Psychiatria Danubina, 2018; Vol. 30, Suppl. 5, pp 276-281 *Conference case report*

WOULD THE WELL-TIMED USE OF EMDR THERAPY IN THE SCHOOL SYSTEM SAVE THE MENTAL HEALTH OF YOUTH? CASE REPORTS

Ivana Kokanović[1] & Mevludin Hasanović[2,3]

[1]*High school "Vaso Pelagić" Brčko, Brčko, Bosnia and Herzegovina*
[2]*Department of Psychiatry, University Clinical Center Tuzla, Tuzla, Bosnia and Herzegovina*
[3]*School of Medicine University of Tuzla, Tuzla, Bosnia and Herzegovina*

* * * * *

INTRODUCTION

What would be a well-timed use of psychotherapy? Adolescence is a period of development full of challenges and changes. Adolescents are very sensitive to every life situations and curious to learn and work on themselves. Being extremely vulnerable due to distinctive features of their period of development, always somewhere in the middle, between childhood and adulthood, stable and unstable, in the gap of individual internal processes of individualization, they attempt to solve interpersonal conflict and get the answer to the famous question: Who am I? (Greenwald 2000, Sagle 2013). Children and adolescents do not respond in the same way as adults to dangerous and threatening situations. Sometimes small changes in their emotional reactions can be a call for help which we sometimes fail to notice. The reasons why we need to include school psychologists are not only traumatic events, but also challenging ordinary situations in which we can see their incapability to resolve interior conflicts, impossibility to react in the right way or make acceptable decisions (Fisher et al. 2011). Taking into account that they spend most of their time in school, every change, and every new symptom can easily be observed by well educated professionals (Atkinson et al. 2014). It is estimated that in every generation about 20% of adolescents have issues serious enough to be classified as dysfunctional. But even those 80% who behave in acceptable and adaptive way are in this period of life when they have tendency to react intensively to stressful life situations, to behave risky, and this is all part of normal growing up process (Guillotta 2015). Well-timed reactions and elimination of symptoms as soon as they occur and start to disable normal everyday life could prevent appearance of psychological disorders later in life (Fleming 2012).

Eye Movement Desensitization and Reprocessing (EMDR) is relatively new psychological therapy developed by Francine Shapiro in 1989. It is originally designed to alleviate the distress of traumatic memories. The most concise definition is taken from EMDR Institute web site: Adaptive Information Processing model (Shapiro 2001) posits that EMDR facilitates the accessing and processing of traumatic memories to bring these to adaptive resolutions. After successful treatment with EMDR, affective distress is relieved, negative beliefs are reformulated, and physiological arousal is reduced. During a typical EMDR session, the client focuses on emotionally disturbing materials while also focusing on an external stimulus in the form of therapist's directed eye movements, audio stimulations or tactile stimulation to create bilateral stimulation of the brain. Negative memories stored in brain network are reprocessed during that procedure so that they can be connected with healthy memories and become adaptive. In a healthy individual, all new experiences are processed, useful details are learned and stored with appropriate emotions and made available to be used in future. Persistent anxiety suggests that information processing system has stored the experience without adequately processing it to an adaptive resolution. This leads us to future inappropriate responses to similar events since it becomes a touchstone event for any associated experiences. Unprocessed experiences are stored in their own networks unable to link with other new information, positive experiences and adaptive emotions. EMDR therapy links unprocessed experiences with healthy memories and this leads client to an insight in the condition and efficient disappearance of symptoms (Shapiro 2007).

Latest intentions are that EMDR is more than just a therapy for traumatic experiences and that we can use it as a successful treatment for variety of psychological disorders. Trauma or any adverse life event can be causal factor for many psychopathological symptoms later in life. The AIP suggests that if we can trace basic memory we can treat it with EMDR. The latest studies illustrate that the EMDR is very efficient with wide range of disorders as generalised anxiety disorder, phobias (the main reason why adolescents come for a treatment), as well as depression, obsessive compulsive disorders and psychosis (Logie 2014).

Many studies investigate the effectiveness of EMDR therapy with children and adolescents exposed to various kinds of traumatic experiences. All studies manifest successful diminishing of symptoms at Type I traumas (Fleming 2012), and compared with CBT, another

advised treatment for traumatic experiences, EMDR results in more efficiency with less necessary sessions for recovery (Sagle 2013). It is very important to provide EMDR treatment as soon as possible in order to reduce symptoms easily and promptly (Abdulbaghi 2007).

