EMDR and the Art of Psychotherapy With Children

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EMDR and the Art of Psychotherapy With Children

Robbie Adler-Tapia, PhD
and
Carolyn Settle, MSW, LCSW

New York

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This book is dedicated to our husbands—
Hugo Tapia and Ron Smith,

and our children—
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and
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—our greatest joys, blessings, and accomplishments!

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Foreword

It is an honor to write the foreword to *EMDR and the Art of Psychotherapy With Children*, which can serve as the Gold Standard for EMDR treatment with children and adolescents. The authors, with their combined talents as researchers and skilled mental health practitioners, have crafted procedures with age-appropriate language and modifications for the application of EMDR to young clients incorporating all the phases and steps of Dr. Francine Shapiro's standard protocol and underlying Adaptive Information Processing (AIP) model. They articulately provide an A–Z step-by-step approach for the application of EMDR to specific populations, including complicated cases with highly traumatized children.

The *Treatment Manual* that accompanies the book gives clinicians a clear road map to follow by providing examples and scripts to illustrate all 8 phases of Shapiro's model, forms with detailed instructions to assist in organizing and conceptualizing a case, and detailed procedural steps for applying each phase of EMDR to children.

In addition, Adler-Tapia and Settle have conducted research showing the efficacy of using each step of Shapiro's standard protocol to treat highly traumatized children, and contributed the resultant *EMDR Fidelity Treatment Manual for Children* to the EMDR Humanitarian Assistance Programs (see HAP Store at www.emdrhap.org).

I was fortunate to have met Dr. Shapiro at a time when I was becoming discouraged with how the school system was failing to respond to the emotional needs of so many children who struggled to survive academically and socially in the school environment. With EMDR treatment, children were able to overcome their low self-esteem; control their impulses; modify their behaviors in school; change their relationships with peers, teachers, and family members; organize their lives; and, essentially, change their low opinions of themselves. In each session every child would take one more step (and sometimes several steps at once) up the ladder toward positive growth. Needless to say, I became passionate about the EMDR methodology and its potential for treating children and adolescents.

Over the years, EMDR clinicians have discovered that the range of issues EMDR is able to treat with children is beyond the scope of what had originally been envisioned. Developmentally delayed, autistic, Down Syndrome, and ADHD children respond positively to EMDR. They are able to change their behaviors and beliefs about their self-worth once their fears and confusion are reprocessed. As a therapist, I worked with a developmentally delayed child, age 9, who learned to express herself more appropriately in her special education classroom and overcame her nightly bedwetting habits with EMDR treatment. I also used EMDR to help Ben, a Down Syndrome child, to process the sexual abuse of a nursery school teacher. In a follow-up session, Ben's mother, a trained EMDR therapist, reported to me that Ben would ask her to tap his hands (bilateral stimulation) to calm him when he was frustrated and agitated.

Learning EMDR in 1989 was a pivotal point and peak experience in my professional career. At this time I did not envision the impact EMDR would have on my life and the lives of millions of people around the world. Although I was inspired by the brilliance and creativity of Dr. Francine Shapiro, I underestimated her global intentions and far-reaching visions. To quote one of the EMDR Institute trainers as he was responding to Dr. Shapiro's comments at the conclusion of a trainers' meeting: "You plan to take on the healing of the entire world." To most of us, this seems like an impossible and lofty goal, but the impossible has never deterred Dr. Shapiro from pressing forward in her mission to bring EMDR to the far corners of the world in an attempt to stop the cycle of violence and suffering. Currently, her books have been translated into Italian, French, German, Serbian, Spanish, Flemish, Japanese, Korean, Chinese, Portuguese, and Russian.

Through the assiduous efforts of Dr. Shapiro and many devoted EMDR-trained clinicians, EMDR has become available to families and children in more than 80 countries in the world. EMDR Humanitarian Assistance Programs (HAP) send volunteer training teams, domestically and internationally, to underserved communities and those areas struggling to recover after natural or manmade disasters. The accomplishments of EMDR HAP, documented on their Web site (www.emdrhap.org), show that the power of EMDR goes beyond boundaries of racial and cultural differences. EMDR HAP has been instrumental in bringing together other nongovernmental organizations to collaborate in responding to cataclysmic disasters, and, specifically, organizations that serve children in underdeveloped countries. Not only is Shapiro's vision of global healing being implemented, EMDR is being recognized and utilized by children's hospitals and agencies worldwide.

The success of EMDR treatment with children is supported by research, which the authors have documented in chapter 1. Recently, two

Palestinian clinicians presented at the EMDR European Conference in Paris on their findings: Following initial treatment with EMDR, children showed resiliency when experiencing a second trauma (EMDR Humanitarian Assistance Programs, 2007). The group protocol developed by Jarero, Artigas, and Hartung (2006) for treating children traumatized by natural disasters is being successfully utilized by clinicians who have treated children after experiencing the traumatic effects of floods, plane crashes, hurricanes, earthquakes, displacement, and school shootings (see chapter 1).

