

An Important Form of Therapy for Children – EMDR
By Dr. Sandra Wieland, PhD.

As we work with children, we help them explore the empty and frightening places inside. We also help them build a sense of inner security and personal strength. In all of this, EMDR can be an invaluable form of therapy.

Eye Movement Desensitization and Reprocessing (EMDR) is a specific form of treatment originally designed for adults. The individual may be dealing with a trauma from the past or a fear/insecurity in the present. The individual brings up an image of the fear or trauma, identifies the negative cognition that goes with the image, names the positive cognition s/he would like to have, recognizes the emotion connected with the image and negative cognition, and then identifies the location of that emotion in the body. As the individual focuses on the image, alternate hemispheric stimulation is applied (eye movement, tapping on the body, audio tones). Clinical experience has shown that individuals can experience tremendous relief, can come to a new understanding of events, and can experience a shift in their way of responding to situations. Brain scans have shown that the mid-brain (emotional area of the brain) activity occurring with thoughts of a trauma before treatment with EMDR shifts to the frontal lobe (cognitive processing area of the brain) after treatment with EMDR. EMDR is also used to help an individual build within themselves the personal strengths and positive self-beliefs needed to move forward in life.

Numerous therapists trained in EMDR (Level 1 three-day training and Level 2 three-day training – see EMDRIA website) and working with children have developed ways of using EMDR with children (Greenwald, 1999; Lovett, 1999; Tinker & Wilson, 1999). I have incorporated EMDR in my work with children and have found it to be an important and extremely useful form of therapy. EMDR is not a bit of tapping that is performed here and there; it is a carefully planned part of the therapy. A target needs to be identified – this may be a past trauma, a present anxiety, or a needed positive resource. An image, when possible, needs to be developed. The negative thoughts (cognitions) and emotions connected with the event need to be identified, when possible, by the child or the therapist. The positive cognition in turn needs to be verbalized when possible by the child and, if not, by the therapist. Each of these steps -- based on the assessment of the child's needs, the skills of the child, and the timing within therapy -- needs to be thought through by the therapist. Then an EMDR session or portion of a session can occur.

The first time I used EMDR with a child was shortly after I completed Level 2 training. I was working with a 4-year-old girl ("Jane") who had been initially traumatized by seeing her father physically abuse her mother. Subsequent abuses occurred with the final one occurring while the child was in her bedroom but involved the child traveling in the ambulance with her mother to the hospital where she was separated from her mother and later taken home by a neighbor.

Following the parents' separation, the father, during visitation, repeatedly told Jane her mother was going to put Jane out of the house just like she had put father out of the house (this was reported by an older sister). The child's negative behaviour with her mother escalated and no amount of reassurance by the mother seemed to help. Before Jane could feel safe enough to process the trauma, she needed to have a stronger sense of her mother being there for her over time. For many of the children we work with who have moved into a new home after abuse, sense of safety with the new parent is the resource needed. This was not the needed resource for this child. Jane felt safe with her mother but she did not feel secure that mother would continue to be there (this was probably a result not only of father's threats but also of being separated from mother at the hospital). I decided on the resource target, "Mommy is there for Jane." I asked the mother to come into the session and sit on the couch as the child and I set up the family dolls on the floor. As the Jane brought the sister dolls and herself together, I brought in the mother doll. As I noted that the mommy was there with her and her sisters, I asked Jane to look at the couch and I asked her who was there. Jane looked up, saw her mother, and replied, "Mommy." I then alternately tapped her feet and said, "Mommy is there for Jane." The look of anger that came into Jane's face was the most intense look of anger I have ever seen in a child of that age. Clearly a huge fear had been tapped. I repeated the phrase several times as I continued to tap and Jane relaxed. I then asked her to say the phrase and asked where I should tap. Jane smiled and pointed to her cheeks. To be sure, there was considerable work left to be done related to the trauma, dissociative characteristics, and disruptive behaviours. Now that the underlying internal resource that is so important for a 4-year-old child (secure availability of mother) was there, the rest of the work (some with EMDR and some without EMDR) could move along quickly.

More recently I have been working with a 14-year-old child ("Tom") who has experienced multiple losses and abuses (abandonment at birth, emotional abuse from adoptive father, witnessing adoptive father abusing adoptive mother, adoption of a younger sister, adoptive father's suicide, mother's remarriage). When Tom came into my office he would regress to an angry 3 year-old who alternated between hiding and throwing things – a rather difficult age to deal with in a 5'5" body. Using the family's photograph album, the mother and I went through both positive and negative events noting attachment resources and separation traumas. Then using Joan Lovett's story writing technique (Lovett has developed this technique considerably since her publication [1999] of Small Wonders: Healing Childhood Trauma with EMDR), I wrote a story – actually 6 chapters of a story – of Tom's life. Session by session, mother read these chapters as I alternately tapped on Tom's legs or whatever part of his body was not hidden behind the pillows. It would be hard to give an adequate description of the chaos of these sessions. But – Tom's behaviour calmed at home. By the last few story sessions Tom was able to use the tac-audio scan (pulsars held in each hand) and my office looked, at the end of the session, like only a mild hurricane had passed through. In the stories the trauma (e.g., being called

