# EMDR Intervention for a 17-Month-Old Child to Treat Attachment Trauma: Clinical Case Presentation

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This article explores the effectiveness of treating a 17-month-old male diagnosed with posttraumatic stress disorder (PTSD) and a disrupted secure attachment utilizing eye movement desensitization reprocessing (EMDR) and an integrative family therapy approach. The child experienced a life-threatening choking incident requiring hospitalization. Pretreatment, the child was inconsolable by his parents when distressed and could not tolerate anything touching his throat. Posttreatment, the child accepts comfort from his parents and allows his mother to kiss his throat. Results demonstrate a reduction or elimination of PTSD symptoms and a return to a secure attachment. This case study underscores Shapiro's Adaptive Information Processing (AIP) model (2001). Application and customization of the eight phases of EMDR therapy are highlighted along with the Integrative Attachment Trauma Protocol for Children (IATP-C). Treatment consisted of five sessions. Customization included caregiver psychoeducation; EMDR resource development, focused on strengthening attachment and regulating emotion; and facilitating caregiver co-regulation throughout EMDR. The use of EMDR therapy with customization through the IATP-C protocol shows promise as an effective intervention for treating posttraumatic stress symptoms and repairing attachment in very young children.

**Keywords:** eye movement desensitization and reprocessing (EMDR) therapy; early childhood attachment trauma; integrative parent–child therapy; adaptive information processing

Eye movement desensitization and reprocessing (EMDR) therapy is presented as an effective treatment when combined with playful, creative attachment engagement during therapy between the parent, child, and therapist (Adler-Tapia & Settle, 2017; Gomez, 2013; Greenwald, 2007; Lovett, 1999; Wesselmann, Schweitzer, & Armstrong, 2014). EMDR is a standardized treatment protocol created by Dr. Francine Shapiro (2001) using eight phases of treatment for trauma-based symptoms. EMDR emphasizes the Adaptive Information Processing (AIP) theoretical model. The AIP model stresses the body's inherent capacity to integrate traumatic and stressful events. Accessing unprocessed neural networks through bilateral stimulation (BLS) during EMDR treatment activates the inherently present AIP system to process and integrate distressful events. EMDR facilitates letting go of painful information encapsulated in unprocessed neural networks and allows us to connect with more useful information that is readily available (Shapiro, 2001; Shapiro & Forrest, 2004; Wesselmann & Shapiro, 2013).

EMDR therapy is considered an effective treatment for young children who have experienced trauma (Lovett, 1999). When therapists begin to consider case conceptualization and therapeutic interventions with very young children, EMDR may not seem developmentally appropriate or effective, given the emphasis in EMDR foundation training on using the eight phases of EMDR treatment (Shapiro, 2001; Shapiro & Forrest, 2004). However, recently, significant gains have been made in the use of EMDR with children. Resources are available for specific interventions with very young children, but limited case studies are available on children under 2 years of age. Research suggests that therapists can gain confidence and efficacy in implementing the eight phases of the EMDR protocol by conceptualizing cases through a playful, integrative parent–child attachment lens (Adler-Tapia & Settle, 2012; Gomez, 2013; Wesselmann et al., 2014). Parents seeking mental health services often


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have difficulty finding a therapist to work through traumatic attachment events with very young children. The intention of this article is to provide therapists who work with very young children additional information to improve clinical confidence in working within the eight phases of EMDR with very young children.

## The Integrative EMDR and Family Therapy Model

The Integrative Attachment Trauma Protocol for Children (IATP-C) is an EMDR and family therapy model that integrates the EMDR standard protocol with family work and attachment-focused resource work to resolve traumatic material and repair disrupted parent–child relationships (Wesselmann et al., 2014; Wesselmann, Schweitzer, & Armstrong, 2015). The IATP-C family therapy component places a strong focus on strengthening emotional connection within the parent–child relationship. The IATP-C EMDR component includes EMDR resource work to stabilize the child, deepen feelings of emotional connection with the parent, and reinforce the child's experiences of moving from a dysregulated to a regulated affect. The goal of the aforementioned procedures is to create a secure holding environment and to improve regulation as a foundation for desensitization and reprocessing of traumatic material. Once the parent and child have completed this phase of treatment successfully, the child is more receptive to co-regulation from the parent. The child is invited to connect with the parent's regulated state of mind to access adaptive information when processing traumatic material. The shared experience of secure, attuned engagement provides an opportunity for the child to use the parent to activate his or her AIP system in order to tolerate processing of distressful events. The IATP-C includes customization that allows the child to reprocess trauma in manageable pieces. Lovett (1999) therapeutic story method is used to assist very young or very dysregulated children with making sense of their experience while activating traumatic memories for EMDR treatment. The therapist and parent(s) together create a therapeutic story, written in the third person. Older children can also participate in this process. The story begins with positive information about the child, followed by a brief, simple description of the challenging event(s), concluding with adaptive information. The story is read to the child while administering tactile BLS. Later, with a child who is old enough and ready to actively participate, the therapist can reprocess specific incidents from the story utilizing the EMDR standard protocol. This case demonstrates that EMDR therapy with customization through the procedures of the IATP-C is a safe and effective way to resolve posttraumatic stress symptoms and attachment disruption in a child as young as 17 months of age.