In Bosnia and Herzegovina thanking to Humanitarian Assistance Project EMDR UK&Ireland, today Trauma Aid UK, meaningful number of mental health professionals were trained in EMDR therapy (Hasanović et al. 2011). Additionally, the training in EMDR for Children and Adolescents completed for EMDR trainees (Hasanović et al. 2016), so trained EMDR practitioners are in ability to give meaningful psychotherapeutic help to young individuals who are in need after Bosnian war 1992-1995 (Hasanović et al. 2006, Hasanović 2012, 2013).

With this case study we try to show how different, everyday life events can have profound impact on adolescents and can cause psychopathological, mostly anxious symptomatology. Also, our aim is to give insight into the importance of well-timed psychotherapy in order to prevent the appearance of later developmental disorders, possible problems in social activity, substance abuse, psychiatric diagnoses and criminal behaviour as a result of early life stressful events (Sagle 2013).

This case reports deal with four adolescents, three girls and one boy, without any previous psychotherapeutic experiences. They were all reported to treatment within a couple of months to six years since the stressful event had occurred. The Standard EMDR protocol was used, with eye movements as bilateral stimulation, and tapping was used with two clients in moments of high emotional arousal. Sessions were conducted one per week, usually lasting 60-90 minutes. Follow – up sessions were conducted three months after completed EMDR treatment with unstructured interview and a return to the traumatic image in order to estimate the possible level of disturbance.

CASE REPORTS

Case 1

Š.O., aged 15, female, Brod, she is the 1st year of high school, dealing with diversity of obsessive rituals for past two years such as waking up at the same hour, same minute (7.7), bypassing every person walking in front of her... She moved from the Netherlands to Bosnia and Herzegovina when she was nine years old and at the very first day of school she was mocked at and rejected because her classmates thought she was Catholic. Even though her mother and her teacher reacted immediately and settled the situation, from that moment she started to feel unwanted, as if everybody is looking and pointing fingers at her. She becomes withdrawn and distrustful. Soon after that incident different symptoms of anxiety start to appear and for the past six years she has been dealing with them alone. Parents are occupied with their own obligations and do not care a lot about her feelings. They are aware of some symptoms but explain them as part of her"natural shyness". Few months before she comes to the therapy her friend from the Netherlands pays a visit and she remembers how safe and accepted she was there and rejected here. At first glance, she looks well adapted to the new environment. She has few supporting friends even though she has just enrolled in the first grade of high school. She remembers her peaceful childhood in the Netherlands and craves for coming back there. On many occasions her parents talked about ideal childhood in Bosnia and Herzegovina and about great school days, and she was happy about moving. One of her friends successfully diminished symptoms of panic attack and driven with positive experiences persuades her to report to the therapy. She primarily reports for obsessive rituals that she cannot control anymore, that make her nervous and aggressive towards family and friends, problems with sleeping and becoming more withdrawn. She is very receptive. We conducted 4 sessions within a period of 3 weeks: history taking and preparation, two sessions of reprocessing and one of reassessment. After the first session she immediately starts to practice the "safe place", she even visits her "safe place" in reality (a specific spot on the river walk) to exercise in vivo. She identifies the worst picture easily, feelings of guilt, shame, and suffocation in the chest and desire to start crying. Her core beliefs we find in the group of responsibility (shame), she finds herself inadequate, and for negative cognition (NC) she chooses" I`m stupid", and for positive cognition (PC) "I`m smart" which in the process of installation she replaces with" I`m worthy". On validity of cognition scale (VoC) (from 1 being completely false to 7 being completely true) she marks her positive cognition with 4, and after EMDR reprocessing she increases it to 7. The level of disturbances associated with emotions is rated on subjective units of disturbance (SUD) where 0 denotes no disturbance or neutral and 10 is the highest disturbance possible. She marks it with 8 and at the end of first reprocessing it decreases to 3, and after second it becomes 0. Even after the first session of reprocessing she stops with some rituals, becomes noticeably positive and self-confident in her behaviour, and surprisingly, starts an emotional relationship. An interesting detail from desensitization process was when few suppressed pictures appeared from the Netherlands in which she also felt inadequate. That was crucial for an insight that there is no ideal place,"bad" people exist everywhere and it has nothing to do with her. After second EMDR reprocessing she stops with all rituals connected with street behaviour, she feels light and calm. She exercises "safe place" and "light stream" (she imagines a sandbag on her chest, pressing her and vibrating, and blue light presses out of it). After 3 months and after a year, on a follow-up session, by going back again to traumatic memory and with unstructured interview we did the control estimation of level of disturbance. She showed no disturbance and no psychological problems. Four months after last EMDR session she conducted a workshop on Basics of the Dutch language for 15 students.