Adler-Tapia and Settle in conjunction with EMDR HAP have conducted advanced specialized training in EMDR to clinicians working with children in the Gulf Coast in response to the aftermath of Hurricanes Katrina and Rita. The indefatigable efforts and numerous contributions of these two women are limitless. Their visions are as magnanimous as those of Dr. Shapiro. Their intentions in writing this book are to provide a standardized framework for successfully implementing EMDR with children, to encourage other therapists to use EMDR with children, and to promote the acceptance of EMDR as a psychotherapeutic treatment of choice for young clients. Each chapter emphasizes how to creatively adapt Shapiro's entire EMDR protocol, without eliminating any of the steps, to the treatment of children. Chapter 2 teaches not only how to get started but also outlines an overview of how to adjust the language and presentation of each phase to correspond with the cognitive ability of individual children. They include poignant case examples to demonstrate their teaching points and provide useful scripts to illustrate language appropriate for young clients.

In addition to making a significant contribution to the EMDR literature, the authors have provided a guideline for the basic principles, protocols, and procedures for research and treatment of children with EMDR. All practitioners of EMDR, regardless of the populations they treat, will find valuable information and solutions to challenging cases within the pages of this book. I foresee *EMDR and the Art of Psychotherapy With Children* as the first in a series of books by Adler-Tapia and Settle. Their expertise as clinicians, researchers, and writers warrant future books articulating the use of EMDR with advanced clinical applications.

The authors, with creativity, vitality, and passion, inspire readers to join them in their mission to bring EMDR treatment to the multitude of traumatized children regardless of their economic or cultural backgrounds.

Ultimately, the healing of one generation of children will impact the behavior and actions of future generations.

Robbie Dunton, MS
Coordinator, EMDR Institute

Preface

CAN WE LEARN TO USE EMDR WITH CHILDREN?

Why Not?

In 2000, I (R.T.) attended my first Part 1 EMDR training in Phoenix, where I listened to Dr. Sandra Wilson discuss using EMDR to treat traumatized children to expedite their healing. As a psychologist specializing in treating traumatized children, I was intrigued and thought of all the children in my practice that could benefit from EMDR. However, when I returned to my office, I struggled to find ways to implement the EMDR protocol with my child clients. Young children didn't understand the words of the EMDR protocol, and I needed to translate the protocol to try to make it work effectively. Even after searching the literature on EMDR with children, I still found that applying EMDR was challenging and frustrating for me as a psychotherapist. After a year, I decided to take the Part 2 training in EMDR, hoping that I would learn to more effectively use EMDR with children. Even after completing Part 2 training, I found that integrating EMDR into my clinical work with children and their families was problematic. My initial experience of trying to learn to use EMDR with children was so frustrating that I almost gave up trying to use it. I felt like the training that I had with EMDR left me unprepared to use EMDR with my child clients. I searched the literature on EMDR with children and was confused about how to use EMDR with children because what I read seemed to imply that the younger the child, the more the therapist omitted parts of the protocol. I also asked myself, "How many pieces of the protocol needed to be included to continue to call the treatment EMDR?"

How Can This Work?

This was the incredulous question I (C.S.) had in my mind as I started using EMDR. I'm really a skeptic, and EMDR was counterintuitive to my previous training in psychotherapy, but I kept getting good results.

Even so, I hesitated in completing the Part 2 training for 2 years. During those 2 years, I was using EMDR and making mistakes and trying things out and still getting pretty impressive results. I learned a lot, and it also made me realize the robustness of the EMDR treatment protocol. So by the time I completed the Part 2 training, I really learned the protocol the right way, and that's when my results became even more impressive. With precision and practice, I was using EMDR with kids with the whole eight phases. My mistakes were my best teachers, and even though I made mistakes with the protocol, the children still got better.

Tapping a Greater Expertise in the EMDR Community

The EMDR training manuals include a list of local EMDR facilitators with special training. In a quest for direction in effectively using EMDR with children, I (R.T.) sought direction and support through a free EMDR study group offered by certified consultants in the local EMDR community. I was excited to find that Carolyn Settle, MSW, LCSW, and Beverlee Laidlaw-Chasse, LPC, were not only using EMDR with children, but insisted that all eight phases of EMDR could be successfully implemented with even young children. With their support and direction, I gained confidence with using EMDR in my practice.

Soon after, I decided to attend the EMDRIA Conference in Denver to advance my skills with EMDR. Carolyn Settle and I met again at the EMDRIA Conference in Denver and discussed our passion for working with children. I also met another Arizona EMDRIA-approved consultant, Laurie Tetreault, who listened supportively to my excitement about using EMDR with children. She encouraged me to pursue my dream of having EMDR treatment available to all children.