## Alternative Therapies Considered

EMDR and the IATP-C therapies were selected as the treatment of choice in this case study because the protocols are able to work directly with caregivers and children under 2 years of age. The following treatment approaches were promising but ultimately were assessed as not being the best fit to meet this youngster's trauma needs.

### Attachment-Focused Family Therapy

This dynamic therapy developed by Hughes (2011) targets attachment repair with parents and children; however, it does not target the somatic experiencing young children exhibit with PTSD.

### Circle of Security (COS) Intervention

This highly robust, vigorous protocol is effective in reducing disorganized attachment patterns and in increasing secure attachment behavior for young children. The COS intervention is based on 50 years of scientific empirical research, but was not developed to work directly with children under 2 years of age to resolve somatic experiencing and traumatic memories (Marvin & Whelan, 2010).

### Kuban Approach

Caelan Kuban's *Handbook of Trauma Interventions: Zero to Three* provides parent education and activities to improve attachment and reduce arousal symptoms. However, Kuban's (2007) handbook does not appear to target specific trauma symptoms in the child or the neural networks that encapsulate trauma memories.

### Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

This therapy claims 15 randomized controlled trials supporting its efficacy, but the age range for TF-CBT is 3–17 years of age (Hanson, 2016).

### Scheeringa's Adapted TF-CBT

Scheeringa (2016) has created a promising protocol—*Treating PTSD in Preschoolers: A Clinical Guide*—by

adapting TF-CBT for use with preschoolers. However, this protocol is designed for 3- to 6-year-olds, not for children under 2 years of age with PTSD.

Ultimately, incorporating play therapy techniques with EMDR and IATP-C treatments was assessed as the appropriate intervention for the treatment needs presented for this case. These protocols address the specific needs of young children, while offering concrete strategies to decrease somatic experience through healing the attachment relationship. (Greenwald, 2007; Lovett, 1999; Luby, 2006; Wesselmann et al., 2015).

## Case Report

This case presents the treatment of a 17-month-old boy, Peter (name has been changed), who experienced an acute, single-event medical trauma and subsequent development of an attachment disruption with his primary caregiver. At the start of treatment, he met all the criteria for a diagnosis of PTSD (American Psychiatric Association [APA], 2013). Evidence of a disrupted attachment was assessed based on the report of his mother and father post-trauma, therapist assessment, and observations of parent–child interactions in session. If left untreated, it was likely that behavioral and emotional symptoms would persist. Continued activation of attachment trauma can negatively impact normal development and the quality of the attachment bond between mother and child (Brisch, 2012; Ford & Courtois, 2013; Pianta, Marvin, & Morog, 1999).

A large body of research supports that infants and young children with secure attachment behavior will seek close proximity to their primary caregivers (in this case, the biological mother) as their secure base. Secure children will venture from their secure base, confident they will be protected. They will continue to seek protection and emotional soothing whenever physical and emotional needs arise (Bowlby, 1988; Brisch, 2012; Cassidy & Marvin, 1992; Gomez, 2012; Greenspan & Lewis, 1999; Oppenheim & Goldsmith, 2007; Solomon & George, 1999; Zaccagnino & Cussino, 2013). As a securely attached child, Peter should have sought out his mother for comfort during and after this highly traumatic event, but the life-threatening medical trauma disrupted Peter's secure attachment with his mother. So even though Peter's mother responded in an appropriate, protective capacity, Peter linked his mother with the trauma, and thus she became a trigger for his traumatic memories of the event. Peter exhibited behaviors assessed as symptoms of a break in the trust of his previously secure attachment with his mother. Symptoms pretreatment are detailed in the matrix provided by Peter's mother and as reported to the therapist, as shown in Table 1.

