considered particularly suitable given the study's exploratory aims and its focus on clinicians working across diverse professional backgrounds and clinical settings. Unlike approaches that aim to produce a consensus or establish coding reliability, RTA acknowledges the active role the researcher has in interpreting the data and emphasises that themes are generated through the researcher's engagement with the dataset rather than emerging passively from it (Braun & Clarke, 2019; Byrne, 2022), aligning with the critical realist stance of this study.

Data analysis followed Braun and Clarke's six phases of RTA as outlined below, conceptualised as iterative and recursive rather than linear (Braun & Clarke, 2006, 2021b). NVivo 14 was used to support data management, coding, and retrieval of data extracts. Microsoft Excel supported reflective comparison of codes and documentation of analytic decisions.

Phase 1: Familiarisation

The first phase involved deep familiarisation with the dataset. The researcher listened to each audio recording alongside the corresponding transcript to check for accuracy and to support immersion with the data (Braun & Clarke, 2006). Each transcript was read multiple times, attending to both individual accounts and the whole dataset. During this process, brief notes were taken alongside the transcripts, including initial reflections and potential initial analytic ideas (see Appendix J for an example). These initial familiarisation notes and reflections were documented in the researcher's reflexive diary and discussed in supervision (Braun & Clarke, 2022).

Phase 2: Coding

Initial coding was conducted line-by-line across all transcripts. This was primarily inductive and grounded in participants' accounts, while remaining attentive to unanticipated meanings within the dataset shaped by the research aims and interview schedule (see Appendix K for an example of initial codes). Codes were used to label data extracts relevant to the research questions, capturing both semantic content (explicit meaning) and, as analysis progressed, more latent or interpretive meaning (implicit meaning). Coding was reflexive and iterative, with transcripts revisited in different sequences and codes revised, expanded, merged, and reworked as the researcher's understanding developed (Braun & Clarke, 2021b). Multiple NVivo project versions were saved to capture analytic development over time. Appendix L presents an example of a transcript extract with refined codes.

Codes were exported to Microsoft Excel to support comparison and reflective refinement, enabling attention to similarities, differences, and relationships among the initial codes. An audit coding trail (see Appendix M for an example) was maintained to document

decisions to rename, collapse, or reconceptualise codes as the analysis developed (Braun & Clarke, 2021b).

Phase 3: Generating Candidate Themes

Candidate themes were developed by examining patterns of meaning across the codes and clustering conceptually related codes. This phase involved iteratively moving among coded data extracts, emerging thematic ideas, and the full dataset (Braun & Clarke, 2006). To support conceptual exploration beyond the digital interface, the refined code list was also printed, and the researcher physically grouped codes to experiment with different candidate themes (see Appendix N for a visual representation).

Phase 4: Developing and Reviewing Themes

Candidate themes were reviewed for coherence and distinctiveness. Themes and subthemes were refined by collapsing, separating, or discarding candidate themes as required, ensuring that each theme captured patterned meaning relevant to the research questions (Braun & Clarke, 2022). See Appendix O for the initial thematic map generated. Research supervision supported reflection on analytic decisions and alignment between codes, subthemes, and overarching themes.

Phase 5: Refining, Defining and Naming Themes

Following refinement, themes and subthemes were defined as clear analytic statements that captured their central concept and contribution to the overall analytic narrative. Theme names were developed to be engaging and analytically precise, conveying the essence of their meaning and remaining close to participants' words (Braun & Clarke, 2013). The final thematic structure was reviewed in supervision and is outlined in Appendix P, which illustrates relationships among themes/subthemes and describes the overall narrative of the data.

Phase 6: Producing the Report

The final phase involved producing the written analysis as a doctoral thesis for the University of Essex Doctorate in Clinical Psychology programme. The Results chapter integrates analytic discussion with data extracts (participant quotes) to demonstrate shared patterns and diverse participant experiences (Byrne, 2022). Participant quotes were selected for their analytic relevance rather than representativeness or frequency in the dataset, consistent with RTA's guidance (Braun & Clarke, 2022). The analysis is then contextualised within existing relevant literature and theory in the Discussion chapter.

Conceptualising Quality and Rigour in Reflexive Thematic Analysis

Within RTA, rigour is demonstrated through coherence between the research questions, methodological design, data collection methods, analytical approaches, and the findings from the data, alongside transparency and reflexivity throughout the research process (Braun & Clarke, 2022). Braun and Clarke argue that good-quality research should demonstrate a strong fit between the research question and the analytical approach, the generation of coherent themes, and the inclusion of sufficient data extracts to support analytical claims. Accordingly, this study prioritised methodological transparency, reflexive engagement, and a thorough analytic process and report write-up.

Credibility was supported through the researcher's immersion in the dataset (repeated reading, transcript-audio checking), the use of probing and clarification during interviews, and the inclusion of data extracts that directly supported analytic claims during report writing. Credibility was also enhanced through supervisory feedback on theme development and final analytic narrative.

Inter-rater reliability was not used because it reflects a different epistemological approach aligned with coding-reliability variants of thematic analysis. In RTA, meaning is

understood as co-produced through the researcher's interpretive engagement with the dataset; therefore, quality in this research is demonstrated through reflexivity, analytic depth, transparency, and data support for interpretive claims rather than coder consensus (Braun & Clarke, 2022).

Participant validation, sometimes referred to as member checking, was not applied in this research. Member checking involves returning interview transcripts, summaries, or themes to participants to review. However, this was not undertaken because within RTA, there is no assumption of a single "correct" interpretation of the data that participants can verify. In contrast, themes are understood as the product of the researcher's reflexive and interpretative engagement with the dataset. In addition, participants may interpret or make sense of their experiences differently over time, meaning that returning findings to participants would not necessarily enhance the quality or validity of the analysis (Braun & Clarke, 2022).

Dissemination

This study forms part of the requirements to obtain a Doctorate in Clinical Psychology at the University of Essex. Findings are planned to be disseminated through various channels including: presentation at the University of Essex Staff–Student Research Conference in 2026; a summary report shared with the EMDR Association UK (with potential for publication in the EMDR Quarterly); submission to peer-reviewed journals such as the Journal of EMDR Practice and Research and the Journal of Child and Adolescent Trauma; presentations to NHS and other services delivering trauma-informed care to adolescents in the UK to inform clinical practice, supervision, and service development; other relevant professional conferences and associations (e.g., EMDR Europe); and a lay summary of results offered to participants, with access to the full thesis available on request.

The aim of dissemination is to contribute to the growing evidence base on adolescent EMDR practice, inform clinicians and service-level learning and confidence, and support understanding to improve EMDR practice and implementation with adolescents in the UK.

Chapter Summary

This chapter discussed the qualitative methodological approach of this study. It discussed the ethical considerations, data collection, and data analysis methods of this research. The following chapter will discuss the results of the analysis.

Chapter 4: Results

Chapter Overview

This chapter presents the findings of a reflexive thematic analysis examining UK clinicians' experiences of delivering EMDR with adolescents. It explores how clinicians describe adapting EMDR to meet adolescents' developmental, relational, and contextual needs, and how they position EMDR in relation to other trauma-focused interventions within adolescent practice.

Sample Characteristics

Fifteen clinicians participated in the study (10 females, five males). Participants ranged in age from 30 to 66 years (M = 52.67, SD = 8.11). All clinicians were White ethnic background.

All clinicians were accredited by the EMDR UK Association and had completed specialist training in child and adolescent EMDR. On average, clinicians reported 21 years of overall clinical experience working with adolescents (range = 2 - 40 years, SD = 8.90), 9.6 years of overall EMDR experience (range = 2.5 - 27 years, SD = 6.71), and nine years of experience using EMDR with adolescents (range = 1 - 26 years, SD = 6.76). Most clinicians (n = 10) self-funded their adolescent-specific EMDR training, while five received organisational funding.

Participants worked across a range of sectors in the UK and, for many, across multiple settings, including private practice (n = 14), education (n = 5), local authority (n = 4), NHS services (n = 4), general practice (n = 1), and secure forensic settings (n = 1). The majority delivered adolescent EMDR in community settings, with some working across both inpatient/secure settings and community contexts (see Table 8). Clinicians' core professions are outlined in Table 8. To maintain participant anonymity, this summary included only

combined demographic information. It did not include the level of EMDR training (e.g., adolescent EMDR consultant/trainer) due to the limited number of such roles in the UK.

Table 8

Summary of Sample Characteristics.

Pseudonym	Sex	Core Profession	UK Setting Use Adolescent EMDR	Currently, the frequency of EMDR use with adolescents
Anna	Female	CBT Therapist	Community	Often
Sophie	Female	Counsellor	Community	Sometimes
Ruby	Female	Clinical Psychologist	Community	Often
Maya	Female	Educational Psychologist	Community	Very Often
Jasmine	Female	Systemic Family Therapist	Community	Very Often
Olivia	Female	Mental Health Nurse	Community	Often
Hannah	Female	Counsellor	Community	Very Often
Beth	Female	Clinical Psychologist	Inpatients/Secure and Community	Very Often
Sarah	Female	CBT Therapist	Community	Sometimes
Chloe	Female	Clinical Psychologist	Inpatients and Community	Very Often
Marcus	Male	Mental Health Nurse	Community	Very Often
Ethan	Male	Educational Psychologist	Community	Sometimes
Sam	Male	CBT Therapist	Inpatients and Community	Very Often
Frank	Male	Counsellor	Community	Very Often
Aaron	Male	Social Worker	Community	Very Often

Thematic Analysis

Themes are presented below with illustrative extracts from clinicians' accounts. Overall, five themes and six associated subthemes were found. These are presented in Table 9, and the final thematic map is presented in Appendix P. The five themes together capture how clinicians construct and practise EMDR with adolescents. Across accounts, EMDR practice with adolescents was described not as a fixed protocol, but as a relationally grounded, developmentally responsive, and systemically influenced intervention.

Table 9

Overview of Themes and Subthemes.

Main Themes	Subthemes
Theme 1. "You've Got to Build That Relationship": Engagement is Co-Produced	—
Theme 2. "Not to Flood or Overwhelm": Making EMDR Containable for Adolescents	**2.1.** "Constantly Bolstering": Regulation as Continuous Containment **2.2.** "Sometimes Ten Minutes Is Enough": Pacing Within Adolescents' Tolerance
Theme 3. "Meet Them Where They Are At": Making EMDR Work for Adolescents	**3.1.** "That's a Chronological Age, Not a Developmental Age": Translating EMDR Developmentally **3.2.** "If I had Gone Standard, I Would Have Lost Them": Flexibility Within Fidelity
Theme 4. "It Changes Lives… But One Size Doesn't Fit All"	—
Theme 5. "It Just Doesn't Happen": Adolescent EMDR as System-Dependent Practice	**5.1.** "Unless They're on the Verge": Structural Gatekeeping **5.2.** "Where Is That Teenager Going Back To?": Systems That Hold or Hinder EMDR

Theme 1: "You've Got To Build That Relationship": Engagement is Co-Produced

Clinicians conceptualised engagement in adolescent EMDR as co-produced through relational safety, collaboration, and ongoing negotiation, rather than determined solely by the adolescent's individual characteristics. Therefore, clinicians positioned relational work not as a preliminary stage, but as an integral stage throughout EMDR with adolescents. As Hannah explained, "building that relationship with young people is often a big part of the work… before I even start with EMDR", while Ruby described prioritising "trusting the process of the relationship and the safety" and prioritised relational safety over procedural sequencing when practising EMDR with adolescents, explaining that they did not "get too caught up on… which stage". Engagement was framed less as compliance with the standard EMDR protocol and more as a felt experience of safety that enabled adolescents, through the therapeutic relationship, to approach emotionally charged material.

The therapeutic relationship was not a background condition but a primary way in which engaging adolescents in EMDR became possible. Hannah stated, "The therapeutic relationship is key to doing any EMDR… you've got to build that relationship before they'll… access that part of them to work with EMDR", while Maya described the importance of "building up the relationship… to enhance the engagement". Another clinician explained that establishing "trust and common ground" (Anna) was key to helping adolescents feel able to engage with the unfamiliarity of EMDR.

The absence of a therapeutic bond was seen as directly impacting whether an adolescent could engage with EMDR, with one clinician explaining, "It didn't work when it was handed over to me; we didn't have the bond" (Ruby). Building trust was described as particularly important for adolescents with attachment and developmental traumas who have "a lot of trust issues", where clinicians needed to "tune into their lack of safety" (Ruby). One

described, “if they trust you, they’re going to tell you everything” (Frank), which facilitated adolescents’ engagement and participation in EMDR.

Adolescents’ early ambivalence, scepticism, and avoidance when coming to EMDR were described as meaningful communication and understandable protective responses to trauma and previous negative service encounters. Clinicians noted that adolescents were often uncertain about what EMDR involved and cautious about its unfamiliar procedures. Hannah observed that adolescents were “probably a little bit more sceptical and need to understand… what’s happening”, while Marcus explained that many “don’t really know what EMDR is… it’s boring when you explain it”. Such hesitations were situated within adolescents’ developmental stage and previous service experiences, particularly where adolescents’ earlier support had felt intrusive or disempowering for them. Adolescent avoidance in EMDR was understood as a form of meaningful communication. Adolescents were described as having “learned to survive by not feeling or thinking” (Anna) or to “block every emotional expression” (Ruby), making coming to EMDR for adolescents feel threatening, which is something that needs to be managed to facilitate engagement.

Alongside scepticism about EMDR, clinicians described adolescents’ fear of emotional overwhelm as a central threat to engagement. Clinicians noted that adolescents often anticipated that EMDR would require feeling what they were trying hard to avoid. Clinicians described that some adolescents declined “because the EMDR feels scary to them, because it makes them feel it” (Jasmine), and a “fear of targets. Really big fear and not having the emotional resources to overcome [distress]” (Ruby). Another emphasised that adolescents needed to be “open and willing to feel it, experience it, and then reflect on it”, which was described as “uncomfortable… [they] have been trying their best not to feel” (Anna). Clinicians also located anxiety not only in adolescents but within professional cultures. Ethan described a broader context of some professionals and systems getting

"freaked out themselves about trauma" and working within "a culture of just wanting to keep children happy all of the time", where "we don't actually often address the things that are traumatising them or distressing them". Engaging adolescents in EMDR was therefore seen as a negotiated process, grounded in shared decision-making about risk, safety, and tolerability.

The conditions under which adolescents were referred for EMDR further shaped engagement and associated power dynamics. Clinicians described many adolescents being referred for EMDR via parents, schools, or statutory systems rather than adolescents' self-referral, which often produced adolescents to be guarded and limited in ownership in early sessions. Hannah noted that adolescents were "often there because parents want them to be there… so they're not always as open to what they're here for… there's a little bit of a barrier that I have to get across first of all" and described parents sometimes seeking EMDR to "fix their child". School-based pathways also positioned EMDR as something organised around institutional relationships rather than adolescent choice, as Marcus described: "the schools have contacts with the charity, and then the charity says, 'Can you do this piece of [EMDR] work with this child'… It's kind of that relationship". In these contexts, clinicians described adolescents as "voting with their feet" (Chloe) when EMDR did not feel safe or meaningful. Clinicians noted that without a strong therapeutic bond, EMDR "didn't work" (Ruby) with adolescents. Engaging adolescents in EMDR was therefore presented as contingent and fragile, requiring clinicians to actively create and co-produce relational safety and conditions where adolescents could experience some ownership of the EMDR work.

Clinicians also emphasised that engaging adolescents in EMDR often required more sustained motivational and relational work compared to adults where engagement was often established more quickly. Maya described "all the motivational engagement work… all that really hard work… with adults you don't have to spend as long in that", positioning

engagement with adolescents as something that had to be built and repeatedly revisited in EMDR. Rather than this being seen as a delay of 'real EMDR', clinicians framed it as necessary stabilisation and alliance-building that enabled adolescents to tolerate subsequent processing.

Part of building this safety involved clinicians naming and normalising the perceived "weirdness" of EMDR (Olivia), making it safe enough for adolescents to try. Clinicians reported that adolescents often experienced EMDR as unfamiliar, strange, or difficult to take seriously at first. Frank stated: "Adolescents think this is weird shit… It is a bit weird. I think we need to address that", while others described EMDR's approach as "a bit weird" (Sophie), "woo woo shit" (Marcus), or "a bit strange" (Beth). Clinicians also noted that adolescents "might find the whole idea about bilateral stimulation very strange" (Chloe) or "don't sometimes get it" (Sophie). Rather than defending EMDR's unfamiliar mechanisms, clinicians described responding to adolescents' hesitations with openness, humour, and developmentally attuned explanations. Some reported prefacing EMDR to adolescents as "a bit weird… a bit funky" (Jasmine), while others used metaphors such as "magic superpower" (Marcus) or offered explanations that "feel really logical to them" (Marcus) to describe EMDR's underlying mechanisms and processes.

Within this relational context, clinicians emphasised adolescent autonomy as key to engaging adolescents in EMDR. Clinicians described reframing EMDR as a space where adolescents could exercise control, countering their prior experiences of passivity within systems. Beth emphasised the importance of "giving teenagers a lot of control… to treat [them] like an adult rather than… that passive child". Another supported this notion, characterising adolescents as active agents in EMDR: "They're the experts. They do it. I just give them the tools… [it] gives them that sense of control back again" (Aaron). Ethan framed EMDR as enabling adolescents' "choice… about control", and another described

“empowering” adolescents in EMDR by allowing them to stop at any point: “they’re in control, put their hand up if they want to stop at any stage” (Aaron). Adolescents were therefore framed as active agents in EMDR rather than as passive recipients. In these accounts, adolescents’ autonomy was constructed as therapeutic, giving adolescents a choice in pacing, target selection, and when to stop during EMDR.

Autonomy was also reflected in clinicians’ approaches to disclosure during EMDR. Clinicians highlighted that EMDR could enable adolescents to work with traumatic material without being required to verbally describe details, which was described as a particularly protective factor where adolescents’ shame, fear, or overwhelm might otherwise drive avoidance. Aaron explained: “I think the benefit of young people is they don’t have to talk about all their feelings”. Others described using the blind to therapist EMDR protocol when managing disclosure about traumatic details felt intolerable for adolescents. Anna explained, “She couldn’t even tell me that event. It was too horrible, so I used the blind to therapist protocol… she didn’t have to tell me what the image was. We just labelled it”. These practices were described as reducing the pressure for adolescents to narrate their trauma during EMDR, preserving their dignity, and enabling engagement without intensifying adolescents’ threat systems.

Collaboration and transparency were closely linked to the emphasis on giving adolescent autonomy during EMDR. Clinicians described being explicit with adolescents about EMDR processes, boundaries, and uncertainties to reduce mistrust and protect the therapeutic relationship. One clinician characterised EMDR with adolescents as “a partnership”, describing how clinicians and adolescents “can choose targets together… work on the timeline together” (Beth). Clinicians also described adolescent EMDR as “much more conversational” and “collaborative” (Jasmine) compared to using EMDR with adults, suggesting that collaboration itself served as a form of containment.

Transparency about confidentiality and safeguarding processes during EMDR was perceived as essential, particularly for adolescents whose earlier relationships were described as inconsistent or dishonest. Ethan summarised this by stating, “Adolescents appreciate honesty; they appreciate directness”. At the same time, Jasmine described contracting around what would be shared with parents and systems about what might come up during EMDR: “I contract with the young person if you don’t want me to say this part, or is there anything you want me to leave out when your mom or dad comes back”. Similarly, Hannah described setting expectations with parents from the beginning of EMDR: “I make it very clear…. I’m not going to keep a secret from their child... I said, I can’t hold secrets. So, if you don’t tell me unless it’s something that could come up in the sessions”. Honesty and openness with adolescents and care-giving systems (where appropriate) were described as important for building trust and alliances that facilitated adolescents’ engagement in EMDR.

Validation and normalisation were central to this relational engagement work when using EMDR with adolescents. Clinicians expressed the importance of normalising adolescents’ trauma presentation by “reaffirming that they’re okay…they’re not the problem” (Aaron) and validating emotional responses as human and understandable: “we’re all human beings with emotions that go all over the place” (Chloe). Others spoke about the importance of approaching adolescents where they are, by “gauging where they’re coming from, appreciating what a chaotic time being adolescent is, and how difficult it is and all those hormones that people joke about [that] are very, very real” (Ruby). Praising adolescents’ efforts during EMDR was also seen as something that contributed to engagement being relationally co-produced: “Oh, wow, you did that. You did that. Well, and that’s. That, that’s amazing. So, I do a lot of kind of… being really in awe of the young people that show up” (Jasmine). These practices were outlined to help clinicians counter adolescents’ feelings of

avoidance and shame, foster self-compassion, and cultivate a sense of being understood and valued during EMDR.

Theme 2: "Not to Flood or Overwhelm": Making EMDR Containable

Building on the relational emphasis of theme one, clinicians conceptualised containment as key to enabling the safe practice of adolescent EMDR. When describing EMDR with adolescents, clinicians emphasised prioritising emotional regulation and stability over progressing through the standard EMDR protocol at a fixed pace. Rather than treating stabilisation and resourcing as preliminary tasks to be completed before 'real' trauma work begins, clinicians described containment as continuous, iterative, and central to EMDR practice with adolescents. In these accounts, EMDR was not something that progressed through phases; it was something that had to remain emotionally tolerable for the adolescent.

Decisions about pacing, progression, and target selection were shaped by adolescents' regulation states, relational safety, developmental capacity, and broader life circumstances. Clinicians described moving iteratively between EMDR phases, returning to stabilisation when needed, and slowing down EMDR if it felt too overwhelming for the adolescent. In this way, containment was framed as a proactive stance employed continuously during EMDR with adolescents.