After the conference, I decided to participate in an EMDR certification group with Carolyn and Beverlee. Through this group process I gained insight and confidence in using EMDR. Carolyn and I talked about how she had been trained in EMDR and began using the full protocol with children immediately, with tremendous results. Carolyn's ability to explain EMDR in very pragmatic terms was pivotal in my pursuit of expertise with EMDR. Carolyn's work with EMDR as a clinician and teacher has had an impact on many fledgling EMDR practitioners, and especially on me; therefore I was delighted when Carolyn agreed to collaborate with me on a research study on using EMDR with young children.

This Story Is Much More Interesting Than You Could Ever Possibly Imagine

Life is certainly more intriguing than fiction. That being said, it was exciting to meet Robbie, someone who was as interested in working with

children as I (C.S.) was, and we were both curious about using the 8 phases with children. Robbie came to one of my study groups and discussed her pursuit of a research project. I was fascinated by her experience in doing research because that was something I was always interested in doing. At first, I thought I was just going to be doing research at the library and helping with the literature review, but in reality, it turned out to be an enriching and surprising adventure as well.

The Authors' Adventures

We began meeting to discuss the use of EMDR with young children and the process of conducting a fidelity study on EMDR with children. Since we started this adventure 3 years ago, we have spent hours talking about the use of EMDR with children and consulting about particular challenges in using EMDR with severely traumatized children. We have also met amazing clinicians who have shared their successes and challenges with EMDR. We have received incredible support and been given many opportunities from Francine Shapiro, Robbie Dunton, Andrew Leeds, Laurie Tetreault, and many others in the EMDR community.

THE VOICES OF THE BOOK

This book was written primarily in the voices of the two authors, Robbie Adler-Tapia and Carolyn Settle, who are practicing therapists, lecturers, and researchers writing about how we work with children and capturing how we think, play with, and treat children in a multifaceted and complex process. Sometimes words in black-and-white print lack the gestalt of the therapy. How do we capture our process and infuse this into the written word? Our task was to write about what we do with voices that carry context and tone, inflection and emotion with our entire selves that convey our passion for helping children. Making the words come alive with color, action, and emotion to help therapists experience what it is to use EMDR with children motivated our writing throughout this book.

Capturing and integrating the richness and diversity of the voices of therapists we have met in study groups, in consultation, and while facilitating during EMDR training sessions has also guided our descriptions of practicing EMDR. Incorporating what we have learned from training therapists to adhere to the EMDR protocol during our fidelity research study, and what we in turn gained from them, is also integrated into this book. Our experiences as practicing clinicians, and what we have realized from even our youngest clients, make up the richness of description from the voices of the children we have been honored to treat. To better illuminate some of our work, the children's stories are integrated into

the case studies we discuss throughout the book. When we struggle with explaining what we actually do in our offices, we return to the children's stories.

Because we are at times one voice, and other times, we have different perspectives and cases, when we use the word *I,* we have identified which one of us is speaking by adding our initials (R.T. or C.S.) to provide clarification. We also use the terms *parent* and *caregiver* interchangeably throughout the book to refer to the child's primary caregiver. We use the word *child* and *client* interchangeably as well. Even though this book is written to instruct therapists on EMDR with children, most of the techniques and skills can be used with adult clients as well. Many therapists will say, "I only work with adults." We would encourage you to consider that when you work with adult clients, you are working with that client's entire set of life experiences and that, sometimes, the client's experience is from a child's perspective. No matter what the age of your client, we are many times working with maladaptively stored information that originated early in the client's life and thus is driven by a child's perspective.

WHY WRITE THIS BOOK?

As we began talking with each other and then providing training and consultation on EMDR, we found that we were trying to explain what we do in EMDR therapy with children, and we were often repeating what we had said many times before. Because we provided training at the EMDRIA conferences, advanced training on EMDR with children, and consultation with other professionals both together and individually, we wanted to have a tool to organize and guide therapists that was not yet available. Our goal with this book is to create a commonsense, written guide to provide support and direction for therapists to successfully use EMDR after completing basic training in EMDR.

We have also written a treatment manual that includes the protocols, scripts, and forms therapists will need to use EMDR in psychotherapy with children. The treatment manual, titled *EMDR and the Art of Psychotherapy With Children Treatment Manual,* can be purchased in addition to this book. The forms in the *Manual* are available to all purchasers. Please go to www.springerpub.com/adlerforms. After you download the file, you can access the forms by entering the password ADLER1.