Posttreatment, Peter experienced significant improvement in trauma symptoms (see Table 1). His mother reported feeling well informed and well equipped to meet her child's needs when transient trauma symptoms returned. Upon completion of treatment, Peter no longer met the criteria for PTSD. Both his therapist's clinical observations and reports from his parents indicated that significant healing of Peter's attachment relationship with his mother had occurred.

The case format outlines the execution strategy of EMDR with customized procedures of the IATP-C as shown in Table 2. The core EMDR phases are outlined, including identifying how the IATP-C was integrated into each phase. The therapist contacted Peter's mother after the final in-person session to obtain parental permission for this article and to ask his parents to review it.

## Case History

This case concerns Peter, a 17-month-old boy who suffered an acute, life-threatening trauma. When he was 14 months old, Peter attempted to swallow an object that became lodged in his airway. Peter's mother had to hold him at an upside-down angle during the ambulance transport and in the emergency room because whenever she moved him upright, the object would shift and block his airway. In the emergency room, doctors tried but failed to remove the object. Peter's mother had to continue holding him at an upside-down angle; she did so for a total of 2 hours before a pediatric doctor and ear nose and throat surgeons arrived to perform emergency surgery to remove the blockage.

## Presenting Problem

During the initial assessment, Peter's mother described a secure attachment with her son prior to the trauma. The traumatic event disrupted Peter's secure attachment with his mother. Left untreated, an insecure relational attachment pattern between a caregiver and child can have profound negative consequences in all areas of a child's functioning and in the developing brain. Restoring a secure pattern of attachment between caregiver and child is critical to facilitate positive mental and behavioral health (Bowlby 1988; Cassidy, et al. 1992; Courtney, 2016; Dozier & Bates, 2004; Hughes, 2011; Pianta et al., 1999; Schore, 2001;

**TABLE 1. Targets, Behaviors, Cognitions, and Feelings Pre- and Posttreatment**

| Pretreatment Triggers | Pretreatment Behaviors in Reaction to Triggers | Emotion (as evidenced by behavior in session and per report of parents) | Negative Cognitions (NCs) (hypothesized and included in therapeutic story) | Positive Cognitions (PCs)Reinforced With Therapeutic Story | Posttreatment Behaviors |
|---|---|---|---|---|---|
| Mother attempting to provide comfort to Peter when he woke from night terrors | Screaming, arching back, cowering away from mother<br>(Occasionally he let sister cuddle him.) | Scared, frightened | "I'm not safe with mother."<br>"Mother is frightening and frightened."<br>"I'm not safe with Dad." | "Mother is safe.<br>"Mother loves me."<br>"I can go to mother to feel better." | Yells for "Momma." Reaches for mother as she enters the room and settles on her chest for comfort. (Snuggles in and makes soothing sounds.) |
| Throat exposure/<br>Putting on a bib too tight or anything touching the throat | Screaming, arching, and thrashing on floor, inconsolable | Panic | "I can't breathe."<br>"My throat is blocked." | "I can breathe." | When Peter rubs his throat, his parents tell him "It's okay. You can breathe." He extends chin up so mother can kiss his throat. |
| Telling him "No" to something he wants, and fearful in the bathroom, falls on floor, refuses, inconsolable, pushes mother away, may scream (where a lot of the trauma occurred) | Falling on floor, screaming, not letting anyone get near him | Terrified | "I'm not safe in the bathroom."<br>"Bad things happen to me in the bathroom." | "I am safe in the bathroom." | If parents tell him "No" he may show opposition because he does not want to listen, but no trauma reaction, in the bathroom. He does not fall on floor or become inconsolable. Sometimes he listens and he walks out. |