Two interrelated subthemes emerged from this theme, capturing how clinicians enact this containment: (1) "Constantly Bolstering": Regulation as Continuous Containment, and (2) "Sometimes Ten Minutes is Enough": Pacing Within Adolescents' Tolerance.

"Constantly Bolstering": Regulation as Continuous Containment. Clinicians described adolescent EMDR as preparation-heavy, with this regulation work not being treated as a discrete stage to move beyond. Instead, regulation was framed as ongoing throughout EMDR practice with adolescents. As Beth explained, clinicians were "constantly bolstering"

adolescents' capacity to remain regulated during EMDR. Similarly, Maya reflected that "with adolescence, the majority of the time I spend on preparation", often involving "many, many sessions" (Marcus) of grounding and "a lot of resource installation" (Ethan). Preparation was therefore constructed not as a gateway to trauma processing, but as sustained emotional regulation used throughout the EMDR process to contain the adolescent.

When comparing the use of EMDR with adolescents to adults, clinicians described needing "a hell of a lot more preparation with adolescents… where there's slightly less preparation with adults" (Marcus) and "needing a lot more Fresourcing all the way through… every session I would do resourcing work" (Beth). One clinician outlined engaging "maybe about 25 to 30 sessions of resource work… lots of heavy, playful resourcing" (Marcus), positioning preparation as continuous regulation rather than a preliminary phase of adolescent EMDR. Regulation was perceived as developmentally necessary and contextually responsive throughout EMDR. Rather than moving cleanly from stabilisation to desensitisation, clinicians described weaving resourcing throughout EMDR in response to fluctuations in adolescents' distress and containment.

Preparation and resourcing also functioned as a means of understanding adolescents' relational and protective systems. Jasmine explained that resourcing "gives me an insight into their system… who shows up for you and is protective", suggesting that stabilisation supported collaborative formulation. Others highlighted the value of affective resourcing as part of containment, with Ruby describing working with "courage, confidence, bravery, optimism, love… I love these resources with young people", as central to building regulation for adolescents during EMDR.

Grounding techniques were frequently described as ways of keeping adolescents "anchored in the present" (Anna) and "in the here and now" (Maya). Playful and embodied

grounding practices - from games to sensory tools such as “rock, paper, scissors” or “doing keepy uppies” (Anna) - were framed not as peripheral, but as protective strategies that helped adolescents presenting with dissociation maintain their sense of dual attention, an essential mechanism for EMDR. As Maya noted, adolescents needed accessible resources they were “happy to play with”, while Beth described using the “wasabi pea challenge” to counter dissociation and restore attention during EMDR. Frank similarly described using “punching pillows… smells… even pets to enable them to stay in the present rather than dissociating, possibly for traumatic material if it was too distressing”. Clinicians’ grounding through play and embodied techniques may be more challenging in online EMDR work with adolescents, with Maya stating that “you can’t really do that online”. Grounding was framed not only as emotional regulation but also as relational confirmation that the adolescent remained engaged and contained with the clinician and process during challenging moments of EMDR.

Somatic and embodied approaches were applied during adolescent EMDR. Clinicians described guiding adolescents to notice bodily sensations when verbal articulation was limited, with questions such as “What’s the heart telling you now?” (Anna). Sophie described drawing on their professional somatic training to “look for what’s happening in the body”, while Marcus explained using “somatic EMDR… purely working with body sensations", perceiving the body both as the site of trauma and the site of regulation. Here, containment was achieved by carefully titrating adolescents’ attention to bodily cues and “embodied trauma” (Marcus) without pushing toward overwhelming narrative exposure.

Using externalisation as a pathway to internalisation was also described as a means of supporting containment. Clinicians described externalisation helping adolescents place distress “between them and it” and give them “control over what they’re putting there” (Anna), allowing traumatic material to be approached indirectly. Adolescents “could pretend it was somebody else… that distancing helps them manage their own stuff” (Olivia) or use

metaphors and symbolic representation to “remove the proximity” (Chloe) of distressing experiences, which made EMDR feel more tolerable for adolescents.

Clinicians also described using symbolic representation as a way of enabling adolescents to approach traumatic material indirectly and reduce the risk of emotional flooding. Symbolic figures and metaphors were framed as protective mediators that created psychological distance while preserving adolescents’ sense of agency during EMDR. For example, Anna described inviting an adolescent to introduce symbols that could make a threatening “sea monster” feel more manageable: “What other symbols have we got… that might make that sea monster… make us feel better? And she brought the police on a ship… If I put the police on the ship in front of them, it will help me”. In this account, symbolic figures served as emotional-regulation resources and gave adolescents autonomy in constructing their sense of safety during EMDR. Similarly, another clinician described drawing on “marvel characters” or “mythic stories” (Marcus) to build protective narrative frameworks. Across these examples, symbolism operated as a containment strategy, allowing adolescents to engage with traumatic material during EMDR at a tolerable emotional distance.

Imagery was similarly regarded as a resource for containment. Aaron explained how adolescents can have “really great imaginations”, which can be used to imagine protective figures, while Jasmine encouraged adolescents to consider who “would you want showing up for you”. Using imagery with adolescents during EMDR was framed as enabling symbolic engagement and emotional resourcing whilst preserving adolescents’ distance and control.

Music and movement were also outlined as forms of external containment important for adolescents. Anna spoke about using an adolescent’s interest in music as a shared “container”, stating: “She’s into dancing, so we have Billie Eilish music, which is our container and our happy”. The use of “our” in this sentence may indicate that having this as a

"container" also provided the clinician with a sense of confidence in regulating the adolescent during EMDR. These approaches to resourcing were considered essential to enabling adolescents to access regulation through familiar, meaningful avenues better suited to their developmental needs.

Clinicians also described sand tray work as a particularly powerful adaptation for creating containment and emotional distance in adolescent EMDR. Several participants highlighted specialist sand-tray training as transformative to their adolescent EMDR practice, describing Ana Gómez's sand-tray EMDR approach as "a life changer for me" (Anna) and "fantastic" (Olivia). The sand-tray was framed not simply as a creative tool, but as a structured space where adolescents could externalise and reorganise traumatic experience. As Olivia explained, inviting an adolescent to "create their world", which allowed them either to locate themselves within it - "that's me in that world, and this is my story" - or to "pretend it was somebody else", with "that distancing helping them manage their own stuff". Similarly, Anna described using the sand-tray to "build a tray of helpers, a safe place", visually constructing protective resourcing that could be drawn on when using EMDR with adolescents. These accounts show that using the sand-tray in adolescent EMDR functioned as a relational and symbolic container, where it enabled adolescents to hold and express trauma in view while maintaining distance, agency, and a tangible sense of safety that did not rely solely on verbal narration.

"Sometimes Ten Minutes Is Enough": Pacing Within Adolescents' Tolerance.

Alongside ongoing regulation, clinicians described pacing as central to containing adolescents during EMDR. While clinicians described the standard protocol as providing a helpful structure across EMDR work, they emphasised that adolescents often required adjustments to pacing and movement between phases in response to adolescents' emotional states to "work with what the client can work with" (Anna). Similarly, Maya noted,

“Sometimes ten minutes is enough”. Ruby explained that when EMDR becomes overwhelming for an adolescent, “you can take a step back”, which was also echoed by Sarah, stating, “taking a step back if it’s too much and go back into it again”. Clinicians discussed slowing down the stages of the EMDR protocol to “help a titrate a young person, if they’re getting too activated” (Olivia). This was similarly outlined by another clinician, who described how they managed adolescents’ EMDR work through “pendulation and titration into some of the difficult memories” (Sophie). Pacing EMDR with adolescents was therefore treated as dynamic and iterative, requiring continual monitoring and adjustment. Feelings of setbacks and “stuck[ness]” (Hannah) were treated as cues to collaboratively reflect on pacing, safety, therapeutic connection, or contextual factors that may be impacting containment in adolescent EMDR. Slowing down and moving between EMDR phases were framed not as a loss of therapeutic momentum, but as a means of preserving adolescents’ engagement and safety.

Importantly, clinicians challenged the assumption that trauma automatically means that an adolescent needs EMDR. As Ruby stated, “trauma doesn’t equal EMDR therapy… sometimes it’s some resource building”, which explains that EMDR could function primarily as a stabilising intervention. Maya similarly noted that clinicians “might never get to the trauma” if containment could not be sustained. These accounts reframed EMDR with adolescents as not contingent on trauma exposure, but contingent on adolescents’ emotional readiness. The decision not to process was perceived as an ethical restraint rather than avoidance.

Metaphor was also used to articulate this stance of ethical restraint in adolescent EMDR. Aaron drew on the image of “sleeping dogs”, suggesting clinicians should “pet the dog… relax the dog” rather than provoke distress. This metaphor framed adolescents’ protective responses not as obstacles to overcome in EMDR, but as signals that require care

and soothing. Rather than forcing exposure, clinicians described attending to adolescents' protective parts with gentleness, positioning containment as an act of calming and respecting vulnerability.

Titration was frequently expressed as important for regulating adolescents' emotional intensity during EMDR. Rather than expecting adolescents to sustain prolonged exposure to distressing material, clinicians described deliberately moving in and out of stages to help adolescents preserve emotional safety and engagement in EMDR. Sophie explained, "titration… pendulation" involved shifting attention between distressing content and stabilising resources to maintain adolescents' regulation. Similarly, Beth described flexibly moving between phases, "might dip into their history a bit… go into more resourcing", after reflecting that they had "lost teens along the way by following standard protocol and not thinking, oh, hang on a minute. There's no rush to know this history right away". Here, Beth described rigid adherence to the standard protocol as potentially destabilising, whereas adapting the standard protocol responsively to adolescents' needs and pace was seen as preserving engagement. Olivia further emphasised the importance of working within adolescents' "window of tolerance" to "not to flood or overwhelm". Across these examples, clinicians were positioned as actively monitoring adolescents' verbal and nonverbal cues, continually calibrating the balance between therapeutic opportunity in EMDR and the management of adolescents' emotional vulnerability.

Decisions about EMDR pacing were also evident during target selection with adolescents. Rather than prioritising early 'touchstone' memories (foundational memories that form a core negative belief about oneself and underlie later related distress), clinicians sometimes begin with present-day triggers that are perceived as more accessible and less destabilising. Anna reflected, "We are on session 6 tomorrow… we've not even touched the touchstone, we've worked on the present trigger, the most recent panic", highlighting a

willingness to delay historic trauma processing work if it did not feel the right time. Similarly, Maya described "starting with something like where they're at" when working with an adolescent with a complex trauma history, where the adolescent selected a recent relationship breakup as the initial target because it was emotionally immediate and tolerable in the "here and now" for them. Likewise, Olivia framed recent material as "much more pertinent to where they are now in their own minds", suggesting that emotional accessibility, rather than chronological origin, was key in target selection when practising EMDR with adolescents.

Periods of "stuckness" and apparent lack of progress were not seen as signs of EMDR failure, but as clinically meaningful information requiring reflection. Clinicians described adolescents stalling the processing and desensitisation phases of EMDR as feedback about timing, target selection, formulation, or the adequacy of resourcing. As Hannah reflected, feeling "stuck" often signalled that they had "got the wrong target or… wrong negative cognition", prompting opportunities to review the work and formulation. Clinicians experienced nonlinearity in the EMDR protocol as an expected and responsible aspect of working with adolescents rather than as a breakdown of the intervention.

Theme 3: "Meet Them Where They Are At": Making EMDR Work for Adolescents

This theme describes effective EMDR with adolescents as requiring continual translation into ways that make sense to adolescents. Clinicians resisted the idea that adolescents should adapt to engage in "by the book" EMDR (Ruby). Instead, they experienced effective practice as involving flexible delivery of the standard EMDR protocol, adapting its application to meet adolescents' developmental, emotional, relational, and potential neurodevelopmental needs. As one clinician explained, adolescents should not "conform to that protocol"; instead, clinicians must "meet them where they are at" (Chloe).

Instead of viewing fidelity as strict adherence to the sequence or technical elements of the standard EMDR protocol, clinicians described it as attuned responsiveness, preserving EMDR's core structure while adapting it to match adolescents' developmental capacities and contexts. From this perspective, adaptation was not seen as a departure from standard EMDR but as the very process that allows EMDR to be ethically and clinically implemented with adolescents.

That's a Chronological Age, Not a Developmental Age": Translating EMDR Developmentally. A central feature of this responsiveness was clinicians' de-centring chronological age as the primary guide for delivering EMDR to adolescents. Rather than adolescents' age alone indicating cognitive or emotional readiness, clinicians found developmental and emotional functioning to be more meaningful indicators for structuring EMDR practice with adolescents. As Ethan explained, "it's not just the chronological age, but potentially the emotional age… and the experiences they've had that you may not know anything about at that point". Several clinicians described how trauma activation could pull adolescents into significantly younger states, disrupting assumptions about their capacity for reflective or verbal processing based on age alone. Although professional guidance outlines that EMDR can be practised with adolescents without specific adolescent EMDR training, this may not consider how adolescents present with different developmental presentations: "that's a chronological age, that's not a developmental age. You could have a 15-year-old that's developmentally 6 years old, and that's very different" (Olivia). Similarly, Marcus described working with a 13-year-old who, due to learning disabilities, functioned developmentally "around 8 or 9". Clinicians also emphasised considering the age at which trauma occurred, noting that applying "the full protocol" to a 15-year-old processing "six-year-old trauma is not going to be effective" (Ethan). Therefore, adolescent EMDR required

attunement not to chronological markers but to the adolescent's developmental state present in sessions.

This developmental orientation was closely tied to how clinicians understood the trauma histories adolescents came with when coming for EMDR. Rather than discrete, single-incident traumatic events, clinicians described working predominantly with adolescents who have complex, cumulative, and relational trauma histories. As Olivia reflected, "developmental traumas… that's more often than not what you're dealing with", while Marcus similarly noted, "It wasn't kind of single events… It was either abandonment, sexual abuse… complex trauma". For some adolescents, trauma was described as spanning much of their developmental history, as explained by Rudy: "started when she was in utero… right through till she was thirteen… and now she is fifteen". These accounts suggest that trauma can shape, and in some cases can disrupt, the very capacities that standard EMDR often assumes, such as memory integration, affect regulation, and cognitive appraisal. Consequently, clinicians described adolescent EMDR as requiring scaffolding attuned to these disrupted developmental capacities, rather than assuming stable affect regulation and cognitive appraisal based on adolescents' age.

Within this developmental context, adolescents' distress was often described as communicated somatically rather than verbally. Clinicians noted that adolescents "might experience their trauma more somatically… in the body, or through behaviour" (Sam), and that EMDR allowed for processing without extensive verbalisation: "you can literally do sets of processing where they don't say anything… they're not in their heads, they're in their bodies… I think that is one of the best things about EMDR" (Ruby). Difficulties with verbalisation were often linked to the developmental timing of trauma experiences. If adolescents "might not have the words now… because at the time of the trauma, they didn't

have the words" (Frank). Clinicians therefore resisted expecting narrative articulation when using EMDR with adolescents, where developmental capacity had been disrupted.

Some components of the standard EMDR protocol, particularly negative and positive cognitions, were described as requiring greater developmental adaptation when working with adolescents. Using standard forms of negative and positive cognitions was experienced as "clunky", confusing, and potentially "ruptured the flow" (Hannah) of EMDR for adolescents. Others similarly described the most challenging part of using EMDR with adolescents as "recognising cognitions" (Maya) and "for some young people, the questions around positive and negative cognitions can be a little bit confusing" (Frank), with another clinician expressed adolescents "struggling with negative, positive cognitions" but "if they can't get negative or positive cognitions… that's OK, you can still move on" (Ethan). This illustrates how clinicians prioritised emotional engagement and somatic processing over formal cognitive components when this threatened regulation or therapeutic alliance, reframing protocol fidelity as a means of protecting the flow of adolescent EMDR.

Neurodivergence was described as further intensifying the need to translate EMDR into developmentally and cognitively accessible forms. For some neurodivergent adolescents, the technical language and abstract cognitive demands of the standard EMDR protocol were experienced as "like a foreign language" (Maya). In contrast, others experienced adolescents struggling with the sustained "dual attention" (Beth) that it required. In this context, flexibility was framed not as an optional adaptation, but as a requirement for inclusive adolescent EMDR practice. Clinicians described shifting away from abstract or verbally mediated tasks and instead "just going with the image… or how does it feel in your body", emphasising that "EMDR gives you that… flexibility for neurodiversity" (Maya). Here, responsiveness was experienced as a way to preserve access to EMDR, ensuring that

adolescents with diverse needs could engage with EMDR meaningfully, rather than it becoming cognitively overwhelming or excluding.

"If I Had Gone Standard, I Would Have Lost Them": Flexibility Within Fidelity. Alongside developmental attunement, clinicians described flexible EMDR practice as essential to maintaining adolescents' engagement. Rigid adherence to the standard EMDR protocol was framed as potentially destabilising for an adolescent. As Beth reflected, "If I had gone standard, I would have lost them". This explains how inflexible implementation of the standard EMDR protocol could risk rupturing adolescents' engagement, where responsiveness was perceived as a marker of professional competence in practising EMDR effectively with adolescents.

One way this responsiveness was practised was through creative and symbolic translation. Clinicians described using metaphor, narrative, drawing, and colour to help adolescents express internal experiences during EMDR. Transforming traumatic material into a mythical story meant "it didn't have to be factual" (Marcus), while describing EMDR as "like a really nasty splinter… gently peeling back the plasters" (Maya) made abstract processes more concrete for adolescents to understand. Visual methods were valued not only as expressive tools for adolescents, but as mechanisms for feedback and monitoring change without relying on abstract emotional language. One clinician described an adolescent drawing "the same picture, but in a different colour… something's shifting… it gradually got lighter" (Olivia). Others described "using drawing in processing" and "tending to use colours" (Aaron), or revisiting drawings to notice shifts in size, colour, or share over time as part of evaluation, "it's a big brown circle. Is it still that big? Is it still brown? Has it changed or it's got a bit of orange here in the corner? It's called in some orange. And let's go again noticing that" (Anna). These adaptations supported shared meaning and enabled adaptive

feedback strategies, even when adolescents struggled to articulate internal change during EMDR.

The language used in EMDR was also adapted to meet adolescents' needs. Clinicians described modifying technical terms with familiar, softer language, such as calling a "safe place" a "happy place" (Olivia) and replacing numerical scales with descriptors like "very big" or "small" because adolescents "respond a bit better to this" (Sarah). One clinician explicitly referred to the technical language of EMDR as "psychobabble", emphasising the importance of "bringing it down to what a lot of people understand" (Sam). These language adaptations enact the theme's central idea that EMDR must make sense to adolescents' everyday worlds by using their own concepts and words.

Bilateral stimulation (BLS) emerged as a mechanism to be developmentally and relationally adapted with adolescent EMDR. Clinicians described routinely modifying BLS to align with adolescents' sensory presentations, attentional capacities, and comfort with proximity. Eye movements as a form of BLS were experienced differently: while one clinician expressed, "I don't think I've come across a teenager yet that likes the eye movements… I wouldn't use eye movements" (Aaron), another reported the opposite, stating, "I have never had an adolescent that has not done eye movements" (Anna). Rather than using a single preferred BLS method, clinicians emphasised offering choice, such as "TheraTappers, buzzers, switchy cushions, tapping, drumming" (Maya), to tailor BLS to adolescents' individual needs. Some described the physical closeness required for eye movements as invasive for adolescents, as Ruby expressed: "eye movements require you to move closer to kids, and I have had a couple who didn't like that". Therefore, providing options about the method of BLS was experienced as enhancing adolescents' agency and tolerability, enabling them to regulate sensory input and remain engaged in EMDR.

Movement-based BLS was described as particularly attuned to adolescents' energy, attention, and embodied nature of EMDR. Rather than expecting adolescents to remain still during EMDR, clinicians expressed incorporating stamping, bashing, or playful physical activities to channel "all that kinetic energy" (Ruby) and maintain engagement. As one clinician noted, "getting a teenager moving" often elicited a positive response (Beth). At the same time, another reflected that "we never just sit in one place for the whole time" and that BLS was "very seldom eye movements" (Maya). Therefore, movement was not experienced as departing from EMDR's core mechanism, but a developmentally appropriate adaptation of BLS aligned with adolescents' nervous systems and attentional capacities.

Importantly, flexibility was consistently described as operating within, rather than outside, the standard EMDR protocol. The protocol was framed as a "map" (Ethan) that provided clinicians with structure amid clinical complexity. Clinicians described returning to this 'map' to retain coherence, even as sessions moved "in circles" or "loop back around", emphasising that adolescent EMDR was not "unidirectional" (Anna).

At the same time, clinicians acknowledged a tension between "by the book" (Ruby) EMDR training and the realities of adolescent practice. One clinician described feeling "paralysed trying to follow the protocol" (Maya). The phrase "we're not technicians, we're clinicians" (Maya) describes this, locating professional competence in practising adolescent EMDR not in rigid compliance with the standard EMDR protocol, but in reflective, context-attuned adaptations and appropriate supervision. Nevertheless, clinicians emphasised that this flexibility depended on "how skilful the clinician is" (Anna).