Both this book and the accompanying treatment manual were written for two purposes. First, the book is focused on providing advanced training and support for therapists to be successful in using EMDR with child clients. We have written about the specific tools necessary for the therapist to implement the entire EMDR protocol and procedural steps in

psychotherapy with children. This is taken from our professional experiences with our child clients and from the discussions in our EMDR study groups and research group. The second goal of this book is to document a standardized protocol for using EMDR with children for training and research purposes. This book includes a standard EMDR protocol for treating children, which is consistent with the eight phases of EMDR translated into children's language. By using the treatment manual, therapists have a convenient text to assist in practicing the EMDR protocol with young children in psychotherapy. With these two goals, in the following chapters, we will not only provide advanced training for therapists, but the framework for future studies on EMDR with children.

ORGANIZATION OF THE CHAPTERS

This book begins with a review of Adaptive Information Processing theory applied to EMDR with children and an abbreviated review of research on using EMDR with child clients. The second chapter explains how to get started using EMDR, before describing the steps in the EMDR protocol in case conceptualization with child clients. Chapters 3–9 explain the goals for the specific phases of the EMDR protocol, with directions for each session, instructions for the therapist, and finally, a script for therapists to use with child clients. Additional chapters describe advanced skills for using EMDR with special populations and innovative solutions to particular challenges with the EMDR protocol. This book will provide the assistance that therapists need to feel confident in learning to use EMDR successfully with young children.

Because this book was written to assist therapists in transitioning from training in EMDR to the actual implementation of EMDR with clients, we decided to organize chapters in a manner consistent with basic training and then bridge to detailed steps of how to really use EMDR. We have expanded the basic training in several directions. First, we have translated the EMDR standard protocol that is used for adults to effectively use with children. Second, the book instructs therapists on possible procedural considerations and clinical implications for decisions at each stage of the process. The chapters include subheadings of *procedural considerations* and *clinical implications,* where therapists are given options for deciding how to proceed with the EMDR protocol. Procedural consideration headings detail how therapists progress through the protocol, with recommendations for clinical decision making at different junctures in treatment. The clinical implication subheadings explore possible results arising from decisions made during the course of using the EMDR protocol. Finally, we have included case studies of EMDR with

children; however, each child has been disguised in a manner that no case study represents the details of any individual child. We have included one complete transcript of an EMDR session with a 3-year-old, and his parents have consented for the transcript to be included in the book. We have also included pictures drawn by children, and we have parental consent for the drawings as well.

Even though this book is focused on specific skills for using EMDR with young children, many of the techniques are also effective with adolescent and adult clients as well. We use the word "client" to refer to tools for all clients and "child" to focus on tools specific to child clients.

We especially want to encourage practitioners to understand that the entire EMDR protocol can be used with child clients when therapists learn how to translate the protocol into both the verbal and nonverbal language of children. To do so, we wrote specific scripts for each piece of the protocol. Once therapists have acquired the confidence to use the entire protocol with young children, we then apply more advanced skills for clients with more complicated clinical presentations. These advanced skills do not deviate from the protocol but instead add specific tools for working with the specific symptom set.

Finally, the book includes specific language used in conducting EMDR therapy with children in the office. By having a manual, we provide a template for consistency across therapists using EMDR with children to standardize practice and document fidelity to the protocol. In this way, when a therapist says, "I am using EMDR with children," we are all speaking the same language. This is not to imply a rigid process but instead that there are common elements to EMDR that need to also be used with child clients. By establishing a common language and protocol for EMDR with children, we have a framework for both practice and research.

We have a dream that this book will not only provide the foundation to support therapists using EMDR with young children but also contribute to a paradigm shift in clinical work with children. We believe that one day, the mental health community will focus on providing more psychotherapy for children based on research that supports EMDR as evidence-based practice to decrease the use of psychotropic medications with children. Future studies on EMDR with children need to compare treatment with EMDR to treatment with psychotropic medications.

We hope to give each therapist a comprehensive framework to use EMDR in psychotherapy with children of all ages. We believe that someday, EMDR with children will be part of a standard of care in treatment to change the trajectory of the lives of many children toward a positive future for us all.

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CHAPTER 1

Theoretical Underpinnings and Research on EMDR With Children

This book is based on the Eye Movement Desensitization and Reprocessing (EMDR) psychotherapy treatment methodology, as created by Francine Shapiro (1989a, 1989b) and the EMDR training program (Shapiro, 2007). EMDR is a comprehensive treatment approach that is based on the Adaptive Information Processing (AIP) theory. After reading Dr. Shapiro's books and completing basic training in EMDR, the professional is ready to return to the office and begin using EMDR with clients.

BASIC TRAINING IN EMDR

Prior to 2008, training in EMDR consisted of two parts before a psychotherapist completed the introductory training in EMDR. During this two-part training process, EMDR with children was offered as an overview, with recommendations for therapists to pursue advanced training. With this abbreviated training in EMDR with children, therapists returned to their offices to attempt to use EMDR with child clients. This is a daunting task, with little guidance and support for therapists to integrate EMDR into their clinical work with children.

