EMDR & CHILDREN

A GUIDE FOR PARENTS, PROFESSIONALS & OTHERS WHO CARE ABOUT CHILDREN

What is EMDR?

Eye Movement Desensitization and Reprocessing is a treatment method that is effective for resolving emotional difficulties caused by disturbing, difficult, or frightening life experiences. EMDR has been used to help children overcome traumatic events and other childhood problems and symptoms.

When children are traumatized, have upsetting experiences or repeated failures, they lose a sense of control over their lives. This can result in symptoms of anxiety, depression, irritability, anger, guilt, and/or behavioral problems. We recognize that events such as accidents, abuse, violence, death, and natural disasters are traumatic but we do not always recognize the ways they effect and influence children's everyday lives. Even common upsetting childhood events such as divorce, school problems, peer difficulties, failures, and family problems can deeply affect a child's sense of security, self-esteem, and development.

When an upsetting, scary or painful experience happens, sometimes the memory of the experience stays "stuck" or "frozen" in the mind. The experience may return in a distressing and intrusive way. Or the child may cope by avoiding everything associated with the upsetting experience. For example, when a child has experienced a bad bicycle accident, there may be repeated nightmares, fears of trying new things, and avoidance of things associated with a bike.

Most experts agree that one way to get "unstuck" and free from the symptoms is through exposure to the traumatic experience. This means to face the memories or troubling events until they are no longer disturbing. EMDR combines elements of several well-established clinical theoretical orientations (e.g., psychodynamic, cognitive, behavioral, client-centered) together with "bilateral stimulation" in a unique and novel way to dissipate the upset associated with the experience. Bilateral stimulation refers to the use of alternating right-left tracking that may take the form of eye movements, tones or music delivered to each ear, or tactile stimulation, such as alternating hand taps. Creative alternatives have been developed for children that incorporate the bilateral stimulation, using puppets, stories, dance, art, and even swimming.

EMDR helps process the troubling thoughts, feelings, and memories so that children can return to their normal developmental tasks and prior levels of coping. EMDR is being used with other childhood problems that are not caused by trauma, such as attention deficits (AD/HD), anxiety and depressive disorders. EMDR can also help to strengthen feelings of confidence, calmness and mastery.

How Was EMDR Developed? ... Does EMDR Really Work?

In 1987, psychologist Francine Shapiro made the chance observation that under certain conditions eye movements can reduce the intensity of negative, disturbing thoughts. Dr. Shapiro studied this effect scientifically, and in 1989, she published a study reporting success using EMDR to treat adult victims of trauma. Since then, EMDR has developed through the contributions of therapists and researchers all over the world. There are now more scientific studies proving the efficacy of using EMDR to resolve trauma and posttraumatic stress disorder (PTSD) than any other psychotherapy method.

This revolutionary therapy has been adapted and modified for children. Over the last 10 years, EMDR has been used world wide to help children. There are hundreds of case study reports on the positive effects of EMDR with children. Positive outcomes in the Oklahoma bombing, Hurricane Andrew, Hurricane Iniki, the shootings in Jonesboro, Arkansas are just a few case examples of EMDR being successfully used with children. Case reports with children have been consistent with research findings using EMDR with adults. As with many other treatment modalities, scientific controlled outcome studies on child therapy have lagged behind clinical case reports. To date, the research studies conducted on using EMDR with children, have showed positive results, including achieving a positive outcome where previous treatment had failed (Chemtob & Nakashima, 1996).

How is EMDR Used with Children?

EMDR is part of an integrated treatment approach and is often used in conjunction with other therapy practices such as play therapy, talk therapy, behavior therapy, and family therapy. EMDR will be explained and used when agreed upon by the family and child. Children and parents are always in control of the process.

A typical EMDR treatment session begins in a positive way by having children use their imagination to strengthen their sense of confidence and well-being. For example, children may be asked to imagine a safe or protected place where they feel relaxed and comfortable or to remember a time when they felt strong and confident. These positive images, thoughts and feelings, are then combined with the "bilateral stimulation." These beginning experiences with EMDR typically give children increased positive feelings and demystify the process of EMDR, so that children know what to expect.