names and demeaned; father killing himself during the evening the boy had encouraged the rest of the family to go out for dinner) is briefly stated together with the thoughts and emotions that a child of the age when the events happened would experience. The story then goes on to say that now the child has grown up, he realizes Within this realization the meaning of and reason for the event is linked to the relevant adult while continuing goodness is linked to the child and to the positive relationships that continue to exist for the child. The shift in Tom has been wonderful to see. As with Jane, there is more work to be done but, now, Tom is able to sit still and converse. He is able to work together with his adoptive mother and step-father to create more positive experiences and to have more developmentally appropriate interactions in the home.

For many of the children I work with, I do a timeline of their life with both positive events and negative events. I ask the child or the parent figure to bring in photographs of the child growing up. From the photos we identify positive characteristics of the child and create statements about the child that include those characteristics. I then use EMDR with the photos and statements to strengthen these resources. I identify whether there are basic internal needs – safety, security, love – which the child has not been able to internalize (an internal sense is usually more closely related to early experience than to the ongoing outer reality). When a need is identified, I have the parent figure talk to the child about what the parent is providing and then as the parent makes a statement of safety or a demonstration of love (e.g., holding the child as s/he gives the child a bottle), I tap on the child's knees or feet. In situations where the parent is not emotionally strong enough to do this, I have the child create his own cuddle experience (e.g., an 11-year-old boy curling up with a bottle of water, blanket, and teddy as he gives the baby-him 3 minutes of cuddle time; a cup of water, blanket and larger teddy as he gives the 5-year-old-him 3 minutes of cuddle time, and a glass of water, a blanket on the side and a teddy as he gives the 11-year-old-him 3 minutes of cuddle time) as I do some tapping.

And now with the positive resources stronger, the negative events can be targeted. From the timeline, I ask the child to choose one of the negative events (in some cases, toward the end of the work I do the choosing to be sure that the really hard stuff is done) and to draw a picture of the event (in some cases, I need to do the drawing to avoid refusal but I do ask the child about the content and/or the placement of the people). While the child looks at the picture, I use tapping or the tac-audio scan and ask the child to tell me what she notices. The first statement almost always relates to a negative cognition. If dissociation intervenes and the child responds, “nothing” or with irrelevant information, I use therapeutic interweaves (recognizing what is happening, emphasizing safety of the present situation, reintroducing the topic) to help the child back to the situation being processed. As we continue on, I note the emotion I see in the child or, if no emotion is apparent, the emotion a child of the age she was when the trauma occurred would have. As the alternate stimulation occurs the child starts to notice shifts and she becomes aware of the another side of the situation

(e.g., telling someone about the abuse; recognizing that the other person was at fault, noticing that she is no longer in that situation). From the final awareness, a positive statement (cognition) can be stated and processed with alternate stimulation.

In each of the examples given above, a review of (1) the emotional assessment of the child and (2) the child's history provided the basis for identification of the particular target or targets to be used. The format (story telling, timeline, mother in the room) for the EMDR work was determined by the functional age of the child. For the resource installation work with Jane, mother served as the image and the resource statement was given by the therapist. For the loss and trauma work with Tom, the photos and story content served as the image. The statements within the story of early cognitions and emotions served as the negative cognitions and emotions to be targeted. The statements in the story of what the child realizes now he is older served as the positive cognition. For the resource work from the timeline, the photos served as the image and the statements constructed to go with them served as the resource to be strengthened. For the trauma work from the timeline, the drawings served as the image, the initial statements provided the negative cognitions, the therapist verbalization of the emotion shown by the child or deduced from developmental knowledge provided the emotion. The final statement with the alternate-hemispheric stimulation provided the positive cognition.

This does not mean that every use of alternate-hemispheric stimulation during a session is plotted out ahead – oh, that we could be so organized and so prophetic. There will be the moments during play when a new realization emerges and some light alternate tapping on the child's shoulders can help to re-enforce the child's realization (the sand play or art provides the image and the statement by the child or therapist provides the positive cognition). Parents and children themselves can be taught how to use the butterfly hug (alternate tapping on the upper arms with the arms crossed) at home with positive and soothing statements. Whether in or out of session, whether planned ahead or spontaneous, EMDR should always be used carefully and thoughtfully. When used in this way, EMDR provides an important resource for the therapist and for the child.

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Sandra Wieland has a private practice in Victoria where she works with children adolescents, and adults who have experienced neglect and trauma. Sandra provides supervision and consultation for therapists working with children on Vancouver Island, in Vancouver and the lower Mainland and by phone to other areas of B.C. She has provided specific training in using EMDR with children (Vancouver Incest & Sexual Abuse Centre, EMDRAC 2003 conference, ISSD conference 2003). Please contact Sandra (sandrawieland@shaw.ca) if you would like more information on using EMDR with children.