Currently, basic training in EMDR consists of the therapist participating in two weekends of training and 10 hours of consultation regarding the use of EMDR in clinical practice. Both weekends include a brief overview of using EMDR with children; however, therapists who are interested in more in-depth understanding of EMDR with children now need to attend advanced training programs (Adler-Tapia & Settle, 2008).

Basic training in EMDR also includes discussion of the AIP theory that is the foundation for the EMDR treatment methodology.

ADAPTIVE INFORMATION PROCESSING AND EMDR IN CHILD PSYCHOTHERAPY

A comprehensive theory of psychotherapy with children needs to include an explanation of human development (along with hypotheses of how humans grow, learn, change, interact, and relate) as well as how psychopathology occurs. Throughout history, writers have attempted to explain the phases of human development, including cognitive, psychosocial, and psychological development, and at times, these theories have led to the development of models of psychotherapy. Yet many theories of human development have stopped short of explaining the development of psychopathology, much less creating treatment modalities for addressing when human development skews. For example, Piaget created a theory of cognitive development but did not expand his theory to explain how cognitive development goes awry or how cognitive development impacts mental health in children. In spite of the extensive work on human development, the majority of the models of psychopathology and psychotherapy are adult models.

Shapiro (2001) developed the AIP model to explain the mechanisms by which EMDR assists clients in moving disturbance to adaptive resolution. EMDR is a comprehensive treatment methodology, while AIP is the comprehensive theoretical approach to psychotherapy. In the AIP model, Shapiro theorized that the human organism is hard-wired to assimilate new information and to move to adaptive resolution when presented with experiences causing high arousal. In the event that the level of arousal is overwhelming and traumatic to the individual, the AIP progression is thwarted, and healthy processing does not continue. Instead, the event is stored with all the sensations and perceptions that the individual experienced at the time of the event. When the traumatic event is stored in its original form because the information processing system was not able to process the overwhelming event, that event does not continue processing through to adaptive resolution. With *trauma* defined as anything that negatively impacts the psyche, the event that

is experienced as traumatic by the individual remains and continues to affect the individual's functioning. When a traumatic event occurs, the individual continues through life with dysfunctionally stored material manifesting in current symptomatology. The etiological event thus prevents the individual's natural healing process from functioning at full potential. With children, this traumatic event can also impact neurological development and all future experiences in the child's life. What experiences the child engages in or avoids is impacted by those previous life experiences.

The AIP model (Shapiro, 2001) concludes that emotional, behavioral, and mental health symptoms originate from the maladaptive storage of previous life events. In the future, as those stored experiences are activated, the client experiences disturbances and dysfunction in his or her current life.

For example, I (R.T.) treated a 5-year-old girl with moderate mental retardation who was nonverbal and medically fragile. This child had incurred many intrusive and painful medical procedures; therefore, each time she entered a doctor's office and saw a needle, she would faint. At times, the child would faint and experience additional injuries. This child also lived in a home with a family member with diabetes, and the family member regularly used insulin injections. The child would faint each time she saw a needle, an empty needle box, or anything remotely associated with needles. The parents brought the child for psychotherapy to address the child's fear of needles and medical care in general because the child needed ongoing medical interventions to stabilize her health. Physiologically, this child's system identified needles as threatening and as signifying that she was in danger, even though the needles had been used on many occasions to save the child's life. As the therapist (I) used EMDR to treat the fear of needles and medical procedures so that the child would be safe and be able to access the needed medical care with minimal further traumatization. The child's AIP system was accessed through EMDR, and the EMDR treatment process desensitized the child's association of needles and medical care as life threatening.

How does this occur? The AIP model proposes that the brain processes trauma much like the body processes physical injury. The physiological processing of injury occurs when the body automatically searches for the mechanisms for healing. The body continues with this healing process unless there is interference to the healing process such as infection or foreign bodies preventing healing. Under these circumstances, the natural healing process is thwarted. The natural healing process then requires intervention to resume the process of healing.

Shapiro (1989a, 1989b) devised a therapeutic process by which the therapist guides the client through a series of procedural steps to access the

maladaptively stored information. By accessing those memory networks, the EMDR protocol focuses on reprocessing the accessed information so that the client can proceed with the healing process.

Because AIP theory postulates that the information must be accessed, stimulated, and then moved toward adaptive resolution (Shapiro, 2007), the client must be able to access and communicate this information, which is often difficult for children because children have not developed sufficient emotional literacy to report the experience to the therapist. Because children are at different stages developmentally, therapists must assess development in the client prior to proceeding with the EMDR protocol. The therapist then adjusts the EMDR protocol to meet the developmental needs of the client. Children often store memories in sensory/motor format, and therefore children may not have a coherent narrative to describe to the therapists; however, children can report sensations that arise when neuronetworks are probed. This is when the use of play therapy and art therapy techniques are indicated to facilitate the treatment process.

