EMDR THERAPY WITH CHILDREN:
Journey Into Wholeness

ANA M. GOMEZ, MC, LPC

FRANCINE SHAPIRO, PHD

Trauma and adversity affect millions of children and their families. Without appropriate treatment, many of these children are destined to a life of hardship and suffering, transmitting their unresolved trauma into the future generations. Fortunately, treatment approaches such as Eye Movement Desensitization and Reprocessing (EMDR) therapy can now help children find healing and a path that will lead them to achieve full mental health.

EMDR has been validated by over twenty randomized controlled clinical trials (see http://www.emdrhap.org/emdr_info/researchandresources.php) and is now widely accepted by organizations such as the American Psychiatric Association, the Department of Defense and the National Registry of Evidence-based Programs and Practices as an evidence-based approach for the treatment of trauma. In addition, the California Evidence-Based Clearinghouse for Child Welfare has recognized EMDR therapy as an evidence-based approach for children. It is an integrative and comprehensive psychotherapy approach that follows eight phases of treatment:

- Phase one: Client history and treatment planning.
- Phase two: Preparation.
- Phase three: Assessment.
- Phase four: Desensitization.
- Phase five: Installation.
- Phase six: Body scan.
- Phase seven: Closure.
- Phase eight: Re-evaluation.

During the preparation and reprocessing phases (4-6) standardized procedures are used that include the use of dual attention stimulus (bilateral eye movements, taps, or tones). For instance, the child's eyes can be guided back and forth, from right to left; by tracking the clinicians upraised fingers, a toy, puppet or light bar. More than twenty randomized trials have demonstrated positive effects for the eye movements, including an immediate decrease in negative emotions and imagery (e.g., Engelhard et al., 2010; Schubert, Lee & Drummond, 2011). The dual attention stimuli (DAS) is used while the child focuses on various aspects of the memory and then reports briefly what comes to mind. It is unnecessary for the child to describe the disturbing event in detail or to do homework to achieve positive effects. All the therapeutic work is accomplished in the reassuring and attuned presence of the clinician.

EMDR therapy is guided by the Adaptive Information Processing (AIP) model (Shapiro, 2001, 2007, in press). According to this model, when a traumatic or adverse life experience occurs, the adaptive information processing system of the brain can be overwhelmed and inhibited by the high levels of activation experienced during such events (Shapiro, 2001). As a result, this information is encoded with the emotions, thoughts and physical sensations experienced at the time of the event. This material remains isolated from other memory systems that contain adaptive autobiographical material that would normally help contextualize and integrate

such incidents. When the disturbing memory is activated by present environmental stimuli, the past feelings, thoughts, and sensory information are re-experienced. Consequently, the present is seen and interpreted through the lenses of non-assimilated, non-integrated memories of trauma that in turn color the perception of the present, the meanings children attach to current events and their response to future life demands. For instance, an eight-year old girl that asked the teacher permission to go to the restroom throws a huge temper tantrum after the teacher tells her to wait a few minutes. This is a child with a history of sexual abuse where she experienced a deep sense of powerlessness, as she was not able to escape from her abuser. When explored, the child stated that when she did not have control over her environment, she felt "trapped" and experienced a great sense of powerlessness and desperation. The meaning attached to this event was influenced by her past experiences of abuse, causing her to behave in ways that were more congruent and consistent with the past than the present (Shapiro, 2001, 2012).

Children can be affected in this way not only by trauma, but also by adversity and hardship. A tenet of the AIP model is that adverse life events such as bullying, humiliation, arguments at home and physical punishment, among others, can have a similar and even greater impact in the development of psychopathology. This has now been supported by several research studies (e.g., Afifi et al., 2012; Mol et al., 2005). EMDR therapy works to assist the child in processing these experiences of adversity that lay at the core of current symptoms. For instance, a child that presents with symptoms of anxiety and panic attacks may need to address experiences connected to growing up with a caregiver who is highly perfectionist and critical, placing high demands that the child can never meet. Similarly, a child that presents with symptoms of depression might need to come to terms with exposure to frequent arguments at home or humiliation and bullying at school. Even though these experiences may not meet the criteria to be classified as "traumatic," they are similarly encoded in memory and are reactivated by present triggers and environmental stimulus. These children that were not exposed to traumatic events per se may still hold persistent negative beliefs about themselves, such as being defective and unlovable, and may present with deep feelings of shame, fear, pain and accompanying bodily states. EMDR therapy works to help children process the memory networks that contain such painful information and transmutes the memories to adaptive resolution (Shapiro, 2001, 2012). The memories then become a foundation of resilience and strength. It is important to highlight that the focus of EMDR therapy is not merely to reduce or eliminate symptoms. It also helps children develop their ability to experience joy, love and connection with others and to develop a healthy sense of self and an age-appropriate sense of personal responsibility, safety and power.