When agreed upon between the parent, child, and therapist, the child is asked to bring up an upsetting memory or event that is related to the focal problem. Bilateral stimulation is used again while the child focuses on the upsetting experience. When an upsetting memory or event is "desensitized" that means that the child can face the past events or memories and no longer feel disturbed,

frightened, or avoidant of the thoughts and feelings attached to the event. The result of "reprocessing" simply means that the child has a more healthy perspective on the upsetting memories or events. The meaning attached to the event is no longer distorted nor interferes with the child's functioning or development. When the event is reprocessed, children can more comfortably believe and trust, "It's over." "I'm safe now." "I did the best I could." “I have other choices now."

What are Children’s Reactions to EMDR?

It is most helpful if parents support the use of EMDR with their children. Parents and professionals can explain that EMDR is a way to get over troubling thoughts, feelings, and behaviors.

The EMDR process is different for each person, because the healing process is guided from within. Some children report that EMDR is relaxing and have an immediate positive response. Other children may feel tired at the end of an EMDR session, and the benefit from the treatment comes in the days to follow. After some children have experienced EMDR, they will specifically request EMDR in other sessions. And then there may be times when the child tries EMDR but will ask to discontinue the procedure, because he or she is not really ready. One ten-year-old had been injured in an accident. She wore a body cast for a year and was preoccupied with injury, illness, and death. After EMDR, she began crying tears of joy and stated, "I'm so happy, it really is over and I am strong." Another five-year-old boy who had behavioral problems and had worked with the therapist using other kinds of therapy, tried EMDR and stated, "Why didn't you do this with me before?" Another eight-year-old boy who kept having nightmares stated, "It just popped out of my head, the monsters are gone." Other children say little at all, but their behavior changes and parents state: "Things are back on track."

How Does EMDR Work?

While it is not clear how EMDR works, there are ongoing investigations of the possible mechanisms by which EMDR facilitates a reprocessing of human experience. We do know that EMDR is not hypnosis. It may be that EMDR works similarly to what occurs naturally during dreaming or REM (rapid eye movement) sleep, where certain information is processed. It may be that the bilateral stimulation produces a compelled relaxation response or a distraction that helps children and adults relax rather than avoid facing disturbing events and memories. Others think that the bilateral stimulation may help both hemispheres of the brain communicate to one another, and therefore may allow for accessing the body's natural healing mechanisms. In EMDR, all the information, across all modalities (images, sounds, emotions, sensations, and thoughts/beliefs coded in words) is accessed together and metabolized.

Helpful Resources

Chemtob, C., Naskashima, J., & Carlson, J. (2002). Brief treatment for elementary school children with disaster-related posttraumatic stress disorder: A field study. Journal of Clinical Psychology, 58, 99-112. Ass

Greenwald, R. (1999). Eye movement desensitization and reprocessing (EMDR) in child and adolescent psychotherapy. Northvale, NJ:Jason Aronson Inc.

Lovett, J. (1999). Small wonders: Healing childhood trauma with EMDR. New York: The Free Press.

Shapiro, F., (2001). Eye Movement Desensitization and Reprocessing, 2nd Ed. New York: Guilford Press.

Tinker, R. & Wilson, S. (1999). Through the eyes of a child: EMDR with children. New York: W.W. Norton & Co.

For more information on EMDR:

*EMDR Institute (Francine Shapiro): http://www.emdr.com

*EMDRIA (EMDR International Association): http://www.emdria.org.

Background Information About EMDR with Adults copied from EMDRIA website: http://www.emdria.org

Eye Movement Desensitization and Reprocessing (EMDR) is a method of psychotherapy that has been extensively researched and proven effective for the treatment of trauma. EMDR is a set of standardized protocols that incorporates elements from many different treatment approaches.

To date, EMDR has helped an estimated two million people of all ages relieve many types of psychological stress. For EMDRIA's clinical definition of EMDR, click here.

Additional information about EMDR is available to the public in the “What is EMDR?” brochure and to mental health professionals in “EMDR: Information for Professionals” brochure. Copies may be purchased at the EMDRIA Store.