AIP theory concludes that memories are a combination of sensory input, thoughts, emotions, physical sensations, and a belief system but may actually have metacognitions instead. *Metacognitions* are the ability to have cognitions about cognitions, or the ability to think about thinking. Children have not fully developed a belief system with which to understand and process an event or experience because children have not yet developed cognitively to the point where they are able to think about their own thought processes; therefore accessing and processing of neuronetworks is different. In spite of the fact that children have not developed the same cognitive processes and do not have as expansive language skills as adolescents and adults, the AIP model still explains personality development as well as the development of dysfunction and pathology in children.

If, according to AIP, the assimilation of events into the associative memory network and accommodations of the client's previous identity to encompass it can be considered the basis of personality development (Shapiro, 2007), the earlier the intervention, the more positive the impact on the personality and the individual's overall health. AIP suggests that for individuals with extensive abuse and neglect histories, this learning and adaptive resolution cannot take place because they have insufficient internal resources and positive experiences to transform the initial dysfunction. When working with children in psychotherapy, the therapist also has a unique opportunity to provide opportunities for developing internal resources and positive experiences through resource development and mastery skills as part of the EMDR process.

ASSESSING THE LITERATURE ON EMDR WITH CHILDREN

When we began our pursuit of EMDR research with children, we found that the majority of publications that focused on EMDR with children suggested significant modifications to the eight phases of EMDR, if not eliminating steps in the protocol completely. The books on EMDR with children suggested that modifications to the eight phases of the protocol were necessary to treat children (Greenwald, 1999; Lovett, 1999; Tinker & Wilson, 1999). One of the only outcome research studies on EMDR with children, by Chemtob, Nakashima, and Carlson (2002), suggested that EMDR was successful with children. Yet what we read suggested that the younger the child client, the more steps in the protocol were eliminated, therefore decreasing adherence to the eight phases of EMDR. How could it be that we both thought we were using all eight phases of the EMDR protocol, yet there was no written documentation to support our clinical experiences?

We wondered about what conclusions we could then draw from the training and publications we reviewed on using EMDR with children. Was it really true that fidelity to the EMDR protocol was not possible with children, especially those under 10 years of age? Or was it that with more advanced training and support, therapists could find just as much success with EMDR with child clients as was being reported with adult clients? With this question in mind, we set out to document what we were finding in our clinical practices with even the youngest and most severely abused clients.

RESEARCH ON EMDR

The research on EMDR with adults is extensive, and because of that, EMDR is considered best practice for treating adults with posttraumatic stress disorder (PTSD). Unfortunately, the same body of research currently does not exist for treating children with EMDR. Since Shapiro (1989, 1995) introduced EMDR in 1987, a significant body of research has developed to support the efficacy of using EMDR as a treatment for PTSD with adult clients. The American Psychiatric Association (2004) and the U.S. Department of Veterans Affairs and U.S. Department of Defense (2004) endorsed EMDR as one of the treatments of choice for adult patients with PTSD. The National Institute of Mental Health has also endorsed EMDR as an effective form of therapy for trauma. In addition to the support of professional organizations, there is a substantial body of research that demonstrates the efficacy of using EMDR with adults; however, EMDR as

a treatment of choice for adolescents, and especially children, has not been sufficiently documented.

RESEARCH ON EMDR IN PSYCHOTHERAPY WITH CHILDREN

In contrast to the research on EMDR with adult clients, published studies documenting the efficacy of EMDR with young children is limited. Research is necessary to establish EMDR for children as evidence-based practice. As shown in Tables 1.1 and 1.2, 16 studies have reported using the EMDR treatment protocol with children and adolescents (Ahmad, Larsson, & Sundelin-Wahlsten, 2007; Chemtob, Nakashima, & Carlson, 2002; Cocco & Sharpe, 1993; Fernandez, Gallinari, & Lorenzetti, 2004; Greenwald, 1994; Jaberghaderi, Greenwald, Rubin, Dolatabadim, & Zand, 2002; Jarero, Artigas, & Hartung, 2006; Korkmazlar-Oral & Pamuk, 2002; Muris, Merckelbach, Holdrinet, & Sijsenaar, 1998; Oras, Cancela De Ezpeleta, & Ahmad, 2004; Puffer, Greenwald, & Elrod, 1997; Rubin et al., 2001; Soberman, Greenwald, & Rule, 2002; Tufnell, 2005; Wilson, Tinker, Hofmann, Becker, & Marshall, 2000; Zaghrout-Hodali, Alissa, Dodgson, in press). These studies include the implementation of both individual and group protocols with child subjects.