The goal of EMDR therapy is to access the memories that form the basis of the child's current difficulties and struggles, process them and move them to integration and adaptive resolution. For instance, Shapiro (2012) describes the story of an 11-year-old girl coming to therapy because she was compulsively pulling her eyelashes out. These symptoms surfaced after her critical teacher started to yell at her in class. Other stressors were present as well, including her mother starting a new business and her gymnastics coach yelling at her. These adverse life experiences set the groundwork for the development of her self-destructive behaviors. After the memories of being yelled at by her teacher and coach were reprocessed with EMDR therapy, the compulsive eyelash pulling was eliminated.

The changes that are observed in children during EMDR therapy occur on emotional, cognitive, somatic and behavioral levels. Not only do the challenging and disruptive behaviors decrease, but also emotions such as shame, pain and fear are transformed, into feelings of self-acceptance, joy and freedom. Moreover, changes are seen and experienced in the body as

aches, tensions and collapsed postures are transmuted, resulting in a relaxed musculature and regulated bodily states. These therapeutic outcomes are achieved through the use of an eight-phase treatment approach. Each phase contributes in a very unique way to the entire treatment outcome.

During the initial phase (1), a thorough EMDR treatment plan is developed that identifies the child's challenges, the past experiences of trauma and /or adversity that are contributing to the problems, the current situations that trigger disturbance, as well as the desired feelings, thoughts, skills and behaviors needed for the future adaptive functioning consistent with the child's developmental stage.

This phase of treatment is followed by the preparation phase (2) where the EMDR clinician assists children in developing internal and external resources, as well as expanding their capacity to tolerate negative affect. Depending on the needs of each child, different strategies are used to promote emotional regulation and homeostasis. For instance, the EMDR clinician stimulates the development of new adaptive memory networks, as well as the amplification of the child's ability to experience positive emotions and bodily states, by asking the child to identify relational resources, mastery experiences or a calm-safe place. These resources are then enhanced by using EMDR therapy procedures that combine imagery, body awareness and the use of bilateral eye movements, taps or tones which help increase a positive sense of self (e.g., Gomez,2012a; Korn & Leeds, 2002; Shapiro, 2001, 2012).

Once the child has developed enough age-appropriate regulatory strategies to access the memories of trauma and to tolerate the associated affect, the reprocessing of such memories can be initiated (phases 3,4,5,6). The child is then invited to attend to different aspects of the memory while engaging in eye movement or other forms of DAS such as alternating taps or sounds. DAS with children can be administered playfully through the use of puppets, wands, drums and paintbrushes among others. The child

is asked to follow with his or her eyes a puppet from side to side or the clinician can tap the child's hands bilaterally. It is important to highlight that in EMDR therapy the child is invited to give attention to the initial target memory without "reliving" or recounting the entire memory, but in fact stimulating an associative process (Shapiro, 2001). Maintaining dual awareness where the child pays attention to aspects of the memory as they spontaneously arise while maintaining mindful awareness of the present is pivotal in EMDR therapy.

Play can also be incorporated throughout the eight phases of EMDR therapy with children to provide containment and safety as memories of trauma and adversity are identified, explored and processed. For many children the incorporation of a skill- building period may be necessary, such as the use of EMDR games (Gomez, 2012a), which can assist children in developing cognitive, emotional and somatic literacy. It can also help children get acquainted with the different procedural steps of EMDR therapy, build rapport, and identify resources as well as memories of trauma. Children can convey their stories in various ways; art and drawings, play and sand tray therapy strategies may be used. These strategies can assist children who are unable to verbalize their stories of hardship. For instance, the child is asked to think about the memory of trauma, draw a picture of it or create a story of it using the sandtray and initially focus on the part or aspect of the memory that stands out or that represents the worst part. As stated above, the child does not need to recount the entire story or the details contained in it. The child is asked to identify the negative thoughts, emotional and somatic aspects connected to the image that represents the worst part. Even though the negative belief associated with the memory is identified, it is not reflective of a greater importance. In fact, Shapiro (2001) has emphasized how "the affect feeding the person's beliefs is the pivotal element of pathology "(p. 44).