In 1987, psychologist Dr. Francine Shapiro made the chance observation that eye movements can reduce the intensity of disturbing thoughts, under certain conditions. Dr. Shapiro studied this effect scientifically and, in 1989, she reported, in the Journal of Traumatic Stress, success using EMDR to treat victims of trauma. Since then, EMDR has developed and evolved through the

contributions of therapists and researchers all over the world. Today, EMDR is a set of standardized protocols that incorporates elements from many different treatment approaches.

No one knows how any form of psychotherapy works neurobiologically or in the brain. However, we do know that when a person is very upset, their brain cannot process information as it does ordinarily. One moment becomes "frozen in time," and remembering a trauma may feel as bad as going through it the first time because the images, sounds, smells, and feelings haven't changed. Such memories have a lasting negative effect that interferes with the way a person sees the world and the way they relate to other people.

EMDR seems to have a direct effect on the way that the brain processes information. Normal information processing is resumed, so following a successful EMDR session, a person no longer relives the images, sounds, and feelings when the event is brought to mind. You still remember what happened, but it is less upsetting. Many types of therapy have similar goals. However, EMDR appears to be similar to what occurs naturally during dreaming or REM (rapid eye movement) sleep. Therefore, EMDR can be thought of as a physiologically based therapy that helps a person see disturbing material in a new and less distressing way.

A Brief Description of EMDR Therapy

8 PHASES OF TREATMENT

The amount of time the complete treatment will take depends upon the history of the client. Complete treatment of the targets involves a three pronged protocol (1-past memories, 2-present disturbance, 3-future actions), and are needed to alleviate the symptoms and address the complete clinical picture. The goal of EMDR therapy is to process completely the experiences that are causing problems, and to include new ones that are needed for full health. "Processing" does not mean talking about it. "Processing" means setting up a learning state that will allow experiences that are causing problems to be "digested" and stored appropriately in your brain. That means that what is useful to you from an experience will be learned, and stored with appropriate emotions in your brain, and be able to guide you in positive ways in the future. The inappropriate emotions, beliefs, and body sensations will be discarded. Negative emotions, feelings and behaviors are generally caused by unresolved earlier experiences that are pushing you in the wrong directions. The goal of EMDR therapy is to leave you with the emotions, understanding, and perspectives that will lead to healthy and useful behaviors and interactions.

Phase 1: History and Treatment Planning

Generally takes 1-2 sessions at the beginning of therapy, and can continue throughout the therapy, especially if new problems are revealed. In the first phase of EMDR treatment, the therapist takes a thorough history of the client and develops a treatment plan. This phase will include a discussion of the specific problem that has brought him into therapy, his behaviors stemming from that problem, and his symptoms. With this information, the therapist will develop a treatment plan that defines the specific targets on which to use EMDR. These targets include the event(s) from the past that created the problem, the present situations that cause distress, and the key skills or behaviors the client needs to learn for his future well-being. One of the unusual features of EMDR is that the person seeking treatment does not have to discuss any of his disturbing memories in detail. So while some individuals are comfortable, and even prefer, giving specifics, other people may present more of a general picture or outline. When the therapist asks, for example, "What event do you remember that made you feel worthless and useless?" the person may say, "It was something my brother did to me." That is all the information the therapist needs to identify and target the event with EMDR.

Phase 2: Preparation

For most clients this will take only 1-4 sessions. For others, with a very traumatized background, or with certain diagnoses, a longer time may be necessary. Basically, your clinician will teach you some specific techniques so you can rapidly deal with any emotional disturbance that may arise. If you can do that, you are generally able to proceed to the next phase. One of the primary goals of the preparation phase is to establish a relationship of trust between the client and the therapist. While the person does not have to go into great detail about his disturbing memories, if the EMDR client does not trust his clinician, he may not accurately report what he feels and what changes he is (or isn't) experiencing during the eye movements. If he just wants to please the clinician and says he feels better when he doesn't, no therapy in the world will resolve his trauma. In any form of therapy it is best to look at the clinician as a facilitator, or guide, who needs to hear of any hurt, need, or disappointments in order to help achieve the common goal. EMDR is a great deal more than just eye movements, and the clinician needs to know when to employ any of the needed procedures to keep the processing going. During the Preparation Phase, the clinician will explain the theory of EMDR, how it is done, and what the person can expect during and after treatment. Finally, the clinician will teach the client a variety of relaxation techniques for calming himself in the face of any emotional disturbance that may arise during or after a session. Learning these tools is an important aid for anyone. The happiest people on the planet have ways of relaxing themselves and decompressing from life's inevitable, and often unsuspected, stress. One goal of EMDR therapy is to make sure that the client can take care of himself.

