

EMDR Practice Guidelines

EMDR with Children

I. Introduction

Eye Movement Desensitization and Reprocessing [EMDR] (Shapiro, 1989) is a treatment technique during which accelerated processing of traumatic memory is facilitated through the shifting of attention between the left and right hemispheres of the brain. The methods utilized to facilitate the rapid switching of attention include the use of tapping, eye movement or sound. EMDR has also been beneficial in treating other disorders and conditions, i.e. grief and loss, low self esteem, anger management, depression etc. Its use should not be limited to only trauma or anxiety disorders. The methods utilized to facilitate the rapid switching of attention include the use of tapping, eye movement or sound.

Precursors to the acquisition of traumatic memory frequently include the victim's thought and belief that death is imminent or an actual near-death experience. The constellation of neurobiological changes experienced during the psychological and physical arousal associated with extreme or prolonged fear is believed to be stored in discrete "packages" in the brain of the victim. The process of EMDR appears to facilitate the retrieval of the traumatic memory as well as all the associated thoughts, emotions and sensations. Processing the memory allows consolidation of the various associations and facilitates normal memory storage. Participants in the process of EMDR report that the memory is still present, but does not carry the previously associated state of arousal and distress.

II. Guidelines

In using EMDR with children, Tinker and Wilson (1999) offer the following general guidelines:

- Only clinicians trained to work with children should utilize this technique with children.
- Obtain a thorough developmental history from the parents.
- Elicit a history of the trauma and the behaviors believed to be associated.
- Assess the family dynamics and the current psychological environment of the family.
- Select targets for intervention.
- Carefully explain the technique of EMDR and the benefits as well as the risks of using the technique. Document the discussion explicitly in the treatment record.
- Establish a safe relationship with the child. Safety, boundaries and empowerment are important elements of work with children and especially critical when utilizing EMDR.

- Encourage the child to voice and discuss questions and concerns.
- Assist the child in establishing a “safe” place. The use of EMDR in the establishment of a safe place is a useful technique.

Tinker and Wilson place children into four major age groupings—9-12, 6-8, 4-5 and 2-3 (p. 72). They recommend a principal of “minimal creativity” (p. 73) which is that “the clinician modifies the standard adult protocol only as much as she has to, in order to accommodate the developmental level of the child” (p. 73). Specific recommendations for adjustment based on age ranges may be found in their book, listed in the bibliography.

III. Safety factors and contraindications

- “Clients should be able to feel comfortable with the possibility of experiencing a high level of vulnerability, a lack of control, and any physical sensations from the event that may be inherent in the target memory (Shapiro, 1990, p. 90).
- The client should be able to utilize coping strategies such as relaxation and stress management.
- The ability to cope with the arousal accompanying the retrieval and processing of traumatic memory and the between-session surfacing of associated memories is essential. The client and clinician must develop a safety plan and the clinician should feel confident that the client would be able to remember and follow the plan.
- Ideally the client possesses a network of support from family and/or friends. If such a network does not exist the clinician must determine if the client is able to proceed without support other than that of the clinician.
- Memory reprocessing is rigorous; therefore good health is an important consideration.

A large body of controlled research has been conducted on the efficacy of EMDR. For the most part, there are few contraindications. However, if the health of the client is poor; if the traumatic memory involves an actual near-death experience (as opposed to the belief that death was imminent); if the client has a physical impairment or an active drug/alcohol problem, consideration should be given to conducting the EMDR in an inpatient setting. If there is any risk of the client becoming a danger to self or others, the EMDR should be conducted in an inpatient setting.

- According to Shapiro, there is a risk of seizure with the use of this technique. The client (or parents) should be informed of this risk prior to treatment if the candidate has a history of a seizure disorder.
- “A physician consultation should always be sought if the clinician suspects that a physical condition, including neurological impairment, might present a problem” (Shapiro, 1995, p.p. 94-95).
- If a client complains of eye pain, the session should be terminated immediately. Consultation with an eye specialist who has been educated regarding the type of eye movements required should be completed before any further treatment.

Clients who wear contact lenses should remove their lenses if they experience discomfort or dryness during the procedure. If a client cannot use eye movement or is uncomfortable with it, alternate means of bilateral stimulation may be used, i.e. tactile or auditory stimulation.

- Clients with a history of substance abuse should have a strong support system such as a 12-step program before engaging in EMDR treatment. Special care should be taken to inform the client of the risks of resuming or increasing the abuse of substances as a response to the stressful material surfaced in treatment. Documentation of informed consent should be noted in the treatment record.
- Informed consent is critical before a client who is involved in court case engages in EMDR. Clinicians must explain and explicitly document that the client was informed that after EMDR his or her memory of the event may be less clear; that the extreme emotion accompanying the event may have abated; and that case law has not established the acceptance of EMDR by the judicial system. Although EMDR is not hypnosis, it may be viewed as such by judges (Shapiro, 1995).

The assessment of secondary gain and the impact of the loss of symptoms around which a victim's life has been organized are vital. The individual must understand and be prepared for potentially great changes in functioning with the resolution of the trauma. Peer groups, with which the client has identified and derived support, may no longer be beneficial. These issues must be explored thoroughly and appropriate action plans developed before engaging in EMDR treatment.

IV. Training/supervision requirements

- Minimal training required for using this technique is successful completion of a Level I workshop recognized by the EMDR Institute.
- The supervisor has successfully completed Level II training recognized by the EMDR Institute.
- Therapists considering use of this technique with clients who have a diagnosis of Dissociative Disorder should have significant experience in treating clients with this diagnosis, in addition to having successfully completed-a Level II workshop recognized by the EMDR Institute.

V. Exclusions for the use of EMDR

- Clients who are actively psychotic (i.e., experiencing hallucination, delusions, etc.).
- Clients with uncontrolled seizure disorder.
- Clients experiencing a current traumatic situation should not be treated with EMDR for previous traumas until the present trauma is resolved.

EMDR Bibliography

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Shapiro, F. and Forrest, M.S. *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma*. HarperCollins Publisher, New York, 1996.

Wilson, S.A., Becker, L.A., & Tinker, R. H. (1995). Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals. Journal of Consulting and Clinical Psychology, 63, (6), 928-937.

Wilson, S.A., and Tinker, R. H., (1999). *Through the Eyes of a Child: EMDR with Children*. W. W. Norton & Company, 1999, New York.

Internet addresses:

<http://www.childtrauma.com>

<http://www.priory.com/greenwald.htm> Children's Mental Health Care in the 21st. Century: Eliminating the Trauma Burden.