EMDR Individual Studies With Children

Studies published on the use of EMDR in individual psychotherapy with children (Table 1.1) include single case designs, controlled studies, and comparative studies. Although these studies have analyzed the efficacy of EMDR with children and adolescents, of the 11 studies of individual EMDR treatment of children, a total of 162 children of the 216 children included in the research studies were provided a range of 1–12 sessions of EMDR. Eleven of the studies reported the use of less than six sessions of EMDR (mean 3.1 sessions per child) with only the Jaberghaderi and colleagues (2002) study reporting up to 12 sessions of EMDR; however, in this study, the EMDR treatment group of seven girls received eight or less sessions of EMDR (mean 6.1 sessions per child). The children in the studies ranged in age from 4 to 17 years. The EMDR treatment reported in all 12 studies ranged from 0.5 to 1 hour sessions provided by Part 2–trained therapists in all but three of the studies where the therapists had only Part 1 training.

Of the 11 published studies on individual EMDR treatment with children, six were controlled studies (Ahmad et al., 2007; Jaberghaderi et al., 2002; Muris et al., 1998; Puffer, Greenwald, & Elrod, 1997; Rubin et al.,

TABLE 1.1 Studies of Individual Treatment of EMDR With Children

Year of study	Studies	Number of subjects	Subject age range	Setting	Pre/Post-measures	Fidelity assessed	Tx manual used	Total EMDR sessions	Post-tx follow-up	Findings	Therapist training
2007	Ahmad et al. Controlled study EMDR vs. WLC for children diagnosed with PTSD	33 17 EMDR tx group 16 WLC	6–16 years	Child psychiatric outpatient clinic for traumatized children	25	No	Yes with "child adjusted steps."	8 sessions of EMDR (Range 1–8 sessions of EMDR, mean 5.9)	2 months after completing treating	Children in EMDR tx improved on re-experiencing symptoms	No information
2002	Chembtob et al. Brief therapy with disaster-related PTSD	32	6–12 years	School	1, 2, 3, 4, 5, 6	Yes	No (written step-by-step protocol)	3 EMDR	6 months	Substantial sustained improvement	4 PhD clinicians, 2 with PI EMDR training, 2 with PII
1993	Cocco & Sharpe Case study using auditory variant of EMDR	1	4 years, 9 months	Office	7, 8, 9	No	No	1 EMDR	1 month, 6 months	Both symptoms and behavior changed	No information
1994	Greenwald 5 case studies of treatment of traumatized children	5	4–11 years	Office	10, 11	No	No (child EMDR technical manual)	1–2 EMDR	1 week and 4 weeks	Substantial sustained improvement	1 PII trained PhD

(*continued*)

TABLE 1.1 Studies of Individual Treatment of EMDR With Children (continued)

Year of study	Studies	Number of subjects	Subject age range	Setting	Pre/Post-measures	Fidelity assessed	Tx manual used	Total EMDR sessions	Post-tx follow-up	Findings	Therapist training
2002	Jaberghaderi et al. CBT vs. EMDR for sexually abused Iranian girls	147 EMDR 7 CBT	12–13 years	University	12, 13	No	No	Up to 12 sessions of EMDR or CBT (mean 6.1)	2 weeks	A decrease in PTSD symptoms	1 psycho-logist PII trained
1998	Muris et al. EMDR vs. exposure therapy in spider phobias	26	8–17 years	University	14, 15, 16, 17	No	No	1 session of EMDR, in vivo exposure or computerized exposure	Timeline not reported	No significance	1 PII EMDR therapist, 1 behavioral therapist
2004	Oras et al. Traumatized refugee children treated with EMDR in psychodynamic approach	13	8–16 years	University hospital	24, 25	No	No	Range 1–6 sessions of EMDR	Timeline not reported	Significant improvement in functioning and PTSD symptoms, especially in re-experiencing	1 PhD, EMDR training not noted
1997	Puffer et al. Single session EMDR study with traumatized children	20	8–17 years	Office	18, 19, 20	No	No	1	1 week and 1–3 months	Significance on IES; less significant on CMAS	1 limited-licensed psychologist with PI training

Year of study	Studies	Number of subjects	Subject age range	Setting	Pre/Post-measures	Fidelity assessed	Tx manual used	Total EMDR sessions	Post-tx follow-up	Findings	Therapist training
2001	Rubin et al. Effectiveness of EMDR in Child Guidance Center	39 (TOTAL); 23 EMDR 16 No EMDR	6–15 years	Guidance center	7	Yes	No	5	6 months	No significance	8 MSWs, 3 MA psychologists, 1 PhD—all PII trained
2002	Soberman et al. Boys with conduct problems	29 boys 14 Standard of care plus 3 sessions EMDR 15 control	10–16 years	Residential treatment facility or day treatment facility at same facility	21, 22	No	No	3	2 months	Less distress, decreased PTSD symptoms, large reduction in behavior problems	1 Pre-doc intern, PII trained and used 100 sessions of EMDR
2005	Tufnell Case studies of PTSD	4	4–11 years	Mental health center	23	No	No	Range 2–4	6 months	PTSD symptoms resolved, results maintained	Child psychiatrist and psychotherapist—both PII trained