Phase 3: Assessment

Used to access each target in a controlled and standardized way so it can be effectively processed. Processing does not mean talking about it. See the Reprocessing sections below. The clinician identifies the aspects of the target to be processed. The first step is for the person to select a specific picture or scene from the target event (which was identified during Phase One) that best represents the memory. Then he chooses a statement that expresses a negative self-belief associated with the event. Even if he intellectually knows that the statement is false, it is important that he focus on it. These negative beliefs are actually verbalizations of the disturbing emotions that still exist. Common negative cognitions include statements such as "I am helpless," " I am worthless," " I am unlovable," " I am dirty," " I am bad," etc. The client then picks a positive self-statement that he would rather believe. This statement should incorporate an internal sense of control such as "I am worthwhile/ lovable/ a good person/ in control" or "I can succeed." Sometimes, when the primary emotion is fear, such as in the aftermath of a natural disaster, the negative cognition can be, "I am in danger" and the positive cognition can be, "I am safe now." "I am in danger" can be considered a negative cognition, because the fear is inappropriate -- it is locked in the nervous system, but the danger is actually past. The positive cognition should reflect what is actually appropriate in the present. At this point, the therapist will ask the person to estimate how true he feels his positive belief is using the 1-to-7 Validity of Cognition (VOC) scale. "1" equals "completely false," and " 7" equals "completely true." It is important to give a score that reflects how the person "feels," not " thinks." We may logically " know" that something is wrong, but we are most driven by how it " feels." Also, during the Assessment Phase, the person identifies the negative emotions (fear, anger) and physical sensations (tightness in the stomach, cold hands) he associates with the target. The client also rates the disturbance using the 0 (no disturbance)-to-10 (the worst feeling you? ve ever had) Subjective Units of Disturbance (SUD) scale.

Reprocessing

For a single trauma reprocessing is generally accomplished within 3 sessions. If it takes longer, you should see some improvement within that amount of time.

Phases One through Three lay the groundwork for the comprehensive treatment and reprocessing of the specific targeted events. Although the eye movements (or taps, or tones) are used during the following three phases, they are only one component of a complex therapy. The use of the step-by-step eight-phase approach allows the experienced, trained EMDR clinician to maximize the treatment effects for the client in a logical and standardized fashion. It also allows both the client and the clinician to monitor the progress during every treatment session.

Phase 4: Desensitization

This phase focuses on the client's disturbing emotions and sensations as they are measured by the SUDs rating. This phase deals with all of the person's responses (including other memories, insights and associations that may arise) as the targeted event changes and its disturbing elements are resolved. This phase gives the opportunity to identify and resolve similar events that may have occurred and are associated with the target. That way, a client can actually surpass her initial goals and heal beyond her expectations. During desensitization, the therapist leads the person in sets of eye movement (or other forms of stimulation) with appropriate shifts and changes of focus until his SUD-scale levels are reduced to zero (or 1 or 2 if this is more appropriate). Starting with the main target, the different associations to the memory are followed. For instance, a person may start with a horrific event and soon have other associations to it. The clinician will guide the client to a complete resolution of the target. Examples of sessions and a three-session transcript of a complete treatment can be found in F. Shapiro & M.S. Forrest (2004) EMDR. New York: BasicBooks. http://www.perseusbooksgroup.com/perseus-cgi-bin/display/0-465-04301-1

Phase 5: Installation

The goal is to concentrate on and increase the strength of the positive belief that the person has identified to replace his original negative belief. For example, the client might begin with a mental image of being beaten up by his father and a negative belief of "I am powerless." During the Desensitization Phase he will have reprocessed the terror of that childhood event and fully realized that as an adult he now has strength and choices he didn't have when he was young. During this fifth phase of treatment, his positive cognition, "I am now in control," will be strengthened and installed. How deeply the person believes his positive cognition is then measured using the Validity of Cognition (VOC) scale. The goal is for the person to accept the full truth of his positive self-statement at a level of 7 (completely true). Fortunately, just as EMDR cannot make anyone shed appropriate negative feelings, it cannot make the person believe anything positive that is not appropriate either. So if the person is aware that he actually needs to learn some new skill, such as self-defense training, in order to be truly in control of the situation, the validity of his positive belief will rise only to the corresponding level, such as a 5 or 6 on the VOC scale.