## TABLE 2. Five Treatment Sessions Detailed Under Eight Phases of EMDR

| Phase Number and Description | | | | | |
|---|---|---|---|---|---|
| Session Number and Type | Focus | Treatment Goals | Identified Targets: Negative | Identified Targets: Positive | Outcome |
| Phase 1: History-Taking and Treatment Planning | | | | | |
| Session 1—Phone | Intake/history-taking and attachment history | Established to treat disrupted attachment and PTSD | Memory of mother as frightening, physical trauma to throat, and medical procedures | | Case appropriate for EMDR processing using the IATP-C approach |
| Phase 2: Preparation | | | | | |
| Session 2—Phone | Explanation of EMDR and the IATP-C using play therapy | Psychoeducation on effects of trauma on children and attachment security | Introduction to self-regulation development and installation (S-RDI) | Introduction to attachment resource development (ARD) | Assessment and treatment plan |
| Phases 3 & 4: Assessment & Desensitization and Reprocessing | | | | | |
| Session 3—Parent–child in-office session | First target: Reprocessing of mother as frightening, allowing Peter to regulate with his mother<br>Additional target sequence: bathroom where trauma occurred, ambulance, medical staff, choking<br>Skills demonstrated: S-RDI and ARD skills using BLS | SUD assessment modified and adapted for 2-year-old<br>SUD assessed child through five attachment markers: child's tone of voice, proximity seeking with mother, eye contact, facial expressions, content of verbalizations (see Table 1)<br>Child had high level of fear/panic<br>Mother's SUD was not formally assessed as she was not identified client | NC assessment modified<br>NCs identified based on clear emotional and behavioral data that did not exist before trauma (see Table 1): "I cannot use my mother to help me feel better"; "I am not safe in bathroom"<br>Mother's NC identified was: "I do not know how to help my child" | PC-VOC assessment modified<br>Attachment resourcing to access adaptive information and install PCs based on preexisting secure attachment and stored adaptive information<br>Clinician stated PCs: "It feels good to let mommy hold you"; "you feel good in every cell of my body"; installed with BLS | Clear positive shifts in emotion and behavior<br>Modified PC installed with BLS: "Mommy can help me with owies"; child accepts mother's comfort<br>Mother identified PC as: "I know how to help my child"; "I have skills to help my child" |
| Phases 4, 5, 6, & 7: Desensitization and Reprocessing, Installation, Body Scan, & Closure and Future Template | | | | | |
| Session 4—Parent–child in-office session | Installation of modified PC "Mommy can help" and increasing strength of secure attachment behaviors using ARD | Reprocess targets:<br>Fear of not being able to breathe<br>Fear of ambulance<br>Fear of medical personnel | Modified SUD<br>Assessed SUD throughout session by very closely monitoring attachment behavioral markers. After each target was introduced with BLS, Peter was provided with ARD and calm soothing connection games with mother | Modified PC, VOC<br>Installed PC modified by having mother tell Peter: "it is safe now"; "you can breathe now"; "help the baby feel baby"<br>VOC increased as evidenced by Peter's increased use of mother to regulate during reprocessing targets<br>Mother stated she feels hopeful, competent, and skilled to help her child | Peter able to accept body scan provided through mother's touch, skin-to-skin connection, and a distinct calming of Peter's central nervous system after each target reprocessed was observed as session ended |

*(Continued)*

**TABLE 2. Five Treatment Sessions Detailed Under Eight Phases of EMDR (*Continued*)**

| Phase Number and Description | | | | | |
|---|---|---|---|---|---|
| Session Number and Type | Focus | Treatment Goals | Identified Targets: Negative | Identified Targets: Positive | Outcome |
| Phases 4, 5, 6, & 7: Desensitization and Reprocessing, Installation, Body Scan, & Closure and Future Template | | | | | |
| Session 5—Parent–child in-office session | Installation of modified PC "mommy is safe," "mommy can help me" using ARD activities with BLS | Reprocess final target identified: choking incident and throat sensitivity<br>Narrate short therapeutic story with physical desensitization to throat; reprocess with BLS | Modified SUD<br>Assessed SUD throughout session by closely monitoring attachment behavior after each target was introduced with BLS<br>Peter was provided with ARD and connection games with mother | Modified PC, VOC<br>Peter able to accept mother's comfort<br>PC installed with BLS<br>VOC increased as evidenced by Peter's use of mother to regulate during reprocessing<br>Mother stated she feels competent to meet her son's emotional needs | Peter able to accept body scan provided through mother's touch, skin-to-skin connection, and a calming of Peter's central nervous system after each target reprocessed was observed as session ended<br>Progress maintained |
| Phases 7 & 8: Closure and Future Template & Follow-up Reevaluation | | | | | |
| E-mails | Weekly e-mails with mother during treatment to reinforce use of skills in the home to increase parental confidence should future trauma triggers arise | Evaluated effects of treatment via Peter's responses<br>Progress was maintained between sessions | SUD<br>Parents reported that when Peter becomes distressed, they can identify his needs quickly; he is easily soothed accepting parental comfort | PC, VOC<br>Peter runs to mother and allows her to comfort him and comes to her when distressed<br>Mother reports that both she and Peter's father fully believe they can meet their child's needs and are on course to return to a state of pre-trauma functioning | Re-evaluation of reprocessing and positive behavioral and emotional outcome maintained at additional 7-month follow-up per report of mother |

*Note.* NC = negative cognition; PC = positive cognition; SUD = Subjective Units of Disturbance; VOC = validity of cognition.

Siegel, 1999; Wesselmann, Schweitzer, & Armstrong, 2014).