Clinicians also described using additional EMDR-related 'add-on' techniques and protocols to manage activation, risk, time constraints, and contextual instability, again reflecting a pragmatic responsiveness in adolescent EMDR practice in a UK context. For

example, the FLASH technique (a gentle, low-distress technique used in EMDR to reduce rapidly reduce the emotional charge of traumatic memories by using brief BLS while the person keeps their attention on a positive or neutral focus instead of directly revisiting the trauma) was described as a way of reducing adolescent distress and increasing accessibility of the trauma before direct trauma processing begun: “I tend to use that before I would use EMDR… FLASH technique is really nice because we can put the trauma memory in a box” (Jasmine). Another clinician emphasised the role the FLASH technique can have with adolescents presenting in high-risk and suicidality: “I tend to use the FLASH technique a lot with suicidal stuff… bring down the level of disturbance to allow some accessibility into the memory” (Marcus). Here, adapting EMDR techniques for adolescents was often linked to risk management and retention.

Service contexts were also described as shaping the flexible delivery of EMDR to adolescents in the UK. Group and condensed EMDR protocols were valuable when provision was limited, or continuity of care was uncertain. For example, clinicians described using Group Traumatic Episode Protocol (G-TEP) in school contexts for “GCSEs… performance-based” support (Anna). Others described using the Integrative Group Treatment Programme (IGTP) in adolescent inpatient settings where discharge can be unpredictable: “IGTP protocol is more used in inpatients because you never know when a young person gets moved or gets discharged” (Chloe). The value of being able to complete IGTP work quickly and safely was described as helpful in some contexts: “it can be done… in one session or just two sessions… so you don’t have to worry that you open something up and they leave and don’t know whether they’re coming back” (Chloe). These experiences highlight the need for adolescent EMDR practice to be flexible to meet the system constraints and settings where adolescents are in the present.

The temporal structure of EMDR was also adapted when EMDR was used within adolescent practice. Intensive EMDR formats were described as another way of meeting adolescents where they were, particularly in contexts of clinical urgency and time-limited care. Sam described using "intensive EMDR where needed… that child needs more support… at that time", often when adolescents were in a service for a short period, "if I know that they're only here for a particular amount of time… we need to progress with that" (Sam). Another clinician described creating a "bubble wrap" context by offering multiple weekly EMDR sessions to adolescents during the summer: "two a week, three a week… at a time when you didn't have the pressure of college" (Anna). Therefore, clinicians adapted not only the methods but also the temporal structure of EMDR to suit adolescents' lives and service realities.

Flexibility also involved integrating adolescent EMDR with other therapeutic models. Clinicians described "amalgamating" approaches (Sarah), including incorporating "cognitive interweaves as well as CBT. I think the thing is with EMDR is it brings in so many other different angles" (Aaron). Others stated, "they can't separate CBT and EMDR… I don't think you can just separate them very easily" (Anna).

Some clinicians also described practising EMDR alongside broader relational and developmental theories when working with adolescents. One clinician explained, "I've trained in EMDR, but I would always come from Carl Rogers, the Core Conditions… to build that therapeutic relationship first of all… It sits so nicely into other models" (Hannah). Others described "integrating mindfulness into EMDR… very much a bottom-up approach" (Marcus) or incorporating play-based approaches such as "TheraPlay" (Beth). Therefore, meeting adolescents where they are during EMDR required not only technical flexibility but also relational, embodied, and developmentally attuned therapeutic practice.

Building on relational adaptations, attachment-focused EMDR was described as particularly useful when adolescents' trauma was relational and rooted in early developmental experiences. As one clinician reflected, "sometimes you might be doing attachment-focused EMDR, and you are literally the safe person" (Ruby), thereby viewing clinicians not simply as facilitators of EMDR techniques but also as protective resources. Another clinician trained in Laurel Parnell's attachment-focused EMDR described using "her protocol for pretty much everything" (Marcus), suggesting that attachment-informed work was experienced not as separate to EMDR, but as central to addressing complex trauma when using EMDR with adolescents. Similarly, Aaron stated that "attachment stuff… really gives EMDR another level… I think EMDR by itself is not enough", thereby perceiving relational adaptation as deepening, rather than departing from EMDR's mechanism of change.

As part of attachment adaptations in adolescent EMDR, parts-based and Internal Family Systems (IFS) approaches were also experienced as complementary. Rather than dismissing adolescents' avoidant or fragmented parts, clinicians spoke of working alongside these parts in adolescent EMDR. One clinician described the benefit of "working with the parts that don't want to go there… doing a bit of EMDR with those parts. The part that feels anxious and worried" (Sophie). Another clinician spoke about the benefit of using IFS-informed EMDR with an adolescent presenting with multiple dissociative parts, where the clinician approached each part with curiosity:

> He came along with five different personality parts, all displayed, all competing with each other, quite dissociative… like one part could hide something from the other part, the other part didn't know where they'd put it… I have done EMDR with this lad with different parts. (Ruby)

Engaging with protective parts in this way reframed avoidance as a meaningful aspect to work with during adolescent EMDR. As Hannah described, acknowledging a protective part as having "kept [them] safe" and inviting it to "put your feet up and have a cup of tea" illustrated a stance of respect for adolescents' different parts. Here, adaptation was not merely procedural but also interpretative, where clinicians protected adolescents' dignity, reduced shame, and enabled EMDR to proceed without pathologising protective parts that had supported adolescents' survival.

Theme 4: "It Changes Lives… But One Size Doesn't Fit All"

This theme captures clinicians' experiences of EMDR with adolescents as a form of trauma work that feels different from other trauma interventions, frequently described in terms of speed, depth, and reduced reliance on verbal narration. At the same time, clinicians resisted framing EMDR for adolescents as a universal solution. Instead, they perceived EMDR as transformative for adolescents when the conditions were right, and dependent on preparation, relational safety, systemic containment, and developmental readiness. Therefore, this theme centres on a dual experience in which clinicians viewed adolescent EMDR practice as uniquely impactful, yet that impact depended on certain conditions.

A notable feature of clinicians' accounts was the language used to describe the observed accelerated change in adolescent EMDR. Processing was described as generating visible shifts within short timeframes: "literally 30 minutes… massive change… massive shift in one processing session… there's a big shift, really. Fast" (Marcus). Others compared the use of EMDR with adolescents to adults, suggesting that "adolescents process things at a much higher rate than adults…. it's much quicker" (Sarah). Aaron similarly noted that "by three or four sessions… parents are seeing the difference very quickly. That's a massive difference", perceiving the positive outcomes of EMDR observable beyond the therapy room.

For some adolescents, the impact of EMDR was framed expansively: “it just changes their whole life… changes lives… it’s evolution work” (Marcus). These accounts construct EMDR as generating a distinct therapeutic momentum for adolescents, which appears efficient and impactful.

Clinicians often articulated this distinctiveness in relation to other therapeutic modalities. CBT was acknowledged as having its place, but EMDR was perceived as producing more visible change with less cognitive demand for adolescents. One clinician metaphorically described CBT as “prehistoric… like using a horse and cart versus a car. And once you use a car, you don’t go back to a horse and cart” (Aaron), viewing EMDR as a more advanced mechanism of change for adolescents. Counselling, particularly in school settings when this was offered as the standard modality, was sometimes described as insufficiently trauma-focused: “they’re getting… in schools… more like counselling… it doesn’t seem to address the underlying issue” (Anna). While not dismissing the supportive value of counselling for adolescents, clinicians implied that, unlike EMDR, these approaches may not reach the “underneath” trauma material driving the adolescents’ distress and impacted functioning.

Clinicians also experienced EMDR as “kinder for the client” (Sam), particularly for adolescents experiencing shame or difficulty mentalising trauma. EMDR was framed as reaching “underneath… scooping underneath… noticing what your body’s doing” (Ruby), aligning with the idea that “the body keeps the score” (Ruby). In cases of sexual trauma, the non-disclosure element of EMDR was particularly valued for adolescents: “If it was sexual trauma, very often EMDR tends to be more gentle because you don’t have to tell” (Chloe). Adolescents were described as responding positively to this reduced verbal burden, “I don’t have to talk about it. Sign me up. So, it’s quite an easy sell” (Jasmine). Here, tolerability

emerged as central to EMDR's appeal for adolescents who may struggle with sustained verbal or cognitive effort.

This sense of tolerability extended to adolescents' conscious therapeutic 'workload' during and between sessions. Unlike interventions that rely on homework or ongoing cognitive restructuring, EMDR was described as placing much of the work within the session itself. As Olivia reflected, "there's less of a requirement for them to actively do stuff outside of the session". This experience views EMDR change as attributed to the processing system rather than to between-session compliance, reinforcing its perceived fit for adolescents.

Clinicians sometimes attributed EMDR's speed with adolescents as driven by their neuroplasticity. Adolescents were seen as a developmental window of heightened receptivity where "it seems to work a lot quicker" (Sophie), with another adding that "kids are so plastic in the brain… rewiring so, so fast compared to adults" (Marcus). Here, neuroplasticity in adolescents functioned as both an explanation and an opportunity for EMDR's mechanisms of change.

At the same time clinicians explained EMDR's efficacy and adaptability with adolescents, they were careful not to romanticise its speed or outcomes. Experiences of dramatic change of EMDR were embedded within "a tonne of resourcing" (Marcus). Clinicians emphasised that "one size does not fit all" (Ethan) and that EMDR may represent only a component of complex therapeutic work. In some inpatient contexts, the brevity of the IGTP protocol was not always experienced as sufficient to meet adolescents' therapeutic needs: "they said, is that all? So that's it then… they felt that wasn't enough… he felt he needed… 20 sessions" (Chloe). This clinician also noted that some adolescents prefer a space to narrate their experiences, which is not the mechanism behind EMDR: "when they say they want to talk and that isn't EMDR" (Chloe). Certain presentations, such as dissociative

identity disorder, were described as impacting the use of EMDR at that time, with Sophie describing, “I was working with a young lady, think she was DID basically… I didn’t really [use EMDR]. I used it a bit, but not a lot”. These accounts disrupt a purely positive narrative about the power of practising EMDR with adolescents, highlighting that its brevity can feel inadequate or misaligned for some adolescents, depending on their needs, expectations and complexities.

Context further shaped the extent to which adolescents could engage in EMDR. Clinicians described carefully assessing whether it was appropriate to “go deeper into the work” (Beth). When adolescents were embedded in stable, supportive environments, deeper processing felt safer. In contrast, if instability or risky behaviours were present, clinicians exercised caution about whether the adolescent was stable enough to engage in EMDR:

> I’m not going to do active processing on big trauma memories… if there’s a risk they’re going to go off drinking or the risk going to go and find debris… we’re really careful about doing trauma work until they’re ready to do that. (Beth)

The service context where EMDR was delivered also shaped its practice with adolescents. In private settings, adolescents were often described as more self-motivated in seeking EMDR: “young people who come to me privately definitely come because they want to” (Olivia), enabling more direct progression into processing stages of EMDR. At the same time, private practitioners described exercising discretion around the complexity of adolescents’ trauma presentations they worked with, acknowledging the limits of their capacity to manage high-risk presentations in a private context. As one clinician reflected, “as a private practitioner, if I put all my energies in that, I don’t have the energy to help everybody else… it’s about investing my energies in the best way to help as many people as I can” (Aaron). In contrast, clinicians working in the NHS described working with “really,

really full-on cases" (Jasmine), embedding adolescent EMDR practice within longer-term, multidisciplinary interventions. In these accounts, EMDR's practice was shaped not only by adolescent readiness but also by public resources and clinicians' suitability and capacity to work with complex presentations.

Crucially, clinicians' accounts also showed moments of uncertainty about whether desensitisation and processing had occurred for adolescents in EMDR. Even when describing observed improvement, clinicians expressed doubts about whether change has occurred for adolescents as the Adaptive Information Processing (AIP) model presumes. This uncertainty was particularly relevant in remote adolescent EMDR, where one clinician noted, "I can't even tell that she's actually accessed it… difficult to discern whether she's really engaging" (Sophie). Even when clinicians saw clear, dramatic improvement in symptoms and distress, some described having to "check with myself… is he lying?" (Marcus). Therefore, narratives of rapid transformation in adolescent EMDR relied not only on visible changes but also on trust in EMDR's mechanism of change, the therapeutic relationship, and indirect feedback and evaluation.

Theme 5: "It Just Doesn't Happen": EMDR as System-Dependent Practice

This theme captures how clinicians experienced adolescent EMDR as fundamentally shaped by the surrounding systems. EMDR was rarely described as something that existed solely within the therapy room or the clinician-adolescent relationship. Instead, clinicians viewed adolescent EMDR as embedded within wider UK institutional, political, and relational systems that actively shaped what was possible. Funding structures, commissioning priorities, NICE guidance, workforce capacity, professional hierarchies, school infrastructure, social care systems, inpatient contexts, and family relational dynamics were not treated as background conditions for adolescent EMDR. Rather, they were described as actively

influencing what adolescents could access, when EMDR could be offered, how it was paced, whether EMDR was prioritised as a therapeutic modality, and how deeply processing could proceed safely.

Adolescent EMDR practice was perceived as contingent on these surrounding systems. Its accessibility did not automatically follow clinical rationale, and its depth did not depend solely on therapeutic skill. Instead, adolescent EMDR was described as negotiated within structural realities that could both enable and constrain practice.

Two subthemes were evident: (1) “Unless They’re on the Verge”: Structural Gatekeeping, and (2) “Where Is That Teenager Going Back To?”: Systems That Hold or Hinder EMDR

“Unless They’re on the Verge”: Structural Gatekeeping. Clinicians repeatedly described adolescents’ access to EMDR as contingent upon structural capacity rather than clinical need alone. Within UK public services, EMDR for adolescents was experienced as not routinely available when clinically indicated. Instead, it was filtered through funding pathways, workforce shortages, commissioning cultures, and service thresholds.

Service capacity constraints within CAMHS were described as a central barrier. As one clinician reflected:

> They can’t get EMDR through CAMHS… it just doesn’t happen… NHS CAMHS services just don’t have the capacity to look at how we could actually take on letting more children and young people access EMDR because it is so effective. (Maya)

Another clinician reflected that CAMHS was “criticised” yet “never funded… never given the space to actually do it” (Beth), situating the limitations on adolescent EMDR practice within broader political and economic pressures in the UK.

Service thresholds further narrowed adolescents' entry into EMDR. Adolescents were described as unlikely to be seen "unless they're on the verge of hospitalisation… because there's so much demand" (Maya), with long waiting lists and high criteria, meaning many "don't get seen" (Anna). In this way, EMDR was constructed as something offered to adolescents once distress had escalated, rather than as an early trauma-informed intervention. Geographical inequities further affected accessibility, with some local authorities described as "unique" in offering adolescents EMDR, while elsewhere it was "only for those who can pay" (Maya), portraying access as uneven and not clinically informed.

Referral pathways and organisational cultures in the UK also shaped whether EMDR was considered for adolescents. GP services were described as variable in their awareness of EMDR, sometimes requiring clinicians to "educate our GPs" (Jasmine), and EMDR could be seen as a budget-dependent "add-on" within medically dominated models:

> That's a difficult one for the GP surgery because they offer it… I think they do think it adds value. I just think it's budget again. And their primary is a medical model. So, if they've got extra budget, then they will add it on, or they can accommodate. (Anna)

Social care was described as another commissioning route through which adolescents, particularly those who were care-experienced, could access EMDR. One clinician referred to working within an "intensive therapeutic service for care-experienced… looked-after and accommodated children and adolescents" (Maya), while another described using the Adoption Support Fund to commission EMDR with adolescents in some cases "special guardianship order team and adoption support, we had access to the adoption support fund for therapeutic intervention, so a lot of the time we might commission in the EMDR for the child in some cases" (Sophie). However, this access was embedded in complex, often fragmented systems. As one participant reflected, working alongside social care frequently involved

"serious, complex PTSD, developmental trauma… systems are quite fragmented… a lot of them, it's quite hard" (Sophie). Delivering adolescent EMDR in these contexts was therefore enabled by local authority funding yet simultaneously shaped by systemic instability and intersecting adversities.

Alongside these commissioning routes, clinicians described tensions in organisational models of safety and risk. Some described services requiring adolescents to be "stabilised enough" before EMDR, with one clinician countering, "I would never say that because I think the EMDR can be the stabilisation" (Maya), highlighting diverse ideas about managing safety and 'opening up' the trauma within EMDR.

System pressures not only shaped access but also the trauma intervention chosen for adolescents. An adolescent being allocated EMDR as a trauma intervention was frequently described as pragmatic rather than formulation-led, with adolescents often offered trauma-focused CBT rather than EMDR because "that person had a space on their waiting list… EMDR as opposed to trauma-focused CBT is probably to do with waiting lists and availability… it also has to do with the systems… depending on their caseloads" (Olivia) or because "it's decided at the allocation meeting… it also just happens what is available" (Chloe).

Some clinicians went further, locating this experience within a broader political economy of service provision in the UK. CBT-first organisational cultures were described as sustained not only by evidence-based hierarchies but by institutional investment, professional identity, and training infrastructures. One participant characterised this as a "political agenda", noting that:

> The funding is more towards CBT. Also, the high-up people are CBT trained… they would have to retrain again… some people don't want to let that go. Plus, it's a multi-

> million-pound business… if we woke up one day and said… we're actually going to do EMDR, the business… it finishes. (Aaron)

Clinicians identified these structural constraints on adolescent EMDR practice in the UK as embedded within NICE guidance and the wider politics of evidence-based practice. Adolescent EMDR was described as disadvantaged within an evidence hierarchy where adolescent-specific EMDR research is comparatively limited. As one clinician reflected, "The NICE guidelines… there's pretty much poor research… CBT have got more than others… we lack specific research for EMDR for children and adolescents… the consent issues… the ethical issues… it's a minefield" (Frank). Other participants similarly emphasised the need for "proof that it works" (Hannah), arguing that "the world of EMDR really needs research, especially around children and adolescents" (Jasmine). Advocacy, publication, and visibility perceived as necessary strategies for improving systemic legitimacy of adolescent EMDR. As Aaron suggested, "there needs to be more publicity about EMDR… It's really cost effective as well because they need less sessions… more cost effective for parents that have less money… it's easier, cheaper and faster".

Commissioning frameworks and set session numbers were also experienced as actively shaping the practice of adolescent EMDR in the UK. Rather than clinical formulation alone determining modality and duration, insurance and service provision often set parameters in advance on whether and how EMDR could be used with adolescents. One clinician noted that insurers might authorise "Eight sessions of CBT", adding, "just give me eight sessions of EMDR, and we're rocking" (Anna), highlighting how system-imposed limits could override clinical preference, even where EMDR was perceived as more efficient. Time-limited contracts - "six to 12 sessions… be really targeted" (Anna) - compressed EMDR's assessment and pacing, requiring clinicians to prioritise carefully and be transparent about what could realistically be achieved: "I've only got 12… you have to learn to skill up…

be really honest" (Sophie). In this way, commissioning structures did not simply restrict adolescent EMDR practice; they structured its tempo and form of delivery.

Workforce and training shortages further restricted the availability and accessibility of adolescent EMDR in the UK. Clinicians described a limited pool of clinicians trained in child and adolescent EMDR, particularly within NHS contexts. As Hannah reflected, some CAMHS teams had "very few people trained… I knew somebody who worked in CAMHS in [locality redacted], and they hadn't got anybody training, which is very worrying". Similarly, Maya noted that the "demand for EMDR with children and adolescents is massive because there aren't that many people who have that specialism". At the same time, another imagined that "in a perfect world" there would be "more access to it when needed" (Olivia).

Access to specialist EMDR with adolescents training, supervision, and consultancy in the UK was described as limited, with "very few child and adolescent consultants" and "very little CPD for children and young people" (Olivia). These shortages were experienced as creating a structural bottleneck, shaping who could competently offer EMDR to adolescents.

Continuing professional development (CPD) within UK public services was described as limited, highlighting the difficulty of securing organisational support for adolescent EMDR training. Several clinicians reported self-funding specialist EMDR training due to constrained public budgets. As Sophie reflected, "we trained, we paid for ourselves… [the local authority] wouldn't pay", while others described having to "fight for CPD, accreditation, external supervision" amid "squeezed" budgets (Ruby).

Beyond initial standard EMDR training, many clinicians perceived further adolescent-specific training as essential but financially burdensome. One clinician outlined self-funding multiple specialist EMDR courses, such as Ana Gómez sand-tray, Laurel Parnell AF-EMDR, and EMDR with parent-attachment-informed therapy, describing this as "self-driven, not

organisational driven", and suggested that standard EMDR training "isn't enough" for complex adolescent work (Anna). Others echoed this, arguing that "basic EMDR doesn't really work with complex clients… I think probably the basic EMDR needs to be extended somewhat" (Sophie). Another felt that "all the add-on trainings need to be integrated into standard EMDR training because it's so powerful" (Marcus). One clinician explicitly rejected the view that adolescent-specific EMDR training is unnecessary, noting that in most of their adolescent practice, they were adapting beyond the standard EMDR protocol:

> If I'd only done adult EMDR training, then I would struggle with only having the standard protocol. So if EMDR UK, they're kind of saying that you don't have to do the child training to do it with adolescents. That's what they're saying. I do not agree with that because I would say probably in around 80% of my teens, I'm not using standard protocol. I'm doing some adaptation to make it fit them. (Beth)

Concerns about the current regulation and standardisation of adolescent EMDR training and practice in the UK were discussed. Clinicians called for "more long-term training… longer than 7 days" (Sophie), with one clinician expressing it could even be helpful to have EMDR specialist training for adolescents as a post-graduate qualification: "if they professionalise it a bit more by having a postgraduate diploma, that might be nice… especially if you're doing it more intensely" (Sam). Clinicians spoke about wanting more "more regulation around the children and adolescent training part" (Marcus), and policy implementations about the training requirements for practising adolescent EMDR in the UK, with one clinician expressing:

> I absolutely disagree with this idea that you can work with adolescents without child training… So I'd change EMDR UK's policy on that… I know there's like some

> thoughts about getting rid of child and adolescent specialist training for EMDR. I would absolutely, I would wave that thought away. (Beth)

Clinicians were wary that short EMDR courses and a lack of regulation risked unsafe adolescent EMDR practice. As one clinician emphasised, using EMDR with adolescents without appropriate specialist training "could cause more damage or more harm" because "you might work with children and adolescents for quite a long time, but EMDR can be a little bit different" (Sam).