Young children may not be able to identify a negative belief associated

with the targeted memory, or they may use feeling words to describe it. A young child working on a memory of her father getting arrested reported a "mixed-up thought" of "I am mad." A number of playful strategies and EMDR games are available to clinicians to assist children in accessing negative cognitions, emotions and bodily sensations (Gomez, 2012a). Once the aspects of the targeted memory described above have been identified, then the child is invited to concentrate on the image, thought and body reaction while simultaneously engaging in DAS for a short period of time (approximately 30 seconds). During this time, associations to other emotions, cognitions, somatic reactions or other memories spontaneously emerge as the targeted memory begins to link up with more adaptive information. Once the child briefly reports this information to the clinician through words, drawings or by rearranging the sandtray, the child is again invited to "notice" what just came up and engage in DAS. This is repeated until the child can bring up the targeted memory and report no disturbance associated with it. The association process is very different from the procedures used in exposure therapies, as the ultimate goal of EMDR therapy is to promote assimilation and integration and not habituation or catharsis.

Different levels of processing take place simultaneously. Linkages and connections with other memory networks appear to occur in the brain, as the memory is being integrated and assimilated during the reprocessing phases described above (Shapiro, 2001). An important aspect of EMDR therapy is its capacity to foster the binding and integration of the cognitive, affective and somatic aspects of the memory. The brain of the child is then able to stitch the fibers that were isolated from awareness and ruptured by trauma into a coherent and integrated whole. This becomes the foundation for the development of a healthy and whole self.

Once the child reports no associated disturbance linked to the memory being processed, the enhancement of positive and adaptive memory systems is initiated in what is called the "installation phase." The child is

invited to focus on the new positive belief and the memory of trauma while once again using DAS. This is followed by the body scan phase where the focus is on the processing of any residual disturbance held somatically. The child is invited to bring up the targeted memory and scan the body from head to toe to find any disturbing sensations and bodily states. As these sensations arise, the child is once again invited to engage in DAS until all the somatic information is completely processed.

The past distressing memories and current situations that trigger disturbance and lay at the core of current difficulties are processed following the above phases. Treatment time is minimized as positive treatment effects often generalize to associated memories and triggers. The child is also taught needed life skills to address any developmental deficits. Processing is engaged through which the child imagines employing these skills. This encodes positive memory templates for adaptive future behaviors. The EMDR clinician works throughout all the phases of treatment to ensure safety and stability through the use of strategies to appropriately close each session and terminate treatment. This constitutes the "closure phase." The reevaluation phase (8) ensures that all the elements of the EMDR treatment plan have been followed to completion and the treatment effects are solid and pervasive. EMDR therapy is not finished until the child can anticipate the future adaptively with a new sense of self, personal safety, empowerment and responsibility.

The inclusion of parents within a comprehensive EMDR treatment may be necessary when adversity is occurring within the parent-child relationship. The child may be seen and felt through the lenses of the parents' unprocessed and unresolved memories of trauma, loss and adversity. As a result, the capacity of the parent to connect, nurture, attune and respond appropriately to the child's needs is compromised. This may result in interactions that create high dysregulation and turmoil in the child's system and the subsequent development of memory networks that contain nega-

tive and maladaptive information about the self, the parent and the world. Therefore, if the child is wounded within the parent-child relationship and the resulting symptoms are rooted in these asynchronic and dysregulated interactions, the parent can also highly benefit from receiving EMDR therapy. Using the adult attachment interview (AAI), Wesselmann et al. (2009, 2012) have demonstrated that EMDR therapy can help adults and children make positive changes in attachment status and the quality of their relationships. Gomez (2012b) has proposed a multilevel model for working with parents that goes from psychoeducation, emotion regulation work, to the full processing of memories of trauma and hardship.

Techniques drawn from EMDR therapy can also be used outside of the therapeutic setting to foster self-empowerment and personal growth. The book Getting Past Your Past: Take control of your life with self-help techniques from EMDR therapy (Shapiro, 2012) describes a rich and wide variety of self-help techniques rooted in the principles of EMDR therapy that can be effectively used by parents and their children. Written for both clinicians and laypeople, this book explains the therapy with case examples, and many of these techniques can also be taught to children by their parents. Another book, EMDR Therapy and Adjunct Approaches with Children: Complex trauma, attachment and dissociation (Gomez, 2012a) also serves as an important resource for those seeking to use EMDR techniques with children. This book provides step-by-step strategies for clinicians working with children with complex clinical presentations, attachment wounds and dissociative tendencies.

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RECOMMENDED READINGS AND RESOURCES ON EMDR WITH CHILDREN

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