The therapist hypothesized that the neural network encapsulating the unprocessed trauma was linked with Peter's relationship with his mother. Peter perceived his mother as frightened and frightening due to her role in saving his life. When a primary caregiver is perceived as frightened and/or frightening, a child's core belief that his parent can comfort him, protect him, provide safety and security, and organize his feelings is severely compromised (Main, 1999). In Peter's case, a double-bind was created. He needed his mother to survive and to provide comfort following the traumatic event, yet he linked his mother with his life-threatening trauma. This double-bind interrupted the healing process and disrupted attachment security. At the start of treatment, Peter's mother experienced anxiety, fear, guilt, sadness, hyperarousal, and feelings of helplessness to heal her child. Schore (2001) posits that a child's coping capacities are developed in the context of a caregiving relationship. The loss of Peter's secure attachment relationship with his mother prevented the facilitation and resolution of traumatic material, thus compromising his coping capabilities and innate capacity to heal. The neural networks that linked Peter's past traumatic experience with his mother's current state of emotional reactivity and traumatic reenactment was the first target for desensitization and reprocessing.

## Case Conceptualization and Eight-Phase Overview

The following sections detail how the therapist attempted to resolve the child's attachment trauma within the framework of the eight phases of EMDR and the IATP-C.

## Phase 1: History-Taking and Treatment Planning

Due to the difficulties of conducting history-taking with a dysregulated 17-month-old in person, the history-taking and treatment-planning phase was conducted through phone conversations and a series of e-mails with Peter's mother. Treatment was provided in five sessions: two phone sessions with the mother for history-taking and preparation; and three in-office sessions every other week with both mother and child (see Table 2). Follow-up e-mails evaluated progress, provided support, and addressed concerns after each in-office session.

Peter lives with a loving, intact family. His mother presented with a strong self-reflective capacity upon entering treatment and reported a good support system and strong marriage. There was no prior history of medical issues, developmental delays, abuse, trauma, or lifestyle factors that would account for the presenting problems shown in Table 1.

Peter's mother described his birth as beautiful. He arrived into the world curious and calm. Prior to the trauma, Peter was described as lovable, happy, sweet, playful, and easily soothed. He slept up to 13 hours through the night and readily came to his mother for comfort, safety, and protection. After the choking incident, Peter's mother entered individual therapy with a skilled trauma therapist to address her own trauma from her son's medical event. She provided a detailed account of the medical trauma her son had experienced prior to treatment, as well as her own experience and fears. She expressed the desire and curiosity to gain the necessary skills and education to help her son heal from the trauma, and to help him return to pre-trauma secure functioning as shown in Table 1.

## Phase 2: Preparation

Part of the preparation phase was also conducted via phone in preparation for bringing the child into the office. The therapist provided psychoeducation on the effects of trauma on young children; information about EMDR; and a summary of the procedures of the IATP-C (Wesselmann et al., 2014) and attachment-based interventions, including family play therapy and Theraplay (Booth & Jernberg, 2010; Gil, 1991, 2011; Gomez, 2013; Hughes, 2011; James, 1989, 1994; Lichtenstein & Brager, 2017; VanFleet & Guerney, 2003). The therapist asked Peter's mother to sign an agreement to participate in parent–child therapy that would include playful engagement to support safety and stabilization for processing traumatic material. As treatment began with Peter and his mother in sessions, the IATP-C model became integral to the preparation phase. Specifically, the therapist implemented the following IATP-C procedures:

### Self-Regulation Development and Installation (Wesselmann et al., 2015)

Peter's mother described her own anxiety and trauma triggers (prior to this session). She used controlled breathing and accepted slow BLS for her own self-regulation installation in session. Regulating herself enabled Peter to begin to respond to her body and match her relaxed breathing without terror. He was able to wake up neural networks of security and comfort that existed pre-trauma. An automatic cellular connection of co-regulation was evidenced

as Peter's body and face relaxed and as his breathing became in sync with his mother's. As his mother relaxed, so did he.

Peter's mother was encouraged to use the therapist's office to create a safe, calm place in which to strengthen attunement with Peter and to access memories of feeling safe, secure, and connected with her child. While she held Peter, the therapist used tactile pulsars on Peter's legs to provide slow BLS while singing the following words to the tune of "This Old Man":

You're okay, you're okay.
You can breathe in peace today.
You are safe, you are calm.
You can breathe in peace today.
You are safe and calm today.