Despite recognising the value of further specialisation, add-on EMDR training was frequently described as financially prohibitive. For example, Chloe reflected on being unable to access complementary approaches such as IFS, noting that "it's nearly £3000… for the basic IFS training… I would like us to have IFS-informed EMDR training quite a lot as well" (Chloe). In this context, the aspiration to practice EMDR with adolescents in a confident, competent, and developmentally and relationally attuned way was often constrained by structural funding limits on further training.

Beyond UK public services, access to EMDR for adolescents was frequently contingent on private funding. Clinicians described adolescents receiving EMDR only where parents could "afford" it: "I've done EMDR within schools, but they've been privately funded, but I've done it when they're in school time" (Anna). Here, access was negotiated across multiple UK systems, including family finances, school timetables, and institutional willingness to accommodate privately funded EMDR during school hours. EMDR was therefore not available to adolescents in the UK solely on clinical need; instead, it sometimes depended on whether families had the financial resources and on schools' cooperation, thereby reinforcing socioeconomic disparities in adolescents' access to and engagement with EMDR.

"Where Is That Teenager Going Back To?": Systems That Hold or Hinder EMDR. Beyond access, clinicians described how surrounding systems impacted the extent to which EMDR could be safely implemented with adolescents. A recurring question captured this logic: "Where is that teenager going back to? If they've got a stable placement… then you can go deeper. Whereas if they're not, you're a bit more careful" (Anna). Here, systemic stability was experienced as a prerequisite for the depth of EMDR with adolescents.

Family systems were described as sometimes central to adolescents' capacity to tolerate EMDR. Some adolescents "still want their mummy or daddy to be beside them" (Aaron), with clinicians sometimes "roping in families" (Chloe) and involving them in BLS when it was appropriate: "the parents are there as well. So having the parent tapping on the shoulders" (Sam). Parents, teachers, or support assistants were sometimes framed as "the therapeutic partner… it can enhance the efficacy" (Sam). Families having "some level of psychoeducation" (Ethan) was seen as crucial "to help them support the young person" (Hannah), because when carers could understand what was happening, "they then become aware of what to look for, how to support, the kind of aftercare stuff" (Beth). The support process during adolescent EMDR was therefore distributed across relational systems.

Nevertheless, those same relational systems could also sometimes destabilise EMDR with adolescents. One clinician described a "super traumatised parent" (Ruby) wanting to be present in an adolescent's EMDR session, who required compassionate boundary-setting. Intergenerational trauma was an important consideration when practising EMDR with adolescents, involving attending to "how the system is involved in their trauma…. Because the system around the child may also be traumatised" (Frank). One clinician also noted, "Sometimes their parents are parenting them so badly, you have to step off and do that work before you can even do this work" (Ruby). This emphasises that the surrounding system may require support before or alongside EMDR with adolescents. Adolescent EMDR was

therefore embedded within relational systems that could be stabilising or destabilising for the adolescent.

Another ecosystem that was experienced as either enabling or obstructing adolescent EMDR practice was the school system. Adolescents' access to EMDR in UK school settings was considered a means of facilitating broader, more pragmatic access. One clinician expressed, "kids are in school Monday to Friday… put the therapy in there" (Anna), particularly in deprived areas marked by "domestic violence… drug and alcohol misuse" (Anna). Some described "using EMDR within that setting to get referrals from schools" (Ethan) and imagined integrating educational psychologists who "know the school, know the family" (Ethan) to increase adolescent EMDR practice in school settings. Yet school "buy-in from the heads or the teachers" was critical for this to be effective: "if they're viewing it that they are out of lessons, then it's not going to work" (Anna), and some schools were described as "oblivious really" (Sophie). Therefore, schools were viewed not only as venues for adolescent EMDR sessions but also as systems that could either hold or undermine adolescent EMDR practice.

The idea of systemic tolerance was also apparent when clinicians discussed using EMDR with adolescents in inpatient settings. One clinician described using shorter EMDR protocols, like IGTP, being "a good fit" and safer adaptation because "you couldn't plan… You don't want to open up a trauma, and then they're discharged… inpatients are very unpredictable" (Chloe). At the same time, inpatient units could be an advantageous environment where EMDR could be applied with higher-risk adolescents because they can be monitored more closely: "That can be an advantage of inpatients because they are safer on the whole, the inpatient units are really good at keeping people alive" (Chloe). This acknowledges clinicians' need to consider how well the system can contain adolescents outside of EMDR sessions. In the context of using EMDR with adolescents in inpatient

services, Chloe described the benefit of having access to "an EMDR inpatient special interest group… to help because that is quite a challenging thing to do, yet it can be really helpful". This highlights that there may be a lack of understanding, confidence, or support for clinicians about how EMDR can effectively be used with more complex adolescent presentations in UK inpatient services.

Finally, systemic containment also extended to professional support structures. Clinicians discussed the value of peer adolescent EMDR supervision, providing a supportive environment where "we're all learning altogether" (Ruby), a safe space for sharing creative ideas and learning from others about practising EMDR with adolescents. Others described learning through being an adolescent EMDR supervisor themselves:

> I've learned more about EMDR through giving supervision and getting a whole range of different questions, scenarios and patients that we have to apply the knowledge of EMDR to. So I think it's very much a learning process in EMDR supervision. (Frank)

However, clinicians' experiences with the quality of adolescent EMDR supervision in the UK varied. Supervisors experienced in adolescent EMDR and who shared similar professional identities with supervisees were perceived as increasing clinicians' confidence and sense of safety in their adolescent EMDR practice. Where supervision was risk-averse, dismissive, or not grounded in adolescent EMDR, clinician confidence was constrained. One clinician explained they "nearly gave up EMDR because of that supervisor… I didn't feel good enough" (Hannah) and later described changing supervisors and finding a better fit with their professional identity. Some clinicians described having supervisors without expertise in child or adolescent EMDR: "my supervisor… doesn't work a lot with kids really" (Sarah). This supports the idea that EMDR with adolescents may not be practised in the UK as much as it could be, in part due to systemic supervision constraints.

Chapter Summary

This chapter discussed the findings of the analysis. These findings are expanded on in the discussion chapter, which provides further interpretations in the context of theory and existing research.

Chapter 5: Discussion

Chapter Overview

This chapter provides an overview and critical discussion of the current research findings. It begins by revisiting the research aims and questions, then summarises the findings, and discusses them in relation to the existing literature and evidence base. It then considered the implications of the findings, an appraisal of this researcher's strengths and limitations, and recommendations for future research. This chapter concludes with a reflexive summary of the researcher's experience conducting this research and a concluding statement.

Revisiting the Research Aims

This research aimed to address a gap in the literature by understanding how clinicians experience delivering EMDR to adolescents as a trauma intervention in UK contexts. Although quantitative research has documented EMDR's efficacy, less is known about how clinicians adapt the AIP model and EMDR to meet adolescents' developmental needs, support engagement, and respond to the contextual realities of using EMDR with adolescents within the NHS and other systems.

The literature review identified two studies that had explored how EMDR therapists adapted and delivered EMDR to children and young people in the UK (Shaw, 2024; Shipley, 2022), although neither explored adolescent-specific populations and were limited by small, context-bound samples. Therefore, this research builds on the previous literature by focusing specifically on adolescent EMDR practice in the UK. In doing so, it explored the positive and challenging experiences clinicians described, as well as barriers to using EMDR with this population. It also included clinicians practising EMDR with adolescents in both outpatient and inpatient/secure contexts in the UK, included both male and female clinicians, and explored how clinicians experienced using and integrating EMDR with adolescents in

relation to other trauma interventions and modalities. It asked about clinicians' experiences with adolescent-specific EMDR supervision in the UK, a gap in existing research.

In response to gaps in the literature, this research aimed to explore clinicians' subjective experiences of delivering and adapting EMDR as a trauma intervention with adolescents aged 13 to 17 in UK settings. It was hoped that this understanding would inform service delivery, supervision, and training guidance for adolescent EMDR practice in the UK, while also enhancing clinicians' confidence and understanding by learning from others' experiences of delivering EMDR to this population. The following research questions guided the research:

1. What are clinicians' experiences and perceptions of the benefits and challenges of using EMDR with adolescents in the UK?
2. How do clinicians adapt EMDR to meet the developmental and contextual needs of adolescent clients?
3. What are clinicians' experiences of EMDR with adolescents in relation to other therapeutic interventions?

Summary of Findings: Contextual and Empirical Interpretation

Fifteen experienced, EMDR-accredited clinicians (ten female, five male) who practice EMDR with adolescents across UK mental health settings participated in this research. All clinicians were of White ethnic background. Clinicians delivered adolescent EMDR across a range of UK settings, including private practice, education, local authority, NHS services, general practice, and criminal justice services. Most clinicians delivered adolescent EMDR in community settings, with some working both in adolescent inpatient/secure and community contexts. Clinicians' core professions included CBT therapists, counsellors, clinical

psychologists, educational psychologists, family therapists, mental health nurses, and social workers.

Overall, the reflexive thematic analysis found five themes and six associated sub-themes. These will now be discussed and interpreted in relation to existing literature and theory.

Relational-Led Adolescent EMDR

Although EMDR is generally regarded as a structured, eight-phase manualised protocol aimed at facilitating the reprocessing of maladaptive traumatic memories (Shapiro, 2018), the findings from theme one, "You've Got to Build That Relationship": Engagement is Co-Produced, suggest that clinicians experienced relational co-production as fundamental to using EMDR with adolescents. Engagement and rapport-building were not only important during the preparation phases of EMDR with adolescents; rather, relational safety, trust, and collaboration were experienced as active, ongoing conditions that enabled adolescents to engage with EMDR throughout the process. In this way, the findings shift the understanding of adolescent EMDR practice away from a primarily procedural approach and towards a practice that is deeply integrated with co-production and relationally led.

These findings support earlier research emphasising the importance of relational safety and the therapeutic relationship when practising EMDR with young people (Little, 2023; Shipley, 2022). It also builds on existing UK adult EMDR literature, highlighting the role of relational safety in providing containment during EMDR work (Strelchuk et al., 2023). The present findings extend this literature by suggesting that, in adolescent EMDR, relational scaffolding is not only helpful at the start of EMDR, during the assessment and preparation phases, but also remains central throughout adolescent EMDR to support continuous engagement and containment.

A different experience has sometimes been reported in adults engaging in EMDR. For example, Edmond et al. (1999) found that adults experienced EMDR as more technical and less relationally attuned, while still reporting positive outcomes. Therefore, the present findings could suggest that the relational demands of EMDR may vary developmentally. While EMDR with adults may be experienced as more technical, EMDR with adolescents appeared to require relational attunement as a necessary condition for adolescents to tolerate trauma activation and sustain processing.

This is consistent with wider literature suggesting that both the technical mechanisms of EMDR and the therapeutic relationship are important for successful outcomes (Hase & Brisch, 2022). Existing research has found that positive therapeutic relationships within EMDR contributed to clients' sense of safety and trust in the EMDR process (Hase & Brisch, 2022; Wise & Marich, 2016). This attunement may be particularly relevant in adolescence, as it is a developmental period characterised by ongoing changes in attachment and identity, and heightened sensitivity to interpersonal threat (Moretti & Peled, 2004). Therefore, it is important for clinicians to respond to these attachment needs and changes by providing relational-led EMDR to adolescents.

From an attachment perspective, these relational practices described by clinicians can be understood as helping to establish a secure therapeutic relationship where adolescents can safely approach traumatic experiences (Bowlby, 1988). This is important because adolescents with cumulative or relational trauma often experience difficulties with trust and emotional regulation (Hughes et al., 2017; McLaughlin et al., 2013). The current findings indicated that clinicians emphasised confidentiality, collaborative planning, and validation of adolescents' experiences as important ways to reduce adolescents' interpersonal threat and support engagement in EMDR. This is important to consider in the context of existing literature, which has suggested that adolescents may be more sensitive to matters of confidentiality and

privacy due to their developing autonomy and some sharing concerns about caregiver involvement, with perceived lack of privacy acting as a significant barrier to engagement and disclosure in intervention (Agostino & Toulany, 2023; Coyne et al., 2015). Therefore, collaborative and validating therapeutic relationships are especially important for adolescent EMDR as they support engagement and positive therapeutic outcomes in mental health care (Midgley et al., 2017; Stige et al., 2021).

The rupture-and-repair model (Safran & Muran, 2000) provides further insight into these findings, suggesting that the therapeutic alliance is a continuous, co-developed, and renegotiated process throughout intervention. Similarly, Brodin's (1979) working alliance model highlights the importance of bond, task, and goals during therapeutic intervention. Applying this understanding to adolescent EMDR, the bond may involve establishing and repairing relational safety; the task may include helping adolescents make sense of EMDR mechanisms such as BLS; and the goal may require negotiating between the clinician's therapeutic aim of EMDR and the adolescent's understandable protective aim of emotional survival. This framework helps explain why clinicians experienced adolescent engagement in EMDR as requiring ongoing relational negotiation.

This relational emphasis is also theoretically aligned with EMDR's AIP model (Shapiro, 2007), with Hase (2021) suggesting that the therapeutic relationship itself be integral for adaptive memory networks. Similarly, Solomon and Shapiro (2008) argued that adaptive reprocessing requires traumatic memories to be activated in an environment that supports both dual attention and psychological safety. Although Solomon and Shapiro's (2008) findings have been understood as a mechanism of change in EMDR across populations, the present findings extend this understanding by suggesting that within adolescent EMDR, relational safety and support are particularly important for creating

collaborative and validating therapeutic environments that facilitate adaptive information processing.

Neurobiological research further supports the current findings explaining the importance of relational-led EMDR with adolescents. Evidence has shown that when individuals have a manageable level of arousal, brain structures associated with emotion regulation appear to be enhanced, thereby supporting adaptive information processing (Baek et al., 2019; Pagani et al., 2017). Given that adolescence is a developmental stage marked by significant neurological, behavioural, and cognitive reorganisation (Steinberg, 2005), relational safety may be especially important when using EMDR with this population. Co-constructed relational safety may serve as a neurobiological regulatory mechanism that helps adolescents remain within a window of tolerance (Siegel, 1999), thereby facilitating trauma processing in EMDR. Rather than viewing relational factors and dual attention as competing explanations for EMDR outcomes (Lee & Cuijpers, 2013), the present findings suggest that relational safety may enable adolescents to access and benefit from dual attention mechanisms required for EMDR.

Clinicians perceived adolescents' scepticism or hesitance about EMDR as a protective strategy shaped by their previous experiences of trauma and powerlessness within systems. These findings align with trauma-informed frameworks, arguing that avoidance is an adaptive response to threat (Herman, 2015; van der Kolk, 2014). These findings also support previous research identifying scepticism about EMDR among both clinicians and clients prior to observing positive therapeutic outcomes with this intervention (Folland, 2017; McKillop et al., 2024; Smith-Lee Chong, 2016).

Similarly, existing research has described the importance of addressing uncertainty and scepticism when young people come for EMDR (Little, 2023) by offering clear, person-

centred psychoeducation (Marich et al., 2020). Research suggests that confusion about how EMDR works can affect adult clients' trust in the process and increase attrition (Marich, 2012; Marsden et al., 2018). Therefore, the current findings extend this from an adolescent EMDR practice perspective by acknowledging uncertainty and tailoring psychoeducation developmentally may be central to engagement. Clinicians may benefit from using playful, interactive, and video-based explanations of EMDR for adolescents, incorporating metaphors and concrete language aligned with adolescents' interests.

The findings suggest that autonomy and control were also viewed as relational approaches, which made EMDR feel safe enough for adolescents to approach. Clinicians described how adolescents often came to EMDR with previous experiences of passivity and powerlessness. In response, clinicians emphasised the importance of empowering adolescents during EMDR by offering them choices about pacing, target selection, and the level of detail they wanted to disclose about their trauma. While qualitative literature has previously highlighted the benefit of flexible, collaborative EMDR practice when working with complex populations (Kemal Kaptan & Brayn, 2022; McKillop et al., 2024; Shipley, 2022), the present findings extend this understanding by showing that clinicians experienced adolescents' autonomy functioning as a relational, motivational, and trauma-informed process that is central to engagement in EMDR. This can be understood through the self-determination theory (Ryan & Deci, 2000), which suggests that autonomy is a core psychological need that supports motivation and engagement. Therefore, restoring agency may be especially important in making EMDR tolerable and acceptable for adolescents.

One way clinicians supported adolescents' agency in what they wanted to disclose was through using the blind to therapist EMDR protocol (Forgash & Copeley, 2007), allowing adolescents to engage in EMDR without narrating full details about their trauma. Clinicians experienced this approach as processing adolescents' safety, autonomy, and

protection against shame-based feelings. Although the blind to therapist protocol has shown promising outcomes when applied with small adult populations presenting with shame- and fear-based memories (Blore et al., 2013; Farrell et al., 2020, 2022; Forgash & Copeley, 2007), there remains little literature on its use with young people. Therefore, the present findings point to an important area of adolescent-specific EMDR practice that remains underexplored.

Regulation and Containment in Adolescent EMDR

Alongside the emphasis on co-producing relational engagement in adolescent EMDR, theme two, "Not to Flood or Overwhelm": Making EMDR Containable, described how clinicians experienced emotional regulation and stability as vital to making EMDR tolerable for adolescents. Clinicians did not consider preparation and resourcing as phases to be 'completed' at the start of adolescent EMDR, but rather as ongoing processes. Instead, they described these as ongoing regulatory scaffolds that were revisited throughout adolescent EMDR in response to distress, dissociation, or disengagement.

Within the subtheme "Constantly Bolstering": Regulation as Continuous Containment, clinicians described adolescent EMDR practice as particularly preparation-heavy, often involving more resourcing than adult EMDR. This interpretation builds on previous research describing the importance of ongoing regulation work throughout EMDR practice (Phillips et al., 2021; Shipley, 2022; Unwin et al., 2023). Additionally, it adds a more developmentally specific perspective to adolescent EMDR practice, with iterative movement through the EMDR phases reflecting clinical attunement rather than deviation from the EMDR model and protocol.

Clinicians described several ways of supporting adolescents' regulation and containment during EMDR. For example, clinicians experienced drawing on adolescents' internal strengths as helpful, which is consistent with resource development and installation

within EMDR (Korn & Leeds, 2002; Shapiro & Laliotis, 2011). Also, clinicians experienced the use of grounding, playfulness, and somatic strategies as helpful during adolescent EMDR, particularly when adolescents presented dysregulated or dissociative. This finding supports existing literature emphasising the importance of attending to bodily sensations during EMDR, as well as work integrating somatic psychology and EMDR for avoidant or dissociative clients (Greenwald, 2007; Schwartz & Maiberger, 2018; Shapiro & Laliotis, 2011).

Another useful regulation and containing strategy clinicians described using during adolescent EMDR was symbolism, metaphor, and imagery. These practices may function as a transitional space (Winnicott, 1971), enabling adolescents to approach distressing trauma memories while maintaining a sense of safety and agency in how they approach this. The findings highlight that one commonly used approach was sandtray-based EMDR with adolescents, where traumatic memories, resources, and internal experiences are externalised through figures and symbols, a particularly useful adaptation of EMDR for working with complex trauma and dissociation (Gómez, 2013, 2025a). Given that the externalisation of internal experiences has been shown to contribute to the development and maintenance of psychosis symptoms (Frith, 1992; Garety et al., 2001), and that adolescence is a risk period for onset of psychosis (Kessler et al., 2007), further research is needed to consider how externalising techniques like sand-tray EMDR are practised safely and effectively with adolescents across clinical presentations. Recent literature suggests that sand-tray EMDR may be useful with clients across the lifespan (Gómez, 2025b). However, despite evidence indicating that sand-tray therapy reduces PTSD symptoms in young people (Benito Herce et al., 2024), there remains little empirical evidence exploring the integration of sand-tray therapy and EMDR specifically with adolescents.

The subtheme “Sometimes Ten Minutes is Enough”: Pacing Within Adolescents’ Tolerance, emphasised the importance of clinicians pacing EMDR within an adolescent’s window of tolerance (Siegel, 1999). Slowing down the protocol and working at the adolescent’s pace were perceived as central to adolescents’ engagement and containment in EMDR. Trauma processing was often described as inaccessible when an adolescent was too dysregulated, meaning that careful pacing functioned as a responsive and protective strategy, making EMDR possible. This is consistent with the polyvagal-informed understanding of EMDR (Kase, 2023; Porges, 2011), which suggests that adaptive information processing is most likely to occur when the nervous system remains within a tolerable level of arousal that is neither overregulated nor underregulated. Although the polyvagal framework provides a useful explanation for why maintaining a tolerable level of arousal may facilitate adaptive information processing, the underlying assumptions of the polyvagal theory remain debated due to the limited empirical evidence supporting its proposed neurophysiological mechanisms (Grossman, 2023).