Case 2

G.M., aged 17, female, Brčko, she is the 3rd year of high school, refers because of fear of failure that blocks her mentally. She lives with parents, a younger brother and a sister. She has a bad relationship with her sister, since she is quite verbally aggressive and verbally attacks her, often for no reason. It bothers her a lot. She claims that her sister is a beauty, while she and her brother have weight problems but much better relationship. The sister is jealous of her and brother's better school grades and parents often compare them. She claims that her parents support her, but in the process of history taking few details emerge. She admits that her parents are persuading her to enrol in the Faculty of Medicine even though she wants to be a graphic designer. She willingly reports to therapy because of the problems with concentration. She cannot focus when studying, as soon as she starts learning she can hear words ringing inside of her head "...why bother at all, it is useless, you will not succeed...". She has a fear that she will not be able to enrol in the Faculty of Medicine because she has a lack of concentration. Since she could not identify any single traumatic event we used float-back technique and immediately a picture popped up. It was an incident from childhood, when her mother at the age of 10 tried unsuccessfully to teach her how to ride a bike. Finally, when she succeeded, her mother commented her success with words "It's no big deal". From that moment, she starts to consider herself as an unsuccessful person who cannot finish any activity, and believes that there is no sense in making any effort since "it will not be good enough". We conducted 3 EMDR sessions in the period of 3 weeks: history taking and preparation, reprocessing and reassessment. Her safe place was a beach, and after reprocessing we visualised light stream of yellow light that presses out black, squeezed, rough paper from her chest. Core beliefs are from responsibility cluster, self-evaluation. She identified her NC as "I`m not persistent" when she thought of her mother's critique, and her desired direction for change describes her PC as "I can be persistent". She feels sadness and disappointment and pressure in her chests. She rates herself as 3-4 on VoC scale, and she marks SUD with 9, but soon after the beginning of bilateral stimulation it starts to decrease to 1 and 0. Interesting part of this case is one specific situation that happened at the early beginning of desensitization. This is when pictures of mother helping her and supporting in different life situations emerged, and were suppressed by basic memory. At this point her SUD suddenly drops to 0, disturbance disappears and VoC denotes 7. She was stunned "I cannot believe that it was so easy and that I had forgotten all positive events". After installation she feels nice and calm. On the follow up session 3 months later with unstructured interview and reversing memory again we can see that subject has no disturbances. She started to work on herself, lost 4 kg of weight and started to prepare for the entrance exam for the Faculty of Medicine.

Case 3

C.P., aged 16, male, Donji Žabari, he is 2nd year of Medical high school, dealing with social anxiety, confusion and mental blockade when presenting in front of other people. In the beginning he could control negative thoughts and encourage himself, but not anymore. He feels incapable and depressive. He lives with parents, a younger brother and an older sister. Sister is his enormous support and a close friend. He is embarrassed with his mother's boasting about everything and his father's job; his father owns an iron waste business. He wants to study medicine and become a physician and have a decent job. He is an excellent student, loved by classmates and teachers. His homeroom teacher notices symptoms of anxiety when he speaks in front of his class and sends him to visit a psychologist. He complains of fear of public speaking, feels uncomfortable in those situations, gets confused, feels heat in lower part of his back, and claims "I forget everything I have learned, I blush and think what they all will think about me".