### Attachment Resource Development Activities

Attachment Resource Development Activities (ARD; Wesselmann et al., 2015) involves:

- Adaptation of lollipop game, using child's favorite food (blueberries), reinforcing child's experience of closeness with BLS
- BLS while singing and rocking with lyrics to create a sense of calm and connection
- Cord of love, reinforcing experience with BLS
- Application of lotion to hands and feet (Booth & Jernberg, 2010)

### Skills Training for Peter's Mother

Peter's mother was curious about how her own anxiety might be creating a barrier for Peter to connect with her and feel safe. She also asked for support in helping Peter during his traumatic flashbacks at home. The therapist provided concrete skill training for her to use with Peter between sessions:

- Continue Theraplay (Booth & Jernberg, 2010) attachment resource activities at home, including applying lotion, massage, and feeding favorite foods with gentle slow BLS.
- The butterfly hug with parent: Caregiver holds child on her lap and cradles him, crossing her arms in front of him and providing slow BLS (Jarero, Artigas, Montero, & Lena, 2008; Wesselmann et al., 2014).
- Breathe slowly and calmly while making slow soft whooshing sounds similar to in-utero sounds (Karp, 2015).
- Address bathroom trigger: When Peter is using the bathroom, use BLS while remaining calm and breathing gently. Ask Peter to breathe with his mother. Remind him that he is safe; that his mother will not hurt him in the bathroom; that the scary things are over; that he is safe now; and that it is safe to go to the bathroom.
- Address nighttime terrors during which Peter woke up screaming: The therapist suggested that Peter's father gently transfer Peter to his mother's arms while tapping slow, gentle taps on his shoulders, knees, arms, or feet. Sing softly:

  You're okay, you're okay.
  You can breathe in peace today.
  You are safe, you are calm.
  You can sleep all through the night.
  When you wake you'll feel just right.

## Phase 3: Assessment

At the start of treatment, Peter's attachment trauma and disrupted secure attachment with his mother were assessed as the prime targets for desensitization and reprocessing. Clearing Peter's blocked memory networks and restoring adaptive information would enable Peter to feel safe and secure with his mother in session. Restoring a felt sense of security between mother and child was the first step in sequencing traumatic events. Standard EMDR identification for baseline measurements of the Subjective Units of disturbance (SUD) and validity of cognition (VOC) were modified due to the young age of the child (see Table 2). To maintain fidelity with the EMDR protocol, rich, clear, specific, descriptive pre- and post-data were collected that document changes in attachment behaviors and reduction of PTSD symptoms. Data were identified by Peter's mother (see Table 1) throughout the treatment process and by therapist observations in parent–child Sessions 3, 4, and 5. Additional targets for reprocessing were identified as follows: where the event occurred (bathroom), fear of ambulances, and fear of doctors in uniforms, physical sensations of choking, and sensitivity to touch on the throat.

## Phase 4: Desensitization and Reprocessing

### Session 3 Parent–Child in-Office Session

This session focused on Self-Regulation Development and Installation (S-RDI) and ARD to access Peter's memories of comfort and closeness related to his mother. As Peter became triggered in his mother's presence in session, the therapist implemented S-RDI by coaching her in strategies to calm herself and soothe Peter. Peter's mother was instructed to use controlled

breathing exercises for self-calming combined with whooshing sounds as she ran her hands lightly down her son's body, starting from the head and proceeding to the toes. Slow BLS was applied to reinforce Peter's experience of moving from a dysregulated state to a regulated state with his mother.

Next, an ARD activity, the lollipop game, was implemented, substituting Peter's favorite food, blueberries, for the lollipop. Peter's mother asked him to look directly at her and acknowledge when he wanted another blueberry, while the therapist slowly ran alternating tactile pulsars as BLS to reinforce the positive experience of closeness to his mother. Next, Peter's mother applied lotion to Peter's hands and feet, again while the therapist applied slow BLS. The therapist added the PC "Mommy can help me with owies" as Peter's mother held him and slow BLS with tactile pulsars was applied. Additionally, the therapist asked Peter's mother to apply alternating hand taps on Peter and to sing the "I'm okay" song while holding Peter on her lap. His little body needed to access neural connections with his mother to gain access to the adaptive information that his mother could soothe him. Creating skin-to-skin contact through the attachment-resourcing games provided warmth and protection, calming Peter's central nervous system and creating the optimal environment for brain-to-brain connection (Morgan, Horn, & Bergman, 2011). These nurturing-attachment engagements offered Peter opportunities to match his mother's regulated state. Each subsequent session included the previous activities while gently adding traumatic material.