The findings also showed that target selection was described as collaboratively negotiated with adolescents rather than determined solely by the standard EMDR protocol’s assumption of beginning with early “touchstone” memories (Shapiro, 2018). Adolescents were often encouraged to begin with memories or current triggers that felt most impactful in their current lives and functioning. This suggests the importance of carefully considering the sequencing of target selection (past, present, or future targets) in adolescent EMDR, where agreed-upon target selection should respond to adolescents’ developmental needs and promote adolescents’ autonomy. These findings support previous literature arguing the need for flexible pacing when applying EMDR to complex trauma and diverse needs (McKillop et al., 2024; Phillips et al., 2021; Strelchuk et al., 2024). It also extends existing literature by suggesting that beginning with more recent or present-day target memories may help

maintain adolescents' engagement and sense of containment during EMDR. Working initially on material that keeps adolescents within their window of tolerance may reduce the risk of overwhelm and disengagement that could occur when EMDR begins with past "touchstone" trauma memories.

Flexible Fidelity in Adolescent EMDR

The findings of theme three, "Meet Them Where They Are At": Making EMDR Work for Adolescents, suggest that clinicians challenged the idea that EMDR should be delivered strictly "by the book" with adolescents. Instead, they expressed the value of delivering the standard EMDR protocol flexibly to meet adolescents' developmental, emotional, relational, and neurodevelopmental needs. Although EMDR is described as a structured eight-phase process (Shapiro, 2001, 2018), clinicians in this research experienced the protocol more as a "map" when practising EMDR with adolescents, requiring flexible, iterative practice to reach the destination of adaptive information processing. The adaptations clinicians described when practising adolescent EMDR occurred across three interrelated levels: developmental attunement, procedural adaptations within sessions, and structural adaptations to the practice and implementation of EMDR within different contexts and services.

In the subtheme, "If I had Gone Standard, I Would Have Lost Them": Flexibility within Fidelity, clinicians described using the EMDR standard protocol as a principle-based framework that provided structure while allowing clinically informed flexibility when working with adolescents. This is consistent with Kemal Kaptan and Brayne's (2022) description of the "spirit" of EMDR as one of innovation, and literature emphasising the benefits of adapting EMDR to meet different populations and cognitive needs (McKillop et al., 2024; Shipley, 2022; Strelchuk et al., 2024). Kendall et al. (2008) described this balance as "flexibility within fidelity", where adaptations to therapeutic practice should be made to

meet individual needs while also maintaining the core principles of the applied therapeutic model.

As found in the subtheme, “That’s a Chronological Age, Not a Developmental Age”: Translating EMDR Developmentally, a central part of this flexibility involved clinicians attuning to adolescents’ developmental presentation rather than their chronological age. Clinicians described that trauma activation can pull adolescents into younger emotional states, meaning EMDR practice required clinicians to respond and adapt to the developmental presentation in the room rather than making assumptions about how EMDR should be practised based on the adolescent’s age alone. This finding can be understood through attachment and developmental frameworks and theories. For example, Bowlby’s (1969, 1988) discussions of attachment theory propose that early attachment disruptions and relational trauma can shape individuals’ internal working models, which influence how they respond to their environment. Therefore, this environment can arguably include the EMDR environment, where adolescents’ trauma histories can impact their developmental presentation during trauma activation and the EMDR therapeutic space. Research has also shown that trauma has an impact on brain structures responsible for emotional regulation (Teicher et al., 2016), meaning trauma-exposed adolescents may not have developed age-appropriate regulation systems. Given that EMDR relies on dual attention and processing, developmental attunement may be especially important to ensure that the mechanisms’ demands remain accessible to adolescents.

Clinicians also described how adolescents rarely presented with single-incident trauma when coming for EMDR. More often, adolescents had experienced complex, developmental, and intergenerational trauma. In such contexts, strictly linear delivery of the standard EMDR protocol was often experienced as less responsive to adolescents presenting with complex trauma. Instead, clinicians described using flexible, iterative, relationally

grounded EMDR practice with adolescents, echoing the broader EMDR literature discussing the benefits of extended preparation, ego-state work, and flexible pacing when working with complex trauma presentations (Knipe, 2008; Mosquera, 2018).

Moreover, the findings show that clinicians' experiences of adolescents often struggled with the more cognitively demanding elements of standard EMDR, particularly identifying positive and negative cognitions. These tasks were sometimes experienced as confusing, abstract, or disruptive to the flow of processing. Clinicians also described these cognitive demands of EMDR as particularly challenging for neurodivergent adolescents, supporting emphasis on the need to adapt EMDR for neurodivergent populations (Adler-Tapia & Settle, 2023; Fisher et al., 2023). The current findings described ways in which clinicians adapted cognitive components of their adolescent EMDR practice, including using visual, physical, and gesture-based scales and reducing the use of abstract language that adolescents did not understand. Similar adjustments have been described in EMDR work with adults with intellectual disabilities (Unwin et al., 2023).

Cognitive theories, including the working memory theory (Baddeley, 2000) and cognitive load theory (Sweller, 1988, 2011), may help explain why such adaptations were experienced as beneficial during adolescent EMDR. From a cognitive perspective, activating trauma memories alongside verbalisation, scaling distress, and engaging in BLS may place considerable demands on the adolescents' cognitive systems, particularly where executive functioning is still developing or has been impacted by trauma experiences. Applying cognitive theories (Baddeley, 2000; Sweller, 1988, 2011), simplifying cognitive tasks may help preserve adolescents' executive functioning resources for the dual-attention processing in EMDR. This does not undermine the AIP model; instead, it suggests that clinicians' adaptations may help make dual attention, and therefore EMDR, more accessible for adolescents. However, there remains limited formal guidance on adapting EMDR for

neurodivergent individuals, particularly neurodivergent adolescents (Fisher et al., 2023; Schipper-Eindhoven et al., 2024).

Clinicians also described adapting BLS methods in adolescent EMDR. They reported using more tactile devices, tapping, and movement-based forms of BLS, alongside or instead of eye movements. This supports growing evidence indicating that alternative BLS methods may be useful with younger populations (Gómez et al., 2013). Clinicians' experiences with using eye movements as the standard form of BLS varied: some reported that adolescents responded well to eye movements, whereas others reported that adolescents disliked them due to the discomfort with proximity or the attentional demands they required. Movement-based BLS, such as stamping or playful actions, were perceived as better aligned with some adolescents' energy levels and attentional rhythms. The findings showed some clinicians' experiences of integrating Theraplay® (play therapy involving young people and their caregivers; Booth & Jernberg, 2010) when using EMDR with adolescents. This finding supports previous literature on the benefits of integrating these therapeutic approaches with young people for treating attachment-related trauma (Gómez & Jernberg, 2013; McGuinness, 2001), with play therapy facilitating entry into memory networks and adaptive information processing within EMDR (Beckley-Forest, 2021). Importantly, these adaptations were not framed as undermining the EMDR, but as increasing its accessibility for adolescents whilst preserving its key mechanisms.

These findings contribute to the broader debates on BLS methods in EMDR (Jeffries & Davis, 2013). While some studies suggest that eye movements may reduce distress more effectively than other forms of BLS (Mischler et al., 2021), others argue that dual attention may be more important than any specific form of BLS (Shapiro & Laliotis, 2015). The present findings support the view that alternative and playful forms of BLS may be clinically meaningful in adolescent EMDR, helping to meet adolescents' developmental needs and

interests (Alder-Tapia & Settle, 2023), as well as support clients' cognitive, physical, and proximal needs (McKillop et al., 2024; Strelchuk et al., 2023; Unwin et al., 2023).

In addition, the findings showed some clinicians experienced the FLASH technique during EMDR as a useful way to maintain engagement and manage risk with highly distressed or suicidal adolescents. The FLASH technique involves pairing positive imagery with rapid blinking and tactile stimulation, which allows distress associated with traumatic memories to be reduced without having to focus directly on the trauma memory, which can be useful to support engagement alongside or before trauma processing begins in EMDR (Manfield et al., 2017). Initially viewed as a titration tool, the FLASH technique is now seen as both a standalone intervention and as part of standard EMDR when distress levels are high (Manfield et al., 2017). Despite evidence suggesting that the FLASH technique improves PTSD and other co-morbid symptoms amongst non-UK adolescent and student populations (Akyol & Izmir, 2025; Yaşar et al., 2025), the current evidence base of applying the FLASH technique with adolescents remains limited and largely researched with non-clinical and non-UK-based samples. Nevertheless, the present findings highlight clinicians' experiences on the value of using the FLASH technique in adolescent EMDR and suggest an important area for further exploration.

Beyond technique-level adaptations, clinicians also described modifying the structure and delivery format of adolescent EMDR practice in different contexts. Group-based EMDR formats such as Group Traumatic Episode Protocol (G-TEP; Shapiro, 2013) and Integrative Group Treatment Protocol (IGTP; Jarero et al., 2006; Luber, 2014) were described as potentially helpful in responding to shared trauma experiences and in increasing early access, with one clinician describing the implications group-based EMDR could have in schools to manage exam anxiety. Evidence has suggested that IGTP may improve PTSD symptoms among a small sample of adolescents outside the UK who experienced a shared school-based

trauma (Almarcha et al., 2026), as well as reducing distress amongst refugee young people when practised in the UK (Hurn & Barron, 2018). Therefore, it could be argued that group-EMDR formats may offer more proactive and quicker support across clinical, non-clinical, and refugee adolescent populations, particularly when considering the current context of the growing demand for young people's mental health support in the UK.

Similarly, the findings showed that clinicians perceived intensive EMDR (i.e., longer or more frequent EMDR sessions over shorter periods) helpful in some adolescent inpatient and high-risk contexts, where service instability or time constraints made once-weekly EMDR sessions difficult. While small-scale research has explored intensive trauma treatment programmes implemented with young people outside of the UK, identified promising outcomes (Rentinck et al., 2025; van Ee et al., 2024; van Pelt et al., 2021), to the researchers' knowledge, there is currently no research exploring intensive EMDR as a stand-alone intervention for adolescents. Therefore, these findings suggest that flexibility in adolescent EMDR extended beyond the session and included adaptations to the broader service-delivery structure.

At the same time, clinicians emphasised that this "flexibility within fidelity" in adolescent EMDR depended on clinician confidence, prior experience, access to training, and appropriate supervision. This supports previous research identifying these factors as barriers to clinicians' implementing EMDR in practice (Majeskey, 2024). The broader literature has highlighted the role that supervision and sustained practice play in maintaining competence in applying a therapeutic modality (Bradley et al., 2021; Fairburn & Cooper, 2011). Therefore, the present findings suggest that "flexibility within fidelity" is not simply driven by individual clinicians' decision-making but rather requires sufficient training, supervision, and organisational support in the UK to enable clinicians to feel confident in making clinically informed adaptations to EMDR practice with adolescents.

Therapeutic Momentum in Adolescent EMDR

The theme "It Changes Lives… But One Size Doesn't Fit All" discussed how clinicians experienced adolescent EMDR as a form of trauma work that feels different from other trauma interventions. At the same time, clinicians resisted framing EMDR practice with adolescents as universal or inherently superior. Instead, adolescent EMDR outcome and therapeutic momentum with adolescents were experienced as dependent on broader relational, developmental, and contextual factors.

A notable feature of clinicians' experience was the descriptions of accelerated change observed in adolescent EMDR. These experiences constructed adolescent EMDR practice as a distinct therapeutic approach that appeared efficient and impactful by reaching "underneath" to the root of the trauma impacting adolescents' functioning and distress. Therapeutic change was sometimes observed quickly, both inside and outside the session, sometimes after a few or even a single EMDR session with adolescents, and, in some experiences, more quickly than with adult clients. This aligns with literature outlining the capability of EMDR to produce reductions in trauma symptoms in brief treatment periods (Shapiro & Laub, 2008). Some clinicians compared their experience of using TF-CBT and EMDR with adolescents, viewing EMDR as a more advanced therapeutic mechanism of change. This supports research indicating that EMDR led to therapeutic gains in fewer sessions for post-trauma and co-morbid symptoms amongst young people compared with TF-CBT (de Roos et al., 2011; Rodenburg et al., 2009).

In addition, clinicians discussed their experience of adolescents' therapeutic momentum during EMDR being supported by its reduced verbal and out-of-session "homework" demands compared to other more traditional talking therapies. This supports previous research outlining that EMDR may be particularly suited for clients who find

detailed trauma narration overwhelming, shaming, or developmentally inaccessible (Greenwald, 1998; Marich et al., 2020). Similarly, previous research has supported clinicians' experiences of the benefits of EMDR not having "homework" for adolescents by showing that EMDR yields outcomes without the additional demand of "homework" required for TF-CBT (Rothbaum et al., 2005).

One explanation clinicians discussed for the rapid therapeutic momentum of EMDR was adolescents' neuroplasticity. Their perspectives suggest that adolescents, given their neurological development, may be particularly well suited to benefit from the adaptive information processing mechanisms underlying EMDR. This supports literature describing adolescence as a period of increased neuroplasticity and ongoing maturation of regulatory and cognitive systems (Blakemore, 2012; Steinberg, 2005). This understanding is also consistent with the AIP model (Shapiro, 2001, 2018) and neurobiological models suggesting that EMDR may facilitate adaptive changes in neural networks, which are key to trauma processing (Mattera et al., 2022).

Despite the therapeutic momentum of EMDR for adolescents highlighted, clinicians were also careful in their descriptions not to romanticise its speed and potential for change. The perceived speed and change of EMDR practice with adolescents were often context-dependent and integrated with other therapeutic practices and interventions for more complex adolescent presentations. Therefore, the current research suggests that while EMDR may be particularly well matched to some aspects of adolescents' neurological and developmental functioning, its impact still depends on broader relational and contextual conditions.

System Embedded Adolescent EMDR

The finding in theme five, "It Just Doesn't Happen": EMDR as System-Dependent Practice, showed that clinicians experienced adolescent EMDR as embedded within wider

institutional, relational, and structural UK systems. These systems shaped whether adolescents could access EMDR, how it was delivered, and how containable it felt. Ecological systems theory (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006) applies to these findings, suggesting that interactions among the various systems around adolescents shape their experiences of distress and recovery. In this way, EMDR with adolescents was not practised in isolation from adolescents' contexts.

This finding echoes the broader literature suggesting that psychological interventions are shaped not only by clinical rationale but also by structural systems, service priorities, and organisational realities (Fixsen et al., 2005; Proctor et al., 2009). Previous research has similarly described the impact of organisational, managerial, and service-level factors in the UK on EMDR practice with diverse populations (Phillips et al., 2021; Shipley, 2022; Unwin et al., 2023). The present findings extend this literature by showing how particularly significant these systemic influences may be in adolescent EMDR within a UK context.

The subtheme, "Unless They're on the Verge": Structural Gatekeeping, discusses clinicians' experiences of funding shortages, workforce constraints, commissioning priorities, and service eligibility thresholds within UK public services as key influences on adolescents' access to EMDR. Clinicians described long wait lists and high CAMHS referral thresholds meant that often, adolescents with publicly funded specialist mental health, including EMDR, were only accessible once distress and risk had escalated, as also indicated in previous literature support (Ford et al., 2007; Sayal et al., 2018). The growing demand for young people's mental health support in the UK (Children's Commissioner for England, 2024; Newlove-Delgado et al., 2023) is likely to reflect rising demand for adolescents' EMDR, although clinicians discussed current public provision as being unable to meet these needs due to public funding and commissioning constraints. From a trauma-informed perspective, this is concerning, as early intervention is considered crucial in responding to trauma-related

distress (Roberts et al., 2019). Therefore, the present finding suggests that the current public provision of EMDR for adolescents in the UK was experienced as insufficient to meet the growing need, which does not align with the principles of timely trauma intervention.

Additionally, clinicians reported differences in commissioning and funding priorities across UK regions, contributing to geographical inequality in adolescents' access to EMDR within public healthcare services. The inconsistent accessibility of psychological interventions for young people across different NHS trusts and local authorities is well documented in the literature (e.g., Children's Commissioner for England, 2024; Education Policy Institute, 2017; England & Mughal, 2019). Whilst clinicians spoke about some local authorities and social care services providing funding for care-experienced adolescents to access EMDR via the Adoption Support Fund, for example, this was experienced as inconsistent. In the absence of UK public provision, some clinicians reported that adolescents could access EMDR only through private funding. These findings support previous research indicating that the current lack of specialist EMDR training and supervision is likely limiting public access to EMDR for young people in the UK (Shipley, 2022).

Clinicians also described how organisational cultures and professional hierarchies influenced adolescents' access to EMDR. It was highlighted how clinicians experienced some UK mental health services as TF-CBT dominant, or external referrers funding the EMDR, providing time-limited sessions for EMDR. Similar dynamics have been described in previous research, suggesting funding bodies or insurance providers favoured TF-CBT over EMDR despite clinicians perceiving EMDR as more beneficial in some instances (Folland, 2017). Therefore, it could be argued that for EMDR adolescent training and practice to become more accessible in the UK, further advocacy and ongoing research are needed to embed EMDR within professional training programmes, commissioning frameworks, and professional identities.

Additionally, the findings showed that clinicians experienced a limited number of adolescent EMDR practitioners in CAMHS services due to UK workforce and training constraints. Some also expressed concern about the lack of EMDR consultants or supervisors for children and adolescents in the UK. This is an important consideration in the context of previous research, showing that out of 700 UK CAMHS clinicians, 60% reported TF-CBT as an evidence-based therapy they would use, whereas 37.5% reported EMDR as an approach they would like to use, with training, supervision, and years of experience influencing predictors of EMDR endorsement (Finch et al., 2020). The present findings build on this understanding by suggesting that limited organisational support and a shortage of specialist adolescent-specific EMDR clinicians and supervisors in the UK may constrain both adolescents' access and clinicians' confidence.

Likewise, the finding showed that clinicians experienced limited organisational funding for additional EMDR training; instead, they often had to self-fund it to feel competent and skilled in using EMDR with adolescents. The financial burden of such training was seen as prohibitive, particularly for clinicians working in UK public healthcare settings. Clinicians described feeling that these additional trainings were powerful and rejected the idea that specific adolescent EMDR training was unnecessary. This supports Shipley's (2022) findings that standard EMDR training was felt not sufficient for the complexities of working with adolescents' trauma presentations and complex systems. Therefore, this suggests that organisational support is needed within UK public healthcare systems to equip clinicians to deliver EMDR effectively and competently to adolescents with complex needs.

The subtheme "Where Is That Teenager Going Back To?": Systems That Hold or Hinder EMDR highlighted the importance of clinicians' understanding how broader relational and environmental contexts affect adolescent EMDR. Some caregiving systems were described as central to adolescents' ability to engage with EMDR, supporting previous

literature identifying the influence family context and caregiver support can have on EMDR practice with young people (Rodenburg et al., 2009). Supportive parents or carers were sometimes described as “therapeutic partners”, with them supporting adolescents’ emotional regulation between, and sometimes during, EMDR sessions. This aligns with attachment and family-based informed literature suggesting appropriate caregiver support can enhance young people’s engagement in and positive outcomes of trauma-focused interventions (Cohen et al., 2017; Siegel, 1999). Similarly, research examining the integration of EMDR with family therapy practice has shown promising outcomes for young people (van der Hoeven et al., 2023).

Specific attachment-focused EMDR (AF-EMDR) approaches have also emphasised the important role of relational systems in trauma recovery, suggesting how caregiver relationships can influence the safety and integration of trauma processing during EMDR (Parnell, 2013). Clinicians described AF-EMDR as adding another layer to adolescent EMDR, where some experienced standard EMDR as not enough by itself to meet the complex and relational needs of adolescents. AF-EMDR (Parnell, 2007, 2013) builds on the standard EMDR protocol by integrating additional attachment practices throughout the phases. Recent research has shown AF-EMDR had greater reductions in trauma and symptoms compared to standard EMDR for adolescents who experienced bullying-related traumas (Mahmood et al., 2025). Qualitative research has shown that UK clinicians valued using AF-EMDR and found therapeutic attunement stronger in AF-EMDR compared to standard EMDR, particularly when working with developmental trauma and dissociation (Kemal Kaptan & Brayne, 2022). The current research supports this literature, outlining the benefits of adopting attachment-informed EMDR, particularly when working with adolescents with attachment and developmental traumas. Some clinicians felt that standard EMDR training did not adequately equip them to address attachment needs, and the Good

Practice Guidelines (EMDR Association UK, 2019) recognise that young people may require additional specialist training and supervision alongside standard EMDR.

At the same time, clinicians recognised that caregiver involvement was not always possible, safe, or wanted by the adolescent. In some cases, caregiving systems were themselves traumatised or unstable, limiting the extent to which EMDR felt contained outside of the session. In these situations, clinicians sometimes felt that broader relational or systemic work needed to take place before individual EMDR could proceed with an adolescent. Previous research has similarly highlighted how environmental stressors and limited caregiving stability can have a ripple effect on clients' engagement in EMDR (Kiser et al., 2020; McKillop et al, 2024; Unwin et al., 2023). The present finding reinforces the idea that adolescent EMDR cannot be viewed as an individual intervention when the systems surrounding the adolescents may affect the progress and containment of EMDR.