He claims that he cannot point to any specific event that can be the cause of those symptoms and we used timeline technique to find the touchstone event. The worst memory happened 3 years ago while he was working in a barbecue stall with his father and his uncle. He made a mistake and they crudely insulted him. Even though he remembers earlier similar situations of looking down on him, of him being insulted and conceived as incompetent, that particular moment was the emotional peak, and after that day he became depressive, suicidal and mentally blocked in front of others. Core belief can be found in reasonability cluster – shame. He describes his NC as "I`m incapable", and wanted to replace it with the PC "I`m capable enough". He feels sorrow, fear, stress and physiologically he feels heat, burning in the lower part of his back and palms. Pre-EMDR the rating of VoC is 3-4, and SUD rating is 8. We conducted 4 sessions over the period of 5 weeks: history taking and preparations, 2 reprocessing sessions and reassessment. First reprocessing session was very emotional and long. He needed therapeutic intervention at the emerging of suicidal thoughts: Eye movement bilateral stimulation (BLS) - "his words are ringing in my head, you are incapable", BLS – "I see my father's brother in different situations, his face is telling me: incapable,", BLS – "those words are driving me to despair and condition of not wanting to exist anymore", BLS – "I cannot get it out of my head, they keep me from moving forward". EMDR therapist intervention (T): "What do you need to get them out of your head?" C.P.: "My sister...I see her face?" T: "Connect your sister's face to those words and try to get them out." BLS – his face lit up. C.P.: "I did it, I do not hear them anymore." BLS –cries. C.P.:"She is always here, in every situation she is with me, gives me strength..." After this intervention the client rates SUD with 2, and by the end of reprocessing it was 0, and the VoC is rated with 7. During the procedure of body scan he feels an

interesting occurrence of something leaking, draining, and flowing out of his body and extremities. In the second reprocessing he opens the second canal, public speaking, exceeds that much faster which leads him to rating of SUD 0, VoC 7. On the follow up session 3 months later, reversing basic memory and using unstructured interview we can see that there is no disturbance and the client feels excellent. If he feels sensations of heat he performs the exercise light stream and imagines blue light bulb inside his back which cools him down immediately. He changed relationship with his father, he stopped to be submissive.

Case 4

M. L., aged 17, female, Pelagićevo, she is the 3rd year of high school, reports because of emotional fall outs, incapable of controlling crying outbursts in everyday occasions. She lives with parents and a younger sister. She is very attached to her family, especially her mother. She has a circle of friends but still has an impression that her friends do not want to share secrets with her and that she gives in more in those relationships. Three months before she came to therapy she had some form of a panic attack while she was taking a shower. She was flown by fear, suicidal thoughts and she breathed heavily. She develops a variety of obsessive rituals and anxious behaviours, sleeps with her mother, worries about doing something bad to herself or others. It reflects negatively on her self-confidence. She starts to question all and anticipate bad outcomes, and even for the therapy she asks herself "Will it work?". She started to believe in zodiac. Therapy starts with an unusual encounter. Walking down the school halls I heard somebody sobbing and soon discover a girl in one of the classrooms. She reports a problem with self esteem and analyzing things too much. Every conversation, event, scene of a movie "... negative thoughts start automatically, as some kind of a movie tape rolling in my head, fear that I will die, commit suicide or kill somebody. I get very scared of those thoughts and my heart starts bouncing hard. I am afraid I am going mad..." She starts to cry in normal, everyday occasions and cannot control it.

During reprocessing phase series of preceding events and family relationships emerge as possible causes of anxiety. Younger sister is extremely dominant, father verbally abusive and is always sarcastically looking down on her, number of dizziness situations happening in the same period of year at the same place (Christmas – church), a close relative is diagnosed with mental disorder, and first neighbour committed suicide. She is intensively analyzing every thought and body sensation. Core belief can be found in responsibility cluster- control, she describes NC as "I am going mad", and for desired PC she identifies "I am normal". The rating of VoC is 5, pre-EMDR SUD level was rated with 7-8; she feels pressure inside her head, has a lump in her throat, feels anxious and affrighted. During reprocessing she was emotionally hyper aroused, had long crying moments and since she wanted to continue the process we used tapping as BLS. We conducted 6 sessions in the period of 2 months: history taking and preparation, 4 reprocessing and reassessment. With every next reprocessing session level of disturbance was diminishing while she opened new channels that we processed at once. After second reprocessing session she decided to change PC to "I can have control". She notices she stopped crying during reprocessing, and cannot recollect when the last time she cried in public was. After first 2 reprocessing sessions she had intrusive dreams – teeth falling out, death of someone close. In the middle of third reprocessing session she started to yawn intensively, it seemed as if she was going to fall asleep at once, and she finishes the session with interesting pictures: sees a soccer match, ball represents her negative thoughts, fears, anxiety, and her teammates are Self-respect, Love, Hope and Control. In last reprocessing session she gets insight that she has to accept herself and it builds her self-esteem and gives back her stability. "...BLS – "I am visiting my feeble Me in Psychiatry, I get over my feeble Me and I am not sad" (cries), BLS – "That negative side is in fact a little child, oh this is very sad..." (she cries), BLS – "I see a little girl hiding behind her mother's legs, oh that is me in fact..."(she cries)..., BLS – "I am approaching her, taking her hand and taking her outside. We are getting outside, sun is shining, and we are walking through the park…" BLS – "the girl is dancing...". On the follow up session 3 months later, reversing basic memory and using unstructured interview she reports no disturbance and it feels awkward, she does not sleep with her mother anymore, and day by day she can notice disappearance of rituals, one by one. She does not have any emotional fall outs and it makes her very satisfied, "I manage to maintain control".