## Session 4 Parent–Child in-Office Session

Peter's mother continued to use S-RDI and ARD in preparation to process trauma triggers with her son. Exposing Peter to a toy ambulance accessed the traumatic memory. The therapist placed the ambulance within Peter's reach with his mother very close by. Peter tolerated a few minutes of playing with the ambulance while BLS was applied through tactile pulsars. Then he began to become more agitated, moving quickly about the room. Peter's mother was coached to use skin-to-skin contact and BLS to soothe him. Peter was soothed and more ARD was provided using blueberries. Next, a baby doll, stethoscope, doctor puppet, and medical kit were introduced. The therapist guided the play, encouraging Peter's mother to "help the baby feel better." She told the baby, "It is safe now" and "You can breathe," while the therapist implemented BLS with Peter. Peter tolerated the BLS for a few minutes before becoming restless again. Peter was soothed with attachment-connection games and the session ended. Peter's mother continued to use the "You're okay" song and the attachment resource activities between sessions, using tapping at home to soothe him. She reported that this was going well, and she was seeing more of her son's loving, pre-trauma–connected behaviors return. Peter was coming to his mother more often for comfort, and his separation anxiety with his father was decreasing.

Peter's mother provided updates on his progress between sessions. She reported that after each session, Peter had an increase in night terrors. Concurrently, she reported a huge shift in his positive behavior and an improvement in overall functioning and connection with her. At home, Peter's mother was using skills she learned in the office to desensitize Peter to bathroom triggers; this was going well. During reassessment with Peter's mother, the therapist determined that the last session would target the throat. This was the area where Peter had experienced the most intense trauma to his body and was experiencing traumatic reenactment.

## Session 5 Parent–Child in-Office Session

The therapist began with an ARD activity using a simplified cord of love. The cord of love asks the child to imagine a magical cord that goes from the parent's heart to the child's heart and is always connected, no matter where the child goes. While giving BLS, Peter's mother was asked to touch her heart and then her son's heart while stating, "From my heart to your heart, I give you love; from my heart to your heart, you can breathe with me." Next, the therapist asked her to place Peter in her lap and gently rub a cotton ball on his throat where the "owie" was most activated. This was the area where Peter had experienced the most intense trauma to his body and was experiencing somatic trauma reenactment. Peter's mother held her son while very gently rubbing the cotton ball on his throat. The therapist provided BLS by tapping quickly on Peter's legs and knees. Peter clearly was experiencing traumatic emotions and sensations: He began to make soft throat noises and slight moaning sounds; his eyes became big and his body restless. The therapist provided a short therapeutic story:

> Peter had "owies." Peter was scared. Mommy tried to help him. Mommy needed to help Peter breathe by holding him funny. Peter might have thought, "Why is Mommy scaring me" or "Why won't Mommy hug me to help me feel better?"

> But the truth is, Mommy had to hold Peter funny to help him feel better. Mommy can hug Peter now. Mommy loves Peter and Mommy can protect Peter and help him feel better now. Peter can let Mommy help him feel better now.

Peter tolerated the cotton balls and tapping until the story was completed. The session ended with another ARD activity: Peter's mother provided a food treat while the therapist provided BLS in slow sets. Peter relaxed and was comforted by his mother. After the session, when Peter woke up in the night with night terrors feeling he could not breathe, his mother was coached to sing the "You're okay" song with bilateral tapping.

## Phase 5: Installation

Installation was completed in Sessions 4 and 5 (see Table 2). The therapist observed that Peter's body was calm and installed PCs from the therapeutic story with BLS: "Mother feels good. It feels good to let Mother hold you. Mother can help you feel better. I feel good with Mommy."

## Phase 6: Body Scan

Body scans were completed in Sessions 3, 4, and 5 (see Table 2) and conceptualized as follows: After each session, nurturing touch and attachment skin-to-skin interventions were provided. The therapist monitored Peter's body signals for physical and behavioral evidence that he was accepting his mother's touch and comfort. Peter allowed his mother to calm his body while she made a whooshing noise and ran her hands gently over his body from head to toe. His body notably released tension and fear.

## Phase 7: Closure and Future Template

Parent–child Sessions 3, 4, and 5 ended with ARD resourcing and the therapist providing PCs with song and BLS. Peter and his mother were observed to be connected and calm. In lieu of working on a future template with Peter, the therapist provided his parents with interventions to work on with Peter at home. Peter's mother and father, working together, were effective in returning Peter to his pre-trauma secure attachment behavior. Parent–child affect regulation skills learned in sessions were reinforced to increase parental attunement and help Peter's parents better understand his behaviors, provide comfort, and meet Peter's needs, should symptoms resurface.