Alongside caregiving systems influencing adolescents' EMDR, the findings outlined clinicians' experiences integrating EMDR with systemic ego-state and IFS modalities when working with adolescents. Clinicians described the benefits of applying parts-based IFS approaches within EMDR, which was experienced as helping adolescents address different aspects of their complex presentations, as well as the protective parts they could use for resourcing. This supports previous research on the benefits of IFS-informed EMDR to treat complex PTSD and dissociation (O'Shea Brown, 2020; Twombly & Schwartz, 2008). While recent publications have provided clinical guidance for practising IFS-informed EMDR for complex trauma (Fatter, 2026), the empirical evidence supporting this integrative approach remains limited. This reflects broader gaps in the research base for IFS, including limited evaluation of its effectiveness, mechanisms of change, and clinical applications (Buys et al., 2025). Therefore, although clinicians in the current study experienced the integration of IFS and EMDR as beneficial for developing internal resources and identifying aspects of

adolescents' experiences that may help or hinder EMDR, these findings should be considered in the context of the emerging evidence base and the need for future research into IFS-informed EMDR.

Moreover, schools were also described as another system that could facilitate or hinder adolescent EMDR practise in the UK. Some clinicians discussed school-based EMDR as a potentially valuable route to early intervention, particularly because schools are where many adolescents spend most of their time and where difficulties can first be noticed. School-based adolescent EMDR may also reduce practical barriers such as transport and other attendance barriers, which can disproportionately affect the access of socioeconomically disadvantaged adolescents to psychological support (Reiss, 2013; Weist et al., 2018). Research has shown the implications of school-based EMDR in being able to reach many young people quickly (Karadağ et al., 2021), as well as being effective in reducing PTSD symptoms that impair school functioning (Fernande et al., 2004). In this context, EMDR training for school counsellors and therapists could be helpful for trauma-exposed adolescents, which can impact daily functioning and schooling (Teke & Avşaroğlu, 2021). At the same time, clinicians emphasised that successful implementation of adolescent EMDR in the UK would require support from school leadership, staff understanding, and sufficient training. These findings suggest that schools may be an important yet underused context for increasing adolescent access to EMDR.

Finally, the findings showed that clinicians experienced EMDR professional support systems, including supervision and peer support networks, as essential to developing their confidence and competence in safely adapting EMDR for adolescents. However, clinicians described variability in the quality and relevance of available supervision in a UK context, particularly when supervisors lacked adolescent-specific EMDR experience. This is concerning, given the Good Practice Guidelines (EMDR Association, 2025) that outline the

importance of receiving supervision from an appropriate EMDR supervisor with relevant experience. This finding aligns with previous literature describing disparities in access and funding for appropriate EMDR and organisational support in the UK (Dunne & Farrell, 2011; Phillips et al., 2021; Shipley, 2022). In the context of trauma work, this is an especially important consideration, as supervision supports both clinical decision-making and the emotional demands of delivering trauma therapy (Pearlman & Saakvitne, 1995).

Implications

Practical Implications

The findings show the importance of the therapeutic relationship, with relational safety recognised as an essential aspect throughout adolescent EMDR, not merely a requirement established during the initial preparation phases. Clinicians may need to formulate engagement and safety as an ongoing, co-constructed practice that enables trauma processing. This implies that sufficient time and flexibility should be built into adolescent EMDR practice to integrate relational work throughout the EMDR process, rather than assuming readiness for processing based on directional protocol phases or age alone.

The findings suggest that EMDR with adolescents should be guided by developmental formulation and presentation rather than chronological age. Clinicians may need to routinely assess and consider adolescents' emotional and neurodevelopmental functioning, capacity for dual attention, and environmental stability when determining the structure and pace of EMDR. This supports a shift away from rigid, manualised EMDR practice with adolescents towards a more flexible, formulation-led practice, where EMDR is adapted to the adolescent's developmental needs in the moment.

During the final stages of this research, the researcher was informed by D. Kingston, a committee member of the EMDR Association UK (personal communication, April 23, 2026),

that due to ongoing debate regarding the minimum chronological age for applying the standard EMDR protocol, the association is currently preparing the publication of updated guidance. This guidance is expected to outline that the standard EMDR protocol can be used with individuals aged 12 and above, provided the clinician has appropriate experience working with this population. While this clarification is intended to support best-practice guidelines for the use of EMDR with adolescents, it remains important for clinicians to recognise that chronological age alone should not determine how EMDR is applied with adolescents, as implied by this research.

Another implication concerns how EMDR can be practised adaptively with neurodivergent adolescents. Using image-based sensory approaches and offering a range of BLS options to adolescents could enhance accessibility and inclusivity without undermining EMDR mechanisms. This suggests that flexibility is essential in effective adolescent EMDR practice to enhance engagement, retention, and improve outcomes for adolescents with varying cognitive and sensory profiles.

The findings emphasise the implications for risk management and containment when using EMDR with adolescents. Clinicians should carefully manage the pacing of EMDR, balancing the need to process trauma with the adolescent's ability to manage distress during sessions and within broader contexts outside of sessions. Instead of avoiding EMDR or moving too quickly through it, which can destabilise or disengage adolescents, clinicians should adopt a responsive, formulation-driven EMDR practice that prioritises containment, regulation, and relational safety throughout adolescent EMDR.

System-Level Implications

The findings highlighted important systemic implications, demonstrating that the wider systems shape EMDR practice with adolescents in the UK. For instance, factors such

as adolescents' home environment, caregiver involvement, school context, and the unpredictability of inpatient settings were described as playing important roles in the safety and feasibility of adolescent EMDR. This suggests that systemic readiness and considerations should be routinely integrated into adolescent EMDR formulations, with clinicians considering not only the adolescent's internal capacity but also the system's stability and resources for containing adolescent EMDR outside the therapy room.

In addition, the timing and pacing of adolescent EMDR should be understood as system-dependent. Where environmental containment is limited, clinicians may need to delay, slow, or adapt trauma processing by embedding EMDR within parallel systemic interventions. This highlights the importance of multi-agency collaboration, with effective adolescent EMDR practice involving coordination and working across systems such as CAMHS, schools, social care, and inpatient teams to support safe and sustained engagement. This aligns with the NHS Long Term Plans (NHS England, 2025b, 2025c) priorities to implement early, collaborative trauma-informed interventions across settings.

Access to adolescent EMDR in the UK was described as shaped by organisational structures, referral thresholds, and commissioning priorities. This suggests a need for more accessible trauma pathways for adolescents in UK public services to incorporate EMDR. Increasing the availability of adolescent EMDR within a stepped-care framework in UK healthcare systems may support its use as a proactive intervention and delivery across diverse mental health contexts, rather than an intervention only accessible to adolescents once risk and distress have escalated. Clinical leadership and service development initiatives are important for advocating for equitable access to adolescent EMDR in the UK. These should address systemic barriers and ensure that service models meet the relational, developmental, and contextual needs of EMDR practice with adolescents in a UK context, as identified in this study.

Supervision Implications

The findings highlight that clinicians perceived supervision as a central component to safe, confident and effective EMDR practice with adolescents. Reflective supervision grounded in a developmental understanding of adolescents appeared to support clinicians in navigating formulation, determining pacing, managing risk, and adapting EMDR to meet adolescents' specific needs. This suggests that supervision should consider the relational, developmental, and systemic complexities of using EMDR with adolescents, rather than focusing solely on strict directional EMDR practice. In contrast, supervision perceived as overly risk-averse or lacking adolescent-specific expertise may limit clinicians' confidence and clinical decision-making, potentially restricting the use or progression of adolescent EMDR.

Additionally, the findings point to a need to increase access to specialist adolescent EMDR supervision in the UK. The limited availability of appropriately trained adolescent-specific EMDR supervisors, alongside lengthy accreditation pathways, may act as a barrier to the use and effective practice of adolescent EMDR in the UK. This implies that UK organisations and professional EMDR bodies should prioritise investment in supervision infrastructure, including funding, protected time, and clear pathways to develop clinicians' skills and confidence in using EMDR with adolescents. These priorities mirror those outlined in the Good Practice Guidance for adolescent EMDR practice (EMDR UK Association, 2025).

Adolescent EMDR supervision may benefit from more collaborative and peer-based approaches, such as special interest groups or peer supervision forums specific to adolescent-EMDR practice across a range of UK mental health contexts. These spaces could offer more opportunities for shared learning, reflective discussions, and increased confidence, especially

for clinicians providing EMDR to adolescents in complex environments, such as inpatient settings, or using adapted approaches (e.g., intensive EMDR or group protocols). Therefore, organisations need to provide sufficient support for clinicians to fund and access appropriate supervision in the UK, enabling adolescent EMDR clinicians to adapt their EMDR practice to adolescent needs confidentially and competently.

Training and Workforce Implications

The findings highlight important implications for adolescent-specific EMDR training and workforce development in the UK. Clinicians' accounts suggest that standard EMDR training may not fully prepare or equip clinicians for the complexities of using EMDR with adolescents, particularly in relation to developmental attunement, complex trauma, and the integration of creative or relational approaches (e.g., play, narrative, or parts-based work). Although current EMDR UK Association (2019, 2025) guidance indicates that clinicians with experience of working with adolescents and ongoing supervision may apply the standard EMDR protocol with adolescents, the findings suggest that additional, developmentally specific competencies are often required in practice. This implies a need for UK EMDR training providers to more explicitly incorporate adolescent-focused content and practical adaptations into core EMDR training, or to more clearly position adolescent EMDR as a distinct area of training and expertise that is financially accessible to clinicians.

Greater investment in organisational and public healthcare services in the UK may be needed to support access to adolescent-specific EMDR training and continuing professional development (CPD). Reliance on clinicians to self-fund additional EMDR training risks perpetuating inequalities in access to specific EMDR skills and may impact the consistency and quality of adolescent EMDR provision. Expanding access to funded training

opportunities, alongside protected time for CPD, may help strengthen workforce capacity and confidence in adolescent EMDR practice in the UK.

Alongside this, the findings suggest the value of broadening the adolescent EMDR-trained workforce in the UK to include a wider range of professionals working with adolescents, such as educational psychologists and school-based practitioners, who were seen as well-positioned to support early intervention and practical accessibility. It would be helpful if any expansion of adolescent EMDR training and CPD provision in the UK is accompanied by evaluation not only of clinicians' confidence and competence in using EMDR with adolescents, but also of meaningful outcomes for adolescents, to ensure that EMDR training pathways and developments translate into effective and equitable clinical practice across the UK.

Strengths and Limitations

The study was informed by a critical realist stance within a broader contextualist framework. In practice, this meant working from the assumption that meaning and organisational structures exist, but that our own social and professional positions always shape our access to them. From this stance, clinicians' accounts were viewed as interpretive rather than literal descriptions of adolescent EMDR practice. Their narratives were understood as shaped by their roles, workplaces, training histories, and subjective experiences. One advantage of this approach is that it allowed the analysis to consider both structural factors and subjective meaning-making. It required ongoing researcher reflexivity throughout the research, because the themes reflect the researcher's own interpretive readings of patterns in the data rather than an attempt to present a definitive account of adolescent EMDR practice in the UK.

The dataset of fifteen interviews aligns well with guidance on the amount of data needed for RTA at a doctoral research level (Braun & Clarke, 2013, 2022). Instead of aiming for data saturation in the traditional sense, the researcher focused on whether the data allowed for depth, analytical coherence and well-supported themes. While the sample was rich and yielded detailed accounts, it does not claim to represent all clinicians practising EMDR with adolescents in the UK. The findings should be interpreted as situated professional perspectives, and as with most qualitative research, the notion of transferability rests with the reader (Willig, 2013). The UK-specific context of this research, including the predominance of NHS services and Western trauma frameworks, may limit the extent to which the findings translate to other healthcare systems or cultural settings.

A strength of the research was the inclusion of adolescent EMDR clinicians from a range of professional backgrounds and UK service contexts. This interprofessional diversity enabled exploration of how professional identities, training pathways, and governing bodies in the UK shaped clinicians' approaches to practising EMDR with adolescents. Recruiting clinicians from both NHS and private settings across different UK regions enhanced the ecological relevance of the study, allowing wider systemic influences, such as resource constraints, commissioning priorities, and service ethos, to emerge as meaningful factors shaping adolescent EMDR practice.

At the same time, this diversity also introduced a degree of heterogeneity. Differences in professional background, theoretical orientation, and service structure meant that clinicians sometimes spoke about adolescent EMDR practice in the UK in quite different ways. For example, some clinicians viewed the EMDR protocol as a guiding "map" providing structure when working with adolescents (Ethan, Educational Psychologist, Community), whilst others prioritised relational and developmental responsiveness, with Beth (Clinical Psychologist, Inpatient and Community) reflecting that "if I had gone standard, I would have lost them".

There was also variation in preparation, pacing, and BLS techniques, with some, like Aaron (Social Worker), emphasising movement-based BLS adaptations, while others, like Anna (CBT Therapist), described regularly using eye movements as BLS with adolescents. This variation reflects the complexity of real-world EMDR practice with adolescents in the UK. Still, it makes it difficult to establish clear "best practices", as these differences came from varying professional backgrounds, service constraints, and clinical preferences. This study focused on in-depth, reflexive interpretation rather than systematic comparison, meaning that differences across clinicians' professions, levels of experience, and settings were explored interpretively rather than systematically analysed. Therefore, the findings are best understood as illustrating various ways of constructing and practising EMDR with adolescents across different UK contexts, rather than presenting a unified account.

The eligibility criteria of this study required participants to be EMDR Europe-accredited practitioners and to have used EMDR with adolescents in the past five years. This helped ensure that clinicians had formal training and recent experience with adolescent EMDR. Sampling participants with direct expertise increases the likelihood of generating meaningful insight (Patton, 2015). However, this criterion may have narrowed the range of perspectives represented. For example, clinicians practising adolescent EMDR without full accreditation, or those who had discontinued EMDR practice, were not included. Including these clinicians may have provided different perspectives on experiences and challenges in implementing EMDR with adolescents. EMDR accreditation may have also attracted clinicians who feel particularly aligned with EMDR, potentially skewing the sample and results towards more positive or committed perspectives. While participants did describe challenges and constraints, clinicians who are more sceptical or have had negative experiences of adolescent EMDR may have offered alternative views that were not captured. This study also did not explore differences in clinicians' EMDR training locations (e.g., the

UK versus international routes), which may have influenced experiences with fidelity and adaptation in adolescent EMDR practice in the UK.

Clinicians were recruited through professional networks and UK EMDR public directories, enabling purposive and snowball recruitment relevant to the research aims. However, recruitment via professional platforms could have introduced self-selection bias, whereby clinicians engaged in UK EMDR communities or who have undertaken the full accreditation process may have held more positive views of EMDR and been more inclined to participate. Although this research identified critical reflections on adolescent EMDR practice in the UK, it could be argued that recruiting clinicians with more ambivalent or negative experiences of adolescent EMDR might have yielded more diverse perspectives.

The sample included male and female clinicians of various ages and with varying years of clinical and EMDR experience. Collecting demographic data enhanced the transparency and context of the findings. However, all participants were of White ethnic background, limiting the sample's cultural and ethnic diversity. Whilst qualitative research does not aim for representativeness, the lack of ethnic diversity in the sample arguably limited understanding of how clinicians' cultural identity impacted their EMDR practice with adolescents in a UK context, an important consideration given the cultural impact on the formulation of distress, relational engagement, and therapeutic processes (Willig & Rogers, 2017). This gap limits the investigation into how ethnicity and culture might intersect with EMDR practice and relational work with adolescents.

Semi-structured interviews were a suitable method for exploring clinicians' experiences, as they provided enough structure to keep discussions focused while allowing clinicians flexibility in discussing their experiences (Rubin & Rubin, 2011). The interview schedule was refined through a pilot interview, which improved the clarity and flow of the

interviews (van Teijlingen & Hundley, 2002). However, it may have been useful to embed more participant and public involvement to strengthen the interview schedule, such as consulting with an adolescent with lived experience of EMDR or a clinician with specialised expertise in delivering adolescent EMDR in the UK. Involving more collaborative perspectives and partnerships during the research design stage could have enhanced co-production and broadened the scope of exploration.

Conducting the interviews via the virtual placement Zoom allowed clinicians to participate from geographically diverse areas across the UK. This interview format allowed flexibility in participation to accommodate clinicians' busy schedules, a benefit of digital interviewing (Archibald et al., 2019). However, the online format may limit access to clinicians' nonverbal and embodied cues. While the interviews went smoothly and clinicians were engaged, the online format may have subtly influenced the interview interaction.

In line with the epistemological approach of RTA, this research did not use coding reliability checks across different researchers. This decision reflects the critical realist epistemological understanding that meaning is actively constructed rather than discovered, with themes emerging from a single researcher engaging with the data rather than aiming for objective, verifiable findings. To ensure rigour in this research, the researcher used reflexive journaling, iterative application of RTA, and ongoing supervisory discussion. It was important for the researcher to continue reflecting on their positioning throughout the research process and data collection, alongside the development of their EMDR experience. For example, shared professional language may have helped build rapport with participants, but it could have also introduced allegiance effects. The final reflection section in this chapter is provided to ensure rigour and transparency of the researcher's positioning throughout and at the end of this research.

Recommendations for Future Research

This research provided important findings about how clinicians experienced delivering and adapting EMDR with adolescents in UK contexts. The findings also highlight several areas where future research could strengthen the evidence base and understanding for EMDR practice with adolescents.

One important area for future research to build on clinicians' perspectives and reflections is to explore adolescents' voices directly about their experiences engaging with EMDR, and to understand their experiences on the relational, regulatory, and specific adaptations of EMDR practice identified in this research. Research incorporating diverse perspectives from adolescents, clinical leads, and caregivers could help explore where experiences overlap or differ. Pairing adolescent perspectives with observational or outcome data could generate a richer, more triangulated account, rather than relying primarily on clinicians' self-reports (Carter et al., 2014).

Although the present sample included clinicians from a range of professional backgrounds and service types, these differences were interpreted qualitatively rather than compared systemically. Future research could take a more comparative approach, examining variations of experiences linked to core profession, years of experience, work setting (e.g., NHS versus private practice) or service type (inpatient versus community). There is also scope to explore how different EMDR training pathways and core professional experience subsequently shape adolescent EMDR practice in the UK. Understanding clinicians' experiences of EMDR training across different countries, accreditation systems, and core professions could help examine the impacts on clinicians' experiences and confidence in using EMDR with adolescents.

Increasing cultural and ethnic diversity in future samples is also important. Research that includes diverse clinicians and adolescent samples could help develop an understanding of and a more culturally responsive EMDR practice, as well as allow closer examination of how core elements of EMDR, such as target selection, BLS, and cognitive interweaves, are interpreted and experienced across sociocultural contexts in the UK and beyond.

Another important area for future research is how adaptations to adolescent EMDR affect engagement and retention rates. Comparative studies examining protocol-led versus flexible EMDR practice could help inform the use of adolescent-specific adaptations, moving away from the standard EMDR protocol when clinically indicated. Given the current findings highlighted the importance of adapting EMDR for neurodivergent adolescents, future research should explore EMDR practice with these populations to inform neurodevelopmentally specific EMDR protocols, which remain underexplored across all populations.

Additionally, there is currently a lack of understanding of how alternative and integrative EMDR modalities, such as intensive EMDR, AF-EMDR, IGTP, GTEP, and sand-tray EMDR, are applied to adolescents. Similarly, whilst the blind to therapist protocol was described in this research as being used with adolescents, particularly when details were too difficult to narrate, or trauma evoked shame and fear-based responses, there is a lack of research exploring the use of the blind to therapist protocol with younger populations. This indicates a direction for future research to explore the outcomes, experiences, and confidence of clinicians using adapted and integrative modalities of EMDR with adolescents.

As the findings showed the system-embeddedness of adolescent EMDR practice in the UK, future research would be useful for exploring organisational readiness, barriers to specialist adolescent EMDR training, and geographic variability in the provision of

adolescent EMDR across the UK. For example, service-led evaluations across UK healthcare systems and NHS trusts could shed light on systemic factors influencing clinical decision-making about young people's trauma interventions, and the availability of EMDR for young people across UK localities.

Finally, adolescent EMDR training and supervision in a UK context are other key areas for future research. Clinicians described wide variation in access to adolescent-specific EMDR training and questioned whether standard EMDR training was sufficient to equip clinicians to practice EMDR with young people. Research examining the impact of specialist adolescent EMDR training on clinician confidence, adaptive decision-making, and sense of competence could inform future UK training standards. Similarly, exploring how the quality of supervision and supervisors' expertise shape adolescent EMDR practice in the UK could be useful.

Final Reflections

In line with a reflexive qualitative approach, I recognise that this thesis is not a neutral or objective piece of work. Instead, it was shaped through the interaction between clinicians' accounts and my own assumptions, values, and professional development. Over the course of this research, I have come to see reflexivity not as a single chapter or task, but as an ongoing process of self-reflection, openness to sitting with discomfort and uncertainty, and a space within supervision to consider the impact of my position on both research and clinical practice.

My identity as a White British clinician-researcher has inevitably influenced how I interpreted clinicians' accounts and may have contributed to the omission or under-exploration of important issues relating to cultural, racial, and systemic inequalities, particularly within the predominantly Westernised UK healthcare system in which I trained

and practice. For example, I may have been less attuned to how structural barriers and cultural differences shape clinicians' perspectives on adolescents' access to and engagement with EMDR in a UK context. Understanding cultural competence in adolescent EMDR is crucial, as research shows that cultures vary in how they express distress, such as variations in how thoughts and bodily sensations are articulated, which are key components of EMDR processes (Nickerson, 2022). The lack of clinicians from non-White ethnic backgrounds in this research sample limits the discussion of cultural and structural factors that could influence access to adolescent EMDR training and practice in the UK. This absence may reflect broader inequities within professional and training pathways for specialist EMDR practice in the UK. I am also aware that my own cultural background likely influenced which aspects of clinicians' accounts resonated most with me, as I am a White British clinician who has trained in, worked within, and personally accessed the NHS and other healthcare systems in the UK.