DISCUSSION

The review of these four case studies shows how EMDR therapy can efficiently resolve psychopathological symptoms with treated adolescents at the early beginning of their occurrence and disruption of everyday functionality. All clients reported significant and quite dramatic disappearance of symptoms after relatively short time (3- 6 EMDR sessions). Even after the first session they could notice significant improvements and continue to reprocess between sessions independently. Three months after the last session they do not have any psychological difficulties and they became functional in private and social lives.

Youth with reduced capacity for undisturbed development, in high school period develops first symptoms of psychological disorders. These four case studies give us an insight in the fact that ordinary, not obligatory traumatic events can cause high level of anxiety and a number of unpleasant symptoms that disable their everyday functionality. Their immediate reactions include behavioural, emotional and cognitive difficulties. Their

thinking about the world and people around can be disrupted, leading to further problems and secondary effects. One of the main symptoms is refusing to perform school obligations and a decrease in school grades, which is easy visible both by parents and school staff. If not noticed and treated professionally, initial reactions can have a further effect, and impact upon their adult personality with significant consequences sometimes leading into serious psychological and behavioural disorders (Trickey 2000).

School psychologists are in direct, everyday contact with adolescents and can notice small changes they can have, react adequately and immediately and eliminate symptoms if they have appropriate psychotherapeutic education. International researches show the prevalence of mental health problems among children and adolescents and therefore a growing need for therapeutic interventions. School psychologists are well – positioned to notice first symptoms of mental illness, support adolescents annually, through whole process of education and give free important therapeutic help for all youth in social need (Atkinson et al. 2013). Due to their position as applied psychologists working within the school they can reach and follow entire family, identify whole range of family dysfunctionalities, and reduce the risk of emotional problems of adolescents by well-timed reactions (Fisher et al. 2011).

Adolescents are curious and open for new experiences and do not hesitate to visit a psychologist if they get stuck in the situations where they cannot cope with emerging symptoms anymore. Although impulsive and sceptical towards everything, they hardly bear differences in hierarchy which is present in other psychotherapeutic approaches, and they like to find solutions quickly. In the early phases of EMDR therapy, after first exercise "safe place" they get very interested and become active participants in therapeutic process. Since basic memories are relatively fresh in the phase of reprocessing, they come to insights and the disappearance of disturbances appears quickly. This motivates them additionally and encourages them to continue working. Adolescents are specific population and working with them is challenging and requires adapting to their ways of the communicating, avoid judgements and lectures and try to involve them in the EMDR treatment plan. Since all conditions are easily achieved in EMDR therapy, we can consider EMDR as therapy of choice for adolescents (Shapiro et al. 2017).

CONCLUSION

We can conclude that EMDR therapy used with youth is very efficient in eliminating psychological disorder symptoms and functional problems if applied soon after their occurrence. The question is: How much would the systematic EMDR therapy education of school psychologists help in more beneficial treatment of adolescents thus preserving their mental health?

Systematic EMDR therapy education of school psychologists could help in maintaining mental health of adolescents, but also could preserve the mental health of entire population. It is certain that clients who once recovered easily, naturally and quickly, and who start functional life again with the help of eye movement technique, will knock on their EMDR therapist door again if it becomes necessary later in their lives.

Suggestions for further research

It would be interesting to carry out a detailed research in schools of Bosnia and Herzegovina. More precisely, it would be useful to include wider number of participants, discover typical symptoms encountered by school psychologists, estimate percentage of school population in need for therapeutic intervention and estimate the level of psychotherapeutic education of Bosnia and Herzegovina's school psychologists in order to provide well-timed therapeutic support and preserve mental health of youth.

Acknowledgements: None.

Conflict of interest : None to declare.