## Phase 8: Follow-Up Re-Evaluation

Upon completion of therapy, Peter's mother asked whether she could bring Peter back if symptoms resurfaced and she felt the need for support sessions. Progress was assessed at repeated follow-up contacts. Progress was maintained at the 7-month follow-up (see Table 1). Peter's mother shared the following statement at the last follow-up contact: "Peter's entire life was altered by you teaching us how to help him work through his trauma."

## Discussion

This case study presents the effectiveness of a promising approach for resolving posttraumatic stress symptoms and repairing attachment disruption in children under 2 years of age using EMDR therapy customized with an integrative EMDR and family therapy approach, specifically, the IATP-C. Described were two phone sessions, and three in-office sessions with a 17-month-old male and his mother. Convincing pretreatment data support a diagnosis of PTSD and a disrupted attachment disorder. Posttreatment data demonstrate the resolution of PTSD symptoms and the return to a secure attachment. NCs were identified as shown in Table 2. PCs were identified that, as shown in Table 1, indicate adaptive information was integrated. Evidence presented in the data in Tables 1 and 2 indicate that reprocessing of traumatic memories occurred and that a return to a secure attachment was evident.

Positive statements from the mother posttreatment strengthen the evidence for the effectiveness and positive outcome of the illustrated protocol. A mother who felt powerless to help her son prior to therapy came to believe during treatment, "I can help my child. I know what to do when my child is experiencing traumatic memories." Following treatment, convincing behavioral data indicate that Peter had returned to pretreatment functioning. Peter no longer met the criteria for PTSD, and his relationship with his mother had returned to pre-trauma secure functioning. Upon the 7-month follow-up, Peter's mother reported that therapeutic gains made with her son had been maintained and that further healing had occurred. She stated, "He loves me and hugs me now and even calls me 'my momma.' The change is amazing. My heart is so happy. He is a different child! I'm so in love." Peter's mother reported feeling confident and well-equipped to meet her child's needs should transient trauma symptoms return.

Comparable therapeutic modalities for children under 2 years of age were discussed. This study identified EMDR and the IATP-C as an integrated therapy for caregivers and children that could work with children under 2 years of age. In addition, the findings showed that EMDR and the IATP-C highlight accessing adaptive information to allow effective, expeditious processing of targeted neural networks in the body that hold trauma memories. Evidence suggests that comparable therapeutic models would not have provided all of the treatment criteria presented in the EMDR and IATP-C model.

In conclusion, this article demonstrates that EMDR and the IATP-C protocol were safe and effective in increasing adaptive information, thus allowing access to neural networks that would allow the child to process encapsulated traumatic memories with his mother. Peter's repaired connection with his mother created the opportunity to provide him with more useful and adaptive information inherently available to support his healing from a life-threatening trauma.

## Limitations

Lack of psychometric measures was a limitation of this study. Often the level of stress and symptoms of trauma that families present when accessing services create barriers to the timely administration of pretreatment measurements; such was the case in this study. Other therapeutic modalities were considered as possible options for treatment. However, little research based in empirical, scientific studies was available on working directly with children younger than 2; thus, this study could not grapple with them in depth. The generalization of results is limited because this case study identified data from and a course of treatment for only one family.

## Future Research

Systematic scientific research on effective trauma treatment for working directly with children under 2 years of age is quite limited, as may be apparent from the few citations to such research in this article. Even in his clinical guide for treating PTSD in preschoolers, Scheeringa (2016) found "only two randomized studies [that] had focused on trauma-related symptoms of young children and both were limited to sexual abuse" (pp. 4–5). Similarly, Cohen and Mannarino (1996) focused on 3- to 6-year-olds; Deblinger, Stauffer, and Steer (2001) focused on 2- to 8-year-olds. Measurements for children under 3 are almost non-existent. One measurement that was identified that could be used for future research pre- and posttreatment would be Scheeringa's (2012) diagnostic infant preschooler assessment (DIPA). The DIPA is one of the few trauma assessments available for children from birth to 6 years of age.

A case study series providing EMDR and the IATP-C as a comparative treatment with other therapies for very young children could begin to explore and document what therapies produce therapeutic change in children under 2 years of age. The results of such studies would be invaluable to guide clinicians in effective attachment/trauma treatment with children under 2 years of age. Additional research could explore a range of questions for EMDR with very young children: to what extent can children under 2 years of age benefit from EMDR and IATP-C attachment trauma protocols; what is the most effective application of EMDR to mitigate against possible negative long-term effects of unresolved trauma; and in what ways can EMDR address the high risk for mental health problems associated with the continuation of insecure attachment patterns that create life-long problems in relationship security?

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