I approached this research with prior clinical experience in UK adolescent mental health services, including an adolescent inpatient unit marked by complexity, risk, and systemic pressures. Additionally, my placements during doctoral training allowed me to see the effects of various traumatic experiences on young people, as well as the limited availability of early trauma-focused interventions, such as EMDR, within UK public services. My interest in trauma-focused and young people's mental health was a key motivator for choosing this research topic. While I aimed to remain open and exploratory during the research process, I recognise that working within a strained NHS system has inevitably shaped my curiosity about service provision and systemic practice of EMDR.

My understanding of EMDR evolved throughout this research. At the outset of this research, I had not yet completed EMDR training, which initially left me questioning whether I had sufficient expertise to study a therapeutic modality I was not trained to use. My

supervisor helped me to hold this anxiety and see the value of approaching this research topic as an “outsider”. During data collection, I was aware of the potential power dynamics and hierarchies. As such, my trainee status may have reduced participants’ defensiveness and invited them to be more open, but it might also have made me feel I had less authority to question or probe participants’ accounts, which may have shaped the depth and direction of data collection. I feel that taking on the role of an "outsider" during data collection allowed me to engage in the interviews with genuine curiosity. Without any preconceived views about EMDR, I was open to hearing both positive and critical reflections from the clinicians about their experiences using EMDR with adolescents.

By the time I reached the analysis and write-up stages of this research, I had begun my standard EMDR training. At the time of submitting this thesis, I have completed the standard EMDR training with a UK training provider and am awaiting certification, pending HCPC registration. This shifted my position closer to that of an “insider”, helping me better understand clinicians’ theoretical and technical references of EMDR during analysis and write-up. Although I have not yet completed child and adolescent EMDR training or further specialist EMDR training, I hope to pursue this in the future. My interest in ongoing EMDR training may have influenced how I interpreted some findings, particularly when clinicians described the need for more specialist guidance and regulation when using EMDR with adolescents in the UK. With additional experience or advanced training in EMDR, I might have understood or framed clinicians’ accounts differently.

Throughout the analysis process, I experienced periods of anxiety, perfectionism, and what felt like “analysis paralysis”. Immersing myself in the data took longer than I had anticipated, and I sometimes worried whether I was doing the analysis “right”. Balancing the demands of clinical placements, academic assignments, and life outside of the doctorate added to this pressure. Over time, I learned the iterative nature of RTA required me to tolerate

uncertainty and not rush the research process. Research supervision was important in helping me develop confidence in my analytic voice.

There were moments when my clinician and research roles felt difficult to separate. Hearing some participants describe the limited provision of trauma interventions within UK public healthcare services echoed some of my own frustrations I have experienced in clinical practice. At times, I noticed my own inclination to validate clinicians' accounts where their experiences aligned with mine. Reflexivity and supervision helped me identify these moments and ensure that the emerging themes were grounded in the data rather than my assumptions. I was struck by clinicians' enthusiasm, generosity with their time, and commitment to adapting EMDR to support adolescents with complex needs. I felt a sense of responsibility to faithfully represent their experiences, especially since this thesis directly supports my professional development.

Completing this research has been an important part of my development as a scientist-practitioner (Carter, 2002). I have gained confidence in conducting qualitative research and analysing qualitative accounts. One participant's quote, "We are not technicians, we are clinicians", has stayed with me because to me. This reflects my value of clinical judgement, relational attunement, and responsiveness to context, and my application of integrative and flexible therapeutic approaches, particularly when working with adolescents in complex settings. This is the type of clinical psychologist and EMDR clinician I strive to be, viewing psychological support as part of a broader, holistic therapeutic approach rather than a manualised approach.

I am also aware of my privilege in being able to access public funding through university research funds to complete standard EMDR training alongside this research. I recognise that not all trainees or clinicians have equal access to these professional

development opportunities and that structural inequalities can influence who can develop EMDR competencies.

The version of myself writing this final reflection is quite different from the trainee I was when I wrote the research proposal during my first year of doctoral training. I have developed a greater tolerance for ambiguity, a deeper appreciation of reflexivity, and more confidence in integrating research with clinical thinking. Navigating my experiences of personal bereavements during the doctorate has also reinforced to me the importance of self-care and relational support as part of my personal and professional development. As I approach becoming a qualified clinical psychologist, I feel more comfortable understanding the sort of clinician I want to be for myself, service users, and the teams and systems I work alongside. I feel more committed to ongoing reflective practice, systemic awareness, and advocating for evidence-based practice to support service development and psychological practice.

This research topic aligns with my passion for person-centred trauma-informed care, young people's mental health, and integrative practice. It has encouraged me to further reflect on my assumptions and positionality and to apply critical thinking and evaluation to therapeutic modalities. While the findings represent my interpretation at a specific point in my professional development, my understanding will continue to evolve throughout my career. Therefore, this thesis is not the endpoint of my learning but rather a part of my ongoing journey as I develop as a clinical psychologist, scientist-practitioner, and EMDR clinician myself.

Conclusion

Overall, this thesis builds on the existing understanding of using EMDR with young populations by specifically exploring clinicians' experiences of delivery and adapting EMDR

for adolescents as a trauma intervention in a UK mental health context. The findings provide valuable insights into adaptations of EMDR to meet adolescents' developmental and relational needs, as well as contextualising the practice of EMDR with adolescents across various systems. It also discusses clinicians' experiences of practising EMDR, either in isolation or integrated with other therapeutic modalities. The study outlines important implications, including adaptations for practising adolescent EMDR across various UK contexts, as well as the need for increased adolescent-specific EMDR workforce, training, and supervision accessible across the UK.

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Appendix A

PROSPERO Registration

NIHR | National Institute for Health and Care Research

PROSPERO
International prospective register of systematic reviews

What do clinicians say about their experiences of using eye movement desensitisation and reprocessing (EMDR) therapy in UK clinical settings? A systematic review of the literature
[redacted]

Citation

[redacted]What do clinicians say about their experiences of using eye movement desensitisation and reprocessing (EMDR) therapy in UK clinical settings? A systematic review of the literature . PROSPERO 2025 CRD420251038135. Available from https://www.crd.york.ac.uk/PROSPERO/view/CRD420251038135.

REVIEW TITLE AND BASIC DETAILS

Review title
What do clinicians say about their experiences of using eye movement desensitisation and reprocessing (EMDR) therapy in UK clinical settings? A systematic review of the literature

Condition or domain being studied
Eye Movement Desensitization And Reprocessing Therapy

Appendix B

Example of Theme Development for Literature Review

Study	Text extract	Code	Descripitive Themes	Analytical Themes	Analytical Subtheme
Strelchuk et al. (2024)	Therapists were generally supportive of the effectiveness of EMDR in ARMS. One therapist said EMDR was highly effective and far exceeded their expectations (p. 7)	Effectiveness of EMDR	EMDR challenges expectations of 'normal' therapy	1. Making Sense of EMDR	Experiencing EMDR as Different
Follard (2017)	David's experience of EMDR when comparing it to trauma-focused CBT was it being a gentler form of treatment for both the client and therapist. (p. 134)	EMDR a better approach to minimise vicarious trauma	EMDR challenges expectations of 'normal' therapy	1. Making Sense of EMDR	Experiencing EMDR as Different
Phillips et al. (2021)	Therapists shared that clients are able to take more control in guiding the therapy comparatively to other interventions (p. 152)	EMDR empowers clients through control	EMDR challenges expectations of 'normal' therapy	1. Making Sense of EMDR	Experiencing EMDR as Different
Kemal Kaptan & Brayne (2022)	The Modified Protocol is just so much smoother and more elegant (p. 599)	AF-EMDR seen as smoother and more helpful	Following the standard EMDR protocol can feel restrictive	2. Balancing Protocol and Flexibility	Tensions around Fidelity
Shaw (2024)	Trevor said that he uses all the elements of EMDR but that the extent to which the elements are used can differ. (p. 142)	All EMDR phases are used but not always to the same extent	Therapist adapt and modify EMDR to suit client needs	2. Balancing Protocol and Flexibility	Adapting in Practice
Phillips et al. (2021)	Adherence to standard protocol important but should be flexible (p. 150)	Balance between fidelity and adaptability	Therapist adapt and modify EMDR to suit client needs	2. Balancing Protocol and Flexibility	Tensions around Fidelity
Mckillop et al. (2024)	Clinicians reported anxiety towards EMDR and reprocessing phase… Concerns that it would be emotionally distressing for the client (p. 7)	Anxiety about reprocessing phase	Confidence building through practice	4. Developing as an EMDR Therapist	Growth and Meaning

Descriptive Themes			Analytical Themes and Subthemes
EMDR feels different or unfamilar			**1. Making Sense of EMDR**
Discomfort and Uncertainty			1.1 Experiencing EMDR as Different
EMDR challenges expectations of 'normal' therapy			1.2 Negotiating Doubt and Legitmacy
Following the standard EMDR protocol can feel restrictive			1.3 Integrating EMDR into Practice
Therapist adapt and modify EMDR to suit client needs			**2. Balancing Protocol and Flexibility**
EMDR often blended with other therapeutic approaches			2.2 Tensions around Fidelity
Remote delivery of EMDR			2.3 Adapting in Practice
EMDR can strain therapeutic rapport			**Therapeutic Relationship**
Building trust and safety is essential for EMDR to work			3.1 Relational Strain
Therapeutic relationship can progressed when EMDR experienced as effective			3.2 Relational Support
Therapist managing expectations about EMDR			**4. Developing as an EMDR Therapist**
Confidence building through practice			4.4 Emotional Burden
Professional identity			4.5 Growth and Meaning
Importance of supervision			**5. EMDR Within Systems**
Carrying the emotional "weight" of EMDR			5.5 Systemic Barriers or Helpers
Shared Growth with Clients			5.6 Access Inequities
Organisation pressures and service models			
Limited resources restrict EMDR practice			
Inequities in access to EMDR			
Protocol pressures conflict with real-world clinical demands			
Limits of EMDR training/evidence			
Remote EMDR challenges			
Systems as Supports			

Appendix C

Ethical Approval

University of Essex

28/05/2024

[redacted]

Health and Social Care

University of Essex

Dear [redacted]

Ethics Committee Decision

Application: ETH2324-1052

I am pleased to inform you that the research proposal entitled "Exploring therapist's experiences of delivering Eye Movement Desensitisation and Reprocessing (EMDR) to adolescents " has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following conditions:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

[redacted]

Appendix D

Participant Information Sheet

University of Essex

Participant Information Sheet

We would like to invite you to participate in this research. Before deciding to participate, please read this information carefully. Please feel free to contact us if anything is unclear or if you would like more information. If you are happy to participate, you will be asked to sign a consent form.

Study Title: Exploring therapists' experiences of delivering Eye Movement Desensitisation and Reprocessing (EMDR) to adolescents

What is the research about?
This research will form part of the Doctorate in Clinical Psychology course at the University of Essex. This study aims to explore the experiences of EMDR therapists in delivering EMDR to adolescents within healthcare services.

Why have I been chosen?
You have been asked to consider participating in this study because you have been identified as an EMDR Europe-accredited therapist who may have delivered EMDR to adolescents aged 13-17 years old who have experienced a traumatic event/s.

Do I have to take part?
No. It is completely up to you to decide whether you would like to take part in this study. We will go through this information sheet with you, and you will be able to ask any questions you have about the study. If you do decide to take part, you will be given the information sheet to keep and you will be asked to sign a consent form to show you have agreed to take part and you will be given a signed copy to keep. You do not have to give any reason for not wanting to take part.

What will happen if I do not want to carry on with the research?
If you decide to take part, you will be free to withdraw from the study up to 21 days after completing the interview without having to give a reason as to why you want to withdraw. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you. If you wish to withdraw your data up to 21 days after the interview, you will be required to give your participant ID number provided after informed consent is obtained.

What will happen if I take part in the research?
You will be invited to attend an individual online interview facilitated on Microsoft Teams or Zoom with the researcher. You will be asked to complete some demographic information and asked a series of questions relating to the research topic. The interview will take approximately 1 hour of your time, and the interview will be digitally and audiotaped for transcription.

Will my results be kept confidential?
All information gathered from the demographic questionnaire and interviews will be kept anonymous. All information will be kept securely and nobody outside of the researcher and supervisor will have access to individual responses. Every effort will be made to ensure anonymity. As the researcher transcribes the interviews, the researcher will anonymise any identifiable details, such as your name, other names, and the locality of work. All digital files will be saved on a password-protected computer and files. Electronic consent forms will be kept in a password-protected folder only accessible to the researcher during the study process, and after the study, these will be securely deleted. There will be no way of linking you to the anonymised research data collected.

The researcher will keep your name and contact details confidential and will not pass on this information to the University of Essex. Email addresses used for the online interview invites and contact information about the research will only be accessible to the researcher, and any email correspondence via email will be deleted after the study.

All data will be stored in line with the General Data Protection Regulations and the University of Essex Data Protection Policies. If you would like more information on research data, please contact the University of Essex research governance team via e-mail: [redacted]

University of Essex

Are there any risks involved?
It is not anticipated that you will experience any adverse effects or distress by participating in this research. However, due to the nature of your role as a mental health professional and any personal experiences, if you do experience any distress during the study, please inform the researcher and you can stop the interview at any point. If you find the study brings up any distress for you, you are advised to contact your GP, your Occupational Health Team, or the Staff Support and Wellbeing teams in your place of work. Contact details for NHS staff support services by locality can be found at: https://www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs/. There are also 24/7 charities such as the Samaritans whom you can contact by calling 116 123.

What are the possible benefits of taking part?
It is hoped that the findings of this research will help gain a deeper understanding of the clinician's experiences of delivering EMDR for adolescents to consider any aids, barriers and/or adjustments needed in delivering this intervention to adolescents. It is also hoped to gain clinicians' experiences of the positive and/or negative experiences of this intervention for adolescents experiencing post-traumatic symptoms. This can help inform service developments and understanding of using trauma-informed interventions with adolescents, and support is also available to EMDR clinicians.

What happens with the results of the research?
All research data will remain confidential, and synonyms will be used for interview responses. Any identifiable information will be removed from the transcripts and results. The research will be published as part of the researcher's doctoral thesis write-up and may be published in an academic journal and presented at conferences. Anonymised data will be securely stored by the researcher and supervisor until the point of publication/s.

If you would like to see a summary of the research and results, these will be available from July 2026. You can contact the researcher at [redacted] to obtain these.

Concerns and complaints:
If you have any concerns about any aspect of this research or have a complaint, please contact the researcher of this project (see contact details below). If you are still concerned or think your complaint has not been adequately addressed, please contact the research supervisor (details below). If you remain unhappy and wish to complain formally, you can do so by contacting [redacted] the Research Governance and Planning Manager, Research Officer, University of Essex, [redacted]

Who can I contact for further information about the research?
If you require support, or have any queries, or concerns about taking part please contact:

Researcher: **Research supervisor:**
[redacted]

Thank you for considering taking part in this research study.

Appendix E

Participant Consent Form

Study Title: Exploring therapists' experiences of delivering Eye Movement Desensitisation and Reprocessing (EMDR) to adolescents

Please initial box

1. **I confirm that I** have read and understand the Participant Information Sheet dated 21/05/24 for this study and have been given a copy of this to keep. I have had the opportunity to consider the information, ask questions and have these questions answered satisfactorily. ☐

2. I understand that my participation is voluntary and understand I can refuse to answer questions, and I can withdraw at any point during the study, without giving a reason. I understand that after the interview, I can contact the researcher to withdraw my research data for up to 21 days after the interview by providing my participant ID number. ☐

3. I understand that taking part in this study will involve my interview being audio-recorded and manually recorded by Microsoft Teams/Zoom. These transcripts will be destroyed after the researcher transfers data into non-identifiable text transcripts, which will be electronically stored securely by the researchers. ☐

4. I understand that my fully anonymised data will be used for a Doctorate of Clinical Psychology thesis write-up at the University of Essex and any further research publications. I understand that pseudonyms will be used to quote my interview data in the write-up, and any identifiable information will be removed. ☐

5. I understand that any information containing identifiable information about me will be securely stored and only accessible by the research team directly involved in this project, and that confidentiality will be maintained. ☐

6. I agree to the researcher keeping a copy of this identifiable consent form securely stored in a password-protected electronic file until the end of the study, whereupon it will be securely destroyed. ☐

7. I give permission for my anonymised research data to be kept by the researcher/research supervisor until the point of publication/s so it can be used for future research and learning. ☐

8. I agree to take part in the above study.

Participant Name:	Date:	Participant Signature:
_____	_____	_____
Researcher Name:	Date:	Researcher Signature:
_____	_____	_____

Appendix F

Recruitment Poster

Appendix G

Recruitment Email Invitation

Dear …,

I am contacting you because I have seen from the EMDR Association UK website that you may be a practising EMDR therapist with experience working with adolescents.

I am looking for accredited EMDR therapists with experience working with adolescents to participate in my thesis I am completing as part of my Doctorate in Clinical Psychology programme at the University of Essex. Participating in this research will involve undertaking a virtual interview this summer with myself (the researcher) which will last about 60 minutes. In this interview, we will ask about your experiences of delivering and adapting EMDR when working with adolescents who have experienced trauma and/or suffer from post-trauma symptoms.

We hope that by participating in this research you will contribute to the limited understanding of the use and adaptation of EMDR as a trauma intervention for young people.

Please see the poster attached for the eligibility criteria for this research.

If you are interested in participating in this exciting research opportunity or have any questions, please reply to this email. Please feel free to inform other eligible participants about this research who can contact me if they are interested in taking participating.

Many thanks,

[researcher details extracted]

Appendix H

University of Essex

Demographic Questionnaire

Participant ID:

1) Please indicate your age (in years): _____

2) Please indicate your gender:

- ☐ Male
- ☐ Female
- ☐ Other _____
- ☐ Non-binary
- ☐ Trans-gender
- ☐ Prefer not to say

3) Please indicate your ethnic background:
(Choose one option that best describes your ethnic group or background)

- ☐ White
- ☐ Asian / Asian British
- ☐ Black / African / Caribbean / Black British
- ☐ Mixed / Multiple ethnic groups
- ☐ Other ethnic group
- ☐ Prefer not to say

4) How was your EMDR Children & Adolescent training funded?

- ☐ Public sector workplace (e.g. NHS)
- ☐ Private sector workplace
- ☐ Self-funded
- ☐ Other (please state): _____
- ☐ Prefer not to say

5) What is your core profession/s? _____

6) How many years of overall experience do you have working clinically with adolescents? _____

7) How many years have you been practising EMDR? _____

8) How many years have you been practising EMDR with adolescents? _____

9) Which professional body are you accredited as an EMDR therapist with (e.g. EMDR Europe)? _____

10) Please indicate what healthcare sector you have used EMDR with adolescents in:

- ☐ Public sector (e.g. NHS)
- ☐ Private sector
- ☐ Both public and private sector
- ☐ Other (please state): _____
- ☐ Prefer not to say

1) Please indicate what mental health services you have used EMDR with adolescents in:

- ☐ Community
- ☐ Inpatients
- ☐ Both inpatients and community services
- ☐ Other (please state): _____
- ☐ Prefer not to say

2) Approximately how often do you currently use EMDR with adolescents in your clinical practice?

- ☐ Not at all
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Very Often

If you do not currently use EMDR with adolescents, please explain why:

Appendix I

Interview Schedule

Thank you for agreeing to take part in this interview. We are interviewing you to understand better clinicians' experiences of delivering EMDR to adolescents with post-trauma symptoms.

Participation in this study is voluntary. The interview should last approximately one hour, depending on the amount of information you wish to share. With your consent, I will record this interview using automatic recording and live transcription function to ensure that I don't miss any of your comments. All responses will be kept confidential. This means that your de-identified interview responses will only be shared with the research team, and we will ensure that the information included in the research report will not identify you as the respondent. You may decline to answer any question or stop the interview at any time and for any reason.

- Do you have any questions about the interview?
- Are you in a private space to do this interview? Just so you know, I am conducting this interview in a private, confidential space.
- Give each participant ID number
- I am now going to turn on the recording

Section 1- Introduction and Background

1) **Complete the demographic questionnaire**
2) **To begin, can you tell me a bit about your background and experience using EMDR with adolescents?**
3) **Have you used EMDR with adults as well as adolescents?**
   If yes: How would you describe the differences in how you approach EMDR with adolescents compared to adults?

Section 2- Adaptations

4) **Can you describe any ways you adapt EMDR when working with adolescents?**
   Prompts:

- *What specific techniques, materials, or language do you change or add?*
- *Why did you feel these adaptations were necessary or helpful?*
- *What supported or influenced these adaptations?*
- *How do young people respond to these?*
- *Have you needed to adapt your approach in delivering EMDR to adolescents across different clinical context settings (e.g., inpatient vs. community, NHS vs. private)? Are there differences in flexibility, resources, or engagement across these settings?*

Section 3 – Benefits and Challenges

5) What do you like about using EMDR with adolescents?

Prompts:

- *Are there particular parts of the EMDR protocol you find especially effective? (e.g., bilateral stimulation, FLASH, micro-techniques)*
- *Can you give an example of when EMDR seemed particularly helpful?*

6) What aspects of EMDR do you find more challenging with adolescents?