Contribution of individual authors:

Ivana Kokanović: conception and design of the manuscript and interpretation of data, literature searches and analyses, clinical evaluations, manuscript preparation and writing the paper;

Mevludin Hasanović: made substantial contributions to conception and design, participated in revising the article and gave final approval of the version to be submitted.

References

1. *Abdulbaghi A, Larsson B & Sundelin-Wahlsten V: EMDR treatment for children with PTSD: Results of a randomized controlled trial, Nordic Journal of Psychiatry 2007; 61:349-354*
2. *Atkinson C, Squires G, Bragg J, Muscutt J & Wasilewski D: Facilitators and barriers to the provision of therapeutic interventions by school psychologists. School Psychology International 2014; 35:384-397*
3. *EMDR Institute: Available from www.emdr.com Approached 22.09.2017 at 22:30*
4. *Fisher et al: Depressive and other symptoms of emotional disorders in adolescents. International Journal of Social Psychiatry 2011; 57(SI):22–39 http://journals.sagepub.com/doi/pdf/10.1177/0020764010396695*
5. *Fleming J: The Effectiveness of Eye Movement Desensitization and Reprocessing in the Treatment of Traumatized Children and Youth. Journal of EMDR Practice and Research 2012; 6:6-26*
6. *Greenwald R: A Trauma-Focused Individual Therapy Approach for Adolescents with Conduct Disorder. Interna-*

tional Journal of Offender Therapy and Comparative Criminology 2000; 44:146-163

7. *Guillotta PT, Plant WR & Evans AM: Handbook of Adolescent Behavioural Problems: Evidence – Based Approaches to Prevention and Treatment. Springer Publishing Company, 2015*
8. *Hasanović M, Pajević I, Morgan S & Kravić N: EMDR training for mental health therapists in post-war Bosnia-Herzegovina who work with psycho-traumatized population for increasing their psychotherapy capacities. Acta Medica Saliniana 2011; 40:93*
9. *Hasanović M, Sinanović O, Pajević I, Avdibegović E & Sutović A: Post-war mental health promotion in Bosnia-Herzegovina. Psychiatr Danub 2006; 18:74-78*
10. *Hasanović M: Posttraumatic Stress Disorder of Bosnian internally displaced and refugee adolescents from three different regions after the war 1992-1995 in Bosnia-Herzegovina. Paediatrics Today 2012; 8:22-31*
11. *Hasanović M: Neuroticism and Posttraumatic Stress Disorder in Bosnian internally displaced and refugee adolescents from three different regions after the war 1992-1995 in Bosnia-Herzegovina. Paediatrics Today 2012; 8:100-113*
12. *Hasanović M, Morris-Smith J, Morgan S, Oakley S & Šabanović Š: EMDR trainings for Bosnia-Herzegovina mental health workers resulted with child training in Sarajevo for 75 EMDR psychotherapists aftermath the 1992–1995 war. European Psychiatry 2016; 33:S277*
13. *Logie R: EMDR – more than just a therapy for PTSD? The Psychologist 2014; 27:512-517*
14. *Sagle T: The Effectiveness of Psychosocial Interventions for Reducing Psychological Harm in Children and Adolescents who have Experienced Trauma: A Systematic Review and Meta-Analysis. A Thesis Presented to The University of Guelph in partial fulfilment of requirements for the degree of Master of Science in Family Relations and Human Development, 2013*
15. *Shapiro F: EMDR, Adaptive Information Processing and Case Conceptualization: modified reprint from Shapiro F, Kaslow F & Maxfi eld L. (Eds.) Handbook of EMDR and Family Therapy Processes (New York: Wiley). Journal of EMDR Practice and Research 2007; 1:68-87*
16. *Shapiro F, Wesselmann D & Mevissen L: Eye Movement Desensitization and Reprocessing Therapy (EMDR) In: Evidence-Based Treatments for Trauma Related Disorders in Children and Adolescents, 2017; 273-297. Downloaded 14.9.2017 from: https://www.researchgate.net/publication/313690818_Eye_Movement_Desensitization_and_Reprocessing_Therapy_EMDR*
17. *Trickey D & Black D: Long – term psychiatric effects of trauma on children. Trauma 2000; 2:261-268*

Correspondence:

Ivana Kokanović, Psychologist
High school "Vaso Pelagić" Brčko
Dr. Safeta Muratovića 2, 76 000 Brčko, Bosnia and Herzegovina
E-mail: ivana.kokanovi@cmail.com