Phase 6: Body scan

After the positive cognition has been strengthened and installed, the therapist will ask the person to bring the original target event to mind and see if he notices any residual tension in his body. If so, these physical sensations are then targeted for reprocessing. Evaluations of thousands of EMDR sessions indicate that there is a physical response to unresolved thoughts. This finding has been supported by

independent studies of memory indicating that when a person is negatively affected by trauma, information about the traumatic event is stored in motoric (or body systems) memory, rather than narrative memory, and retains the negative emotions and physical sensations of the original event. When that information is processed, however, it can then move to narrative (or verbalizable) memory and the body sensations and negative feelings associated with it disappear. Therefore, an EMDR session is not considered successful until the client can bring up the original target without feeling any body tension. Positive self-beliefs are important, but they have to be believed on more than just an intellectual level.

Phase 7: Closure

Ends every treatment session The Closure ensures that the person leaves at the end of each session feeling better than at the beginning. If the processing of the traumatic target event is not complete in a single session, the therapist will assist the person in using a variety of self-calming techniques in order to regain a sense of equilibrium. Throughout the EMDR session, the client has been in control (for instance, he is instructed that it is okay to raise his hand in the "stop" gesture at anytime) and it is important that the client continue to feel in control outside the therapist's office. He is also briefed on what to expect between sessions (some processing may continue, some new material may arise), how to use a journal to record these experiences, and which techniques he might use on his own to help him feel more calm.

Phase 8: Reevaluation

Opens every new session At the beginning of subsequent sessions, the therapist checks to make sure that the positive results (low SUDs, high VOC, no body tension) have been maintained, identifies any new areas that need treatment, and continues reprocessing the additional targets. The Reevaluation Phase guides the clinician through the treatment plans that are needed in order to deal with the client? s problems. As with any form of good therapy, the Reevaluation Phase is vital in order to determine the success of the treatment over time. Although clients may feel relief almost immediately with EMDR, it is as important to complete the eight phases of treatment, as it is to complete an entire course of treatment with antibiotics.

PAST, PRESENT, AND FUTURE

Although EMDR may produce results more rapidly than previous forms of therapy, speed is not the issue and it is important to remember that every client has different needs. For instance, one client may take weeks to establish sufficient feelings of trust (Phase Two), while another may proceed quickly through the first six phases of treatment only to reveal, then, something even more important that needs treatment. Also, treatment is not complete until EMDR therapy has focused on the past memories that are contributing to the problem,

the present situations that are disturbing, and what skills the client may need for the future. Excerpts from: F. Shapiro & M.S. Forrest (2004) EMDR: The Breakthrough Therapy for Anxiety, Stress and Trauma. New York: BasicBooks. http://www.perseusbooksgroup.com/perseus-cgi-bin/display/0-465-04301-1

Approximately 20 controlled studies have investigated the effects of EMDR. These studies have consistently found that EMDR effectively decreases/eliminates the symptoms of post traumatic stress for the majority of clients. Clients often report improvement in other associated symptoms such as anxiety. The current treatment guidelines of the American Psychiatric Association and the International Society for Traumatic Stress Studies designate EMDR as an effective treatment for post traumatic stress. EMDR was also found effective by the U.S. Department of Veterans Affairs and Department of Defense, the United Kingdom Department of Health, the Israeli National Council for Mental Health, and many other international health and governmental agencies. Research has also shown that EMDR can be an efficient and rapid treatment.

Scientific research has established EMDR as effective for post traumatic stress. However, clinicians also have reported success using EMDR in treatment of the following conditions:

- panic attacks
- complicated grief
- dissociative disorders
- disturbing memories
- phobias
- pain disorders
- eating disorders
- performance anxiety
- stress reduction
- addictions
- sexual and/or physical abuse
- body dysmorphic disorders
- personality disorders