Prompts:

- Are there specific parts of the EMDR protocol that feel less suitable or harder to use with adolescents?
- Do adolescents ever struggle with particular components?
- Have you experienced any barriers when using EMDR with adolescents? What made these barriers difficult? How did you manage this?
- Do you feel this differs from EMDR with adults?

7) What kind of support do you have for your EMDR practice with adolescents?

Prompts:

- Do you feel there is enough support available (e.g. supervision, peer learning, service support)?
- What topics or areas have you needed the most support with?
- How would you describe your experience of EMDR supervision?
- Do you think the wider system (e.g., MDT, organisation) supports EMDR work?

Section 4 – EMDR compared other approaches

8) How do you decide when to use EMDR rather than other trauma-focused approaches with adolescents (e.g., trauma-focused CBT)?

Prompts:

- Are there specific clinical situations where EMDR feels more appropriate?
- Have you ever integrated EMDR with other approaches? If so, how and when?

9) What do you think are the strengths or benefits of using EMDR with adolescents compared to other trauma therapies?

10) What do you think are the limitations or challenges of using EMDR with adolescents compared to other trauma therapies?

Section 5 – Conclusions

11) How would you like to see the provision of EMDR for adolescents improved?

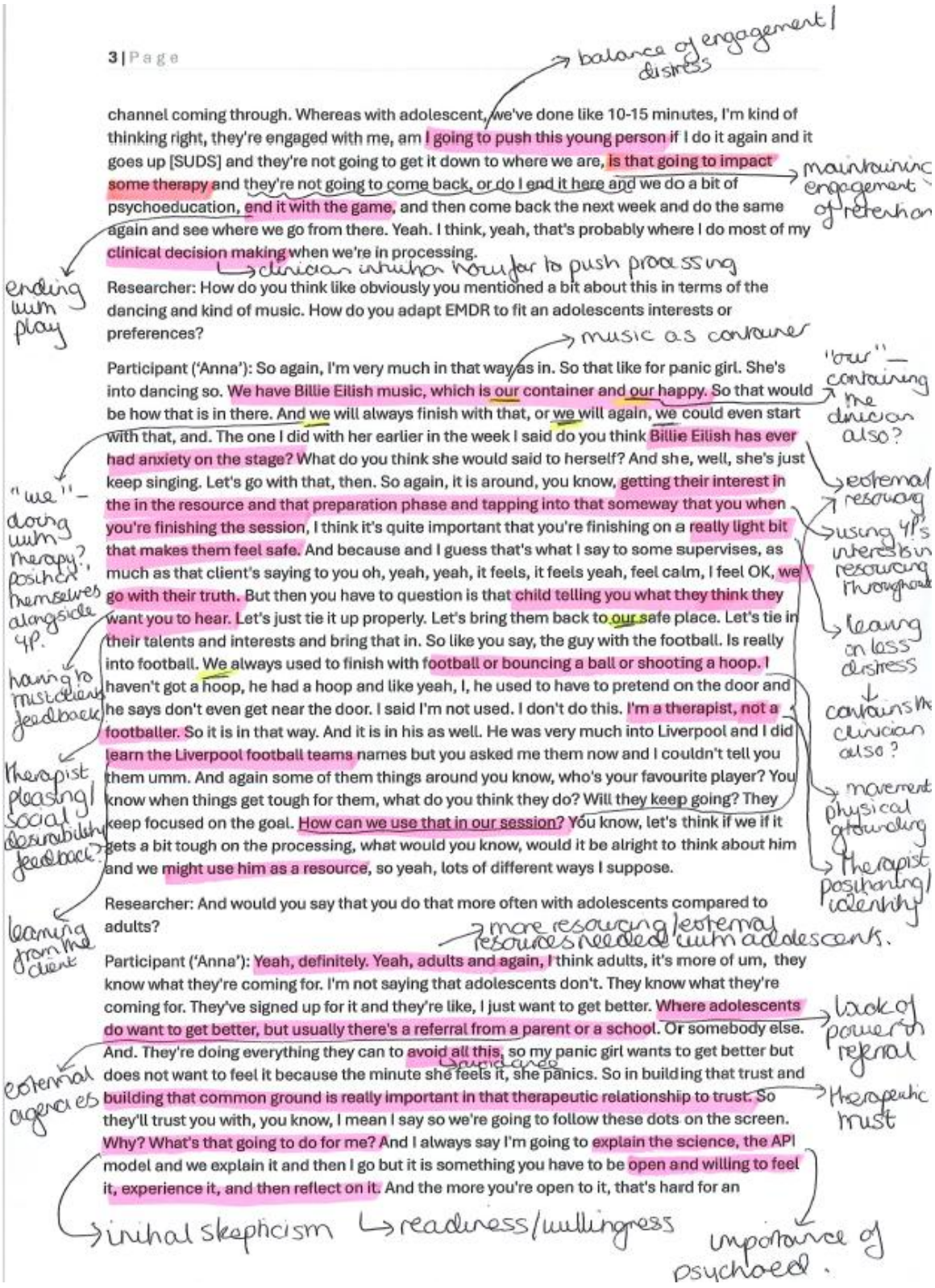
Prompt:

- This might include areas like training, accessibility, service design, clinical pathways or supervision

12) As we come to an end, is there anything else you would like to share or any final thoughts of your experience of using EMDR with adolescents?
General Probes (as needed throughout the interview): - *"Can you tell me a bit more about…"* - *"Can I check what you mean by…"* - *"How do you feel about that?"* - *"What do you think about that?"* - *"Could you give me an example?"*

Appendix J

Example Familiarisation Notes During Data Analysis Phase One



3 | Page

channel coming through. Whereas with adolescent, we've done like 10-15 minutes, I'm kind of thinking right, they're engaged with me, am I going to push this young person if I do it again and it goes up [SUDS] and they're not going to get it down to where we are, is that going to impact some therapy and they're not going to come back, or do I end it here and we do a bit of psychoeducation, end it with the game, and then come back the next week and do the same again and see where we go from there. Yeah. I think, yeah, that's probably where I do most of my clinical decision making when we're in processing.

Researcher: How do you think like obviously you mentioned a bit about this in terms of the dancing and kind of music. How do you adapt EMDR to fit an adolescents interests or preferences?

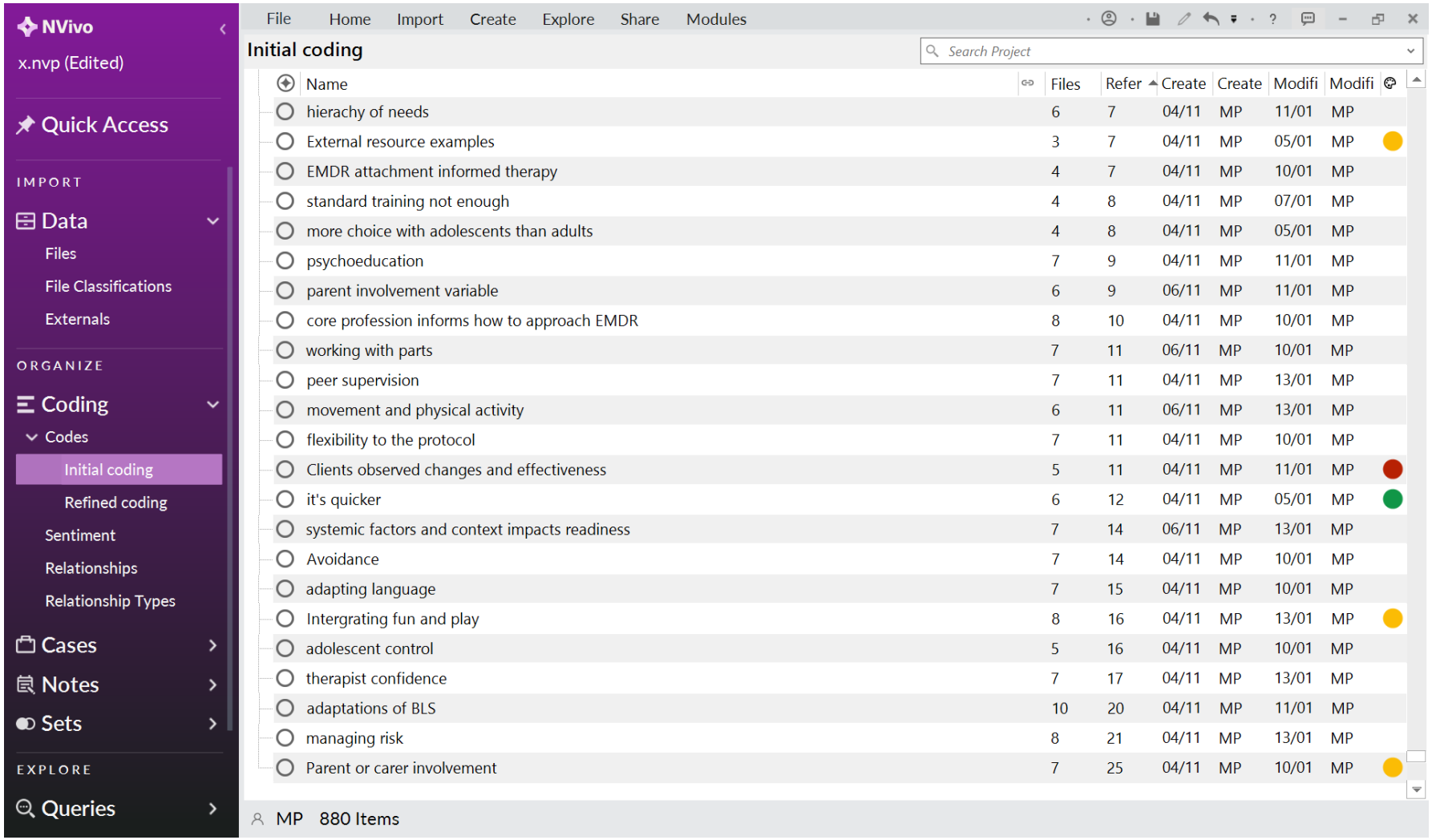
Participant ('Anna'): So again, I'm very much in that way as in. So that like for panic girl. She's into dancing so. We have Billie Eilish music, which is our container and our happy. So that would be how that is in there. And we will always finish with that, or we will again, we could even start with that, and. The one I did with her earlier in the week I said do you think Billie Eilish has ever had anxiety on the stage? What do you think she would said to herself? And she, well, she's just keep singing. Let's go with that, then. So again, it is around, you know, getting their interest in the in the resource and that preparation phase and tapping into that someway that you when you're finishing the session, I think it's quite important that you're finishing on a really light bit that makes them feel safe. And because and I guess that's what I say to some supervises, as much as that client's saying to you oh, yeah, yeah, it feels, it feels yeah, feel calm, I feel OK, we go with their truth. But then you have to question is that child telling you what they think they want you to hear. Let's just tie it up properly. Let's bring them back to our safe place. Let's tie in their talents and interests and bring that in. So like you say, the guy with the football. Is really into football. We always used to finish with football or bouncing a ball or shooting a hoop. I haven't got a hoop, he had a hoop and like yeah, I, he used to have to pretend on the door and he says don't even get near the door. I said I'm not used. I don't do this. I'm a therapist, not a footballer. So it is in that way. And it is in his as well. He was very much into Liverpool and I did learn the Liverpool football teams names but you asked me them now and I couldn't tell you them umm. And again some of them things around you know, who's your favourite player? You know when things get tough for them, what do you think they do? Will they keep going? They keep focused on the goal. How can we use that in our session? You know, let's think if we if it gets a bit tough on the processing, what would you know, would it be alright to think about him and we might use him as a resource, so yeah, lots of different ways I suppose.

Researcher: And would you say that you do that more often with adolescents compared to adults?

Participant ('Anna'): Yeah, definitely. Yeah, adults and again, I think adults, it's more of um, they know what they're coming for. I'm not saying that adolescents don't. They know what they're coming for. They've signed up for it and they're like, I just want to get better. Where adolescents do want to get better, but usually there's a referral from a parent or a school. Or somebody else. And. They're doing everything they can to avoid all this, so my panic girl wants to get better but does not want to feel it because the minute she feels it, she panics. So in building that trust and building that common ground is really important in that therapeutic relationship to trust. So they'll trust you with, you know, I mean I say so we're going to follow these dots on the screen. Why? What's that going to do for me? And I always say I'm going to explain the science, the API model and we explain it and then I go but it is something you have to be open and willing to feel it, experience it, and then reflect on it. And the more you're open to it, that's hard for an

Appendix K

Example of Initial Codes Generated in NVivo during Data Analysis Phase Two



Appendix L

Example Transcript Extract with Refined Codes in NVivo

adolescents who have used buzzers quite successfully. I think as a therapist, you have to be quite confident as you move in to the position where you're going to do eye movements and realised recently that actually it's really it's quite difficult to keep it going over a lot of time. And I did buy myself a wand where it's more like that. Really can hurt your arm, but if you're at it for an hour and a half it's real, isn't it? So I bought a wand. Which is it's, you know, it's it sticks up. And then I think you can use that on a screen if you get practised as well. So that's quite useful. I I have done EMDR therapy with a lab 15 years-old with the different parts and he was so fidgety he was spinning on a chair, crawling onto the furniture, moving around. So if I was gonna do any EMDR processing with any obvious parts, cause that was like obviously a knitting fog as well. He did two things. He bashed his knees with his hands. He had a cushion on his knees. He would bash his knees and he would stamp that foot. So we did that and that. And I felt that took all that kinetic energy that had in to himself and got him moving. And I did it with him because I wanted him to keep going with it. And I needed pace. And that's the problem with butterfly. If they're just doing it on themselves, then you're not there to do it for them. So we agreed with him because he disassociated a lot, that if he went floppy and his feet stopped moving, then we knew that actually he disconnected from the network and there was no point in carrying on. But if his feet were still moving, his dad would put his arms around him and keep his hands going while his feet were still moving and I would keep going as well, so that was was an agreement we came to after I was like this is an adreaction. We can't just stop because he's one floppy. But if he really had gone floppy, dissociation is going offline, isn't it? It's because too difficult. Yeah. Too much so thought about another. There is a trainer who uses pool noodles, but that's maybe the younger children, not adolescent. So you could do, though I suppose 12/13/14 if they're very, very hyper and they need to move and I think she would do kind of sword fighting with a pool noodle? And that's her way of doing bilateral stimulation. I haven't done that, but one of my peer support people has recently been and brought pool noodles to use with a client because he's either hyper or falling asleep in session and she wants him to be engaging in the session. So you have to be quite confident with it and play with it a little bit. Don't assume so as people come to me and they'll. Well, what by bilateral should do I said, well, how do you know? How do they know? Nobody know. Don't ask them. Don't ask me. Go and play with it and see, I did have a kid who was doing she was experiencing involuntary vomiting because of anxiety and the eye movements were awful for her. I get really travel sick, so anything that goes like that in front of my eyes, it's quite likely that it's gonna trigger. I think if you're that way out a bit Vertigo, travel sicky. Yeah, I. And and she was, she goes. I don't know whether I'm feeling sick right now because you're inviting me to think about what it is and making me so anxious or I'm feeling sick cause you're doing that with my eyes, so we had to stop. We had to abandon that and we did tapping with her. So I I think a variety of responses.

Researcher:

You said a little bit about this, but do you think there's any other barriers of using the EMDR with adolescence?

Participant ('Ruby'):

Well, fear of targets. Really big fear and not having the emotional resources to overcome. So I think you need to be cautious and accepting. You need to get consent and sign up an agreement and collaboration. And if they say it's too hard, you take a step back. The protocol can be a bit rigid. You must start with the worst the first, the most recent. We're not a fan of that. I think that's not really so disaccredit me, you know, it's kind of like. I don't think it really works like that. I think it's like, OK, you've got these lists well done. Calm

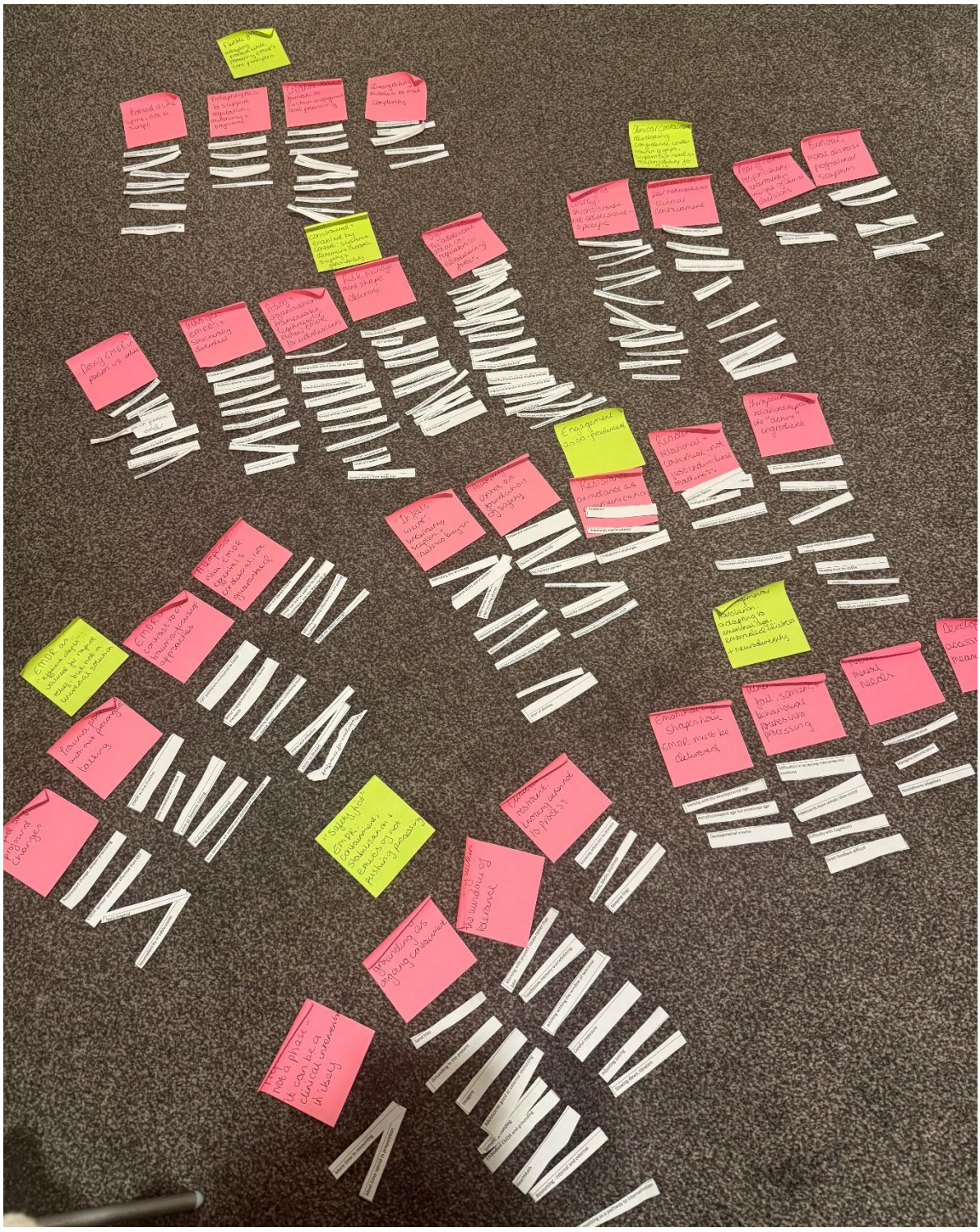
Appendix M

Example of Coding Audit Trail

Refined code	Examples of initial codes that were merged into this refined code	Refinement logic (why they were refined/merged)
Accelerated change, deeper processing	a lot of the work nowadays is for school trauma; adolescents I work with move forward much quicker; quick processing; it really felt like we shifted it	Grouped all codes describing rapid shifts, depth of processing, noticeable change attributed to EMDR.
Access dependant on funding	adopted support fund work…commissioned to deliver; funding cuts limit implementation; number of emdr sessions set by external systems; budget limitations	Collapsed to capture financial/commissioning constraints shaping access and delivery.
Add-on trainings expensive	self-funded additional trainings; self-funded training; add on trainings expensive; we have to fight for CPD	Merged because all refer to cost burden of extra training/CPD beyond core EMDR
Adaptations of BLS	adaptations of BLS; let them play with the light bar; I default to using the buzzers; adolescents prefer light bar or tactile	Grouped all mentions of changing bilateral stimulation delivery to fit adolescent needs/preferences.
Alternative BLS methods	Just adapting it by using movements; Movement-based BLS; dislike eye movements; gender affects BLS methods	Broader than "adaptations of BLS": includes non-standard/creative BLS forms and preference of BLS/dual attention.
Adapting language	adapting language; modify the language; reduce the number of words; don't explain jargon	Captures simplifying/age-appropriate wording and avoiding clinical jargon.
Addressing the weirdness	Adolescents think this is weird shit; I will preface it with this is a bit weird; kind of the weirdness of it	Clinicians name/normalise EMDR weirdness to support adolescents engagement
Adjusting pacing	might have to take it slowly; slowing down the process; balancing engagement and distress; working within window of tolerance	Merged as titration and pacing changes to maintain adolescents safety and engagement.

Appendix N

Visual of Looking and Grouping of Initial Themes during Data Analysis Phase Three



Appendix O

Initial Thematic Map Generated During Data Analysis Phase Four

Appendix P

Final Thematic Map Generated during Data Analysis Phase Five