Pre- and post-measures key: (1) Kauai Recovery Inventory; (2) Child Reaction Index; (3) Revised Children's Manifest Anxiety Scale; (4) Child Depression Inventory; (5) Visits to school nurse; (6) Child Ratings of Helpfulness; (7) Achenbach Child Behavior Checklist Form; (8) Thought Problem Subscale; (9) Parent monitor; (10) Parent interview; (11) Problem Rating Scale; (12) PTSD symptom interview; (13) Problem behavior assessed; (14) DISC-R interview; (15) Spider Phobia Questionnaire; (16) Self-Assessment Manikin; (17) Behavior Avoidance Test; (18) Children's Manifest Anxiety Scale; (19) Impact of Events Scale (IES); (20) Subjective Units of Disturbance (SUD), Validity of Cognition (VOC); (21) Child/Parent Report of Post-Traumatic Symptoms (CROPS/PROPS); (22) Trauma Symptom Checklist for Children (TSCC); (23) Therapist Interview; (24) Post-Traumatic Stress Symptoms Scale for Children (PTSS-C); (25) Global Assessment of Functioning (GAF).

TABLE 1.2 Studies of EMDR Group Protocol With Child Clients

Year of study	Studies	Number of subjects	Subject age range	Setting	Pre/Post-measures	Fidelity assessed	Tx manual used	Total EMDR sessions	Post-tx follow-up	Findings	Therapist training
2003	Fernandez et al. Group protocol with elementary school treatment for disaster trauma	236	6–11 years	Italy School	1	No	No	2 psycho-educational groups using butterfly hugs	30 days & 4 months	Call from teacher, all but 2 had no symptoms at 30 days	3 PII trained PhDs
2006	Jarero et al. Group protocol with children who experienced a flood in their hometown	44 22 girls 22 boys	8–15 years	Pedras Negras, Mexico Temporary Shelters	2, 3	No	No	Two 50–60 minute groups	4 weeks	Significant decrease in CRTES scores and SUDS scores	1 lead therapist and emotional protection team (EPT)
2002	Korkmazlar-Oral & Pamuk Group EMDR with child survivors of earthquake in Turkey	16 13 girls 3 boys	10–11 years	Tent city in Adapazari	None	No	No	3.5 hours total for all activities of EMDR plus other activities	None	Children evidenced reduced SUDS	2 therapists Training not noted

Year of study	Studies	Number of subjects	Subject age range	Setting	Pre/Post-measures	Fidelity assessed	Tx manual used	Total EMDR sessions	Post-tx follow-up	Findings	Therapist training
2000	Wilson et al. EMDR group protocol with children in Kosovar-Albanian Refugee Camp	2 groups	17 6–10 years, 9 11–13 years	Refugee camp, Hemar, Germany	4, 5	No	Butterfly Hug Protocol	Each group received 2 hours on 3 consecutive days for total of 6 hours	Younger group 1 month and 1 week pre; 1 week and 2 months post		2 PhD EMDR facilitators
In press	Zaghrout-Hodali et al. Group EMDR with children in who experienced a shooting	7 3 girls 4 boys	8–12 years	Aida refugee camp in Bethlehem, Israel	SUDS Parent report	No	Butterfly Hug Protocol (Wilson et al., 2000)	5 total sessions: 4 group sessions; 1 follow-up session	5 months	SUD reduced to 0–1 per child report Parent report symptom reduction	2 therapists Training not noted

Pre- and post-measures key: (1) Teachers' pre- and post-behavioral observations; (2) Child Reaction to Traumatic Events Scale (CRTES); (3) Simplified Impact of Events Scale; (4) Saigh Children's PTSD Inventory Measure; (5) Children's Brief Psychiatric Rating Scale.

2001; Chembtob, Nakashima, & Carlson, 2002). Of the six studies, five were comparative studies of EMDR versus other methods of psychotherapeutic treatment for children or wait list control (Ahmad et al., 2007), and one study (Chemtob et al., 2002) used a randomized lagged group design to specifically treat children with posttraumatic symptoms.

EMDR Group Studies With Children

Five published studies (Fernandez et al., 2004; Jarero et al., 2006; Korkmazlar-Oral & Pamuk, 2002; Wilson et al., 2000; Zaghrout-Hodali et al., in press) have documented field studies on the use of the EMDR Group Protocol with children who had experienced a shared traumatic event due to either a manmade or natural disaster (Table 1.2). The EMDR Group Protocol or the Butterfly Hug Protocol was created by Jarero and colleagues (1999) to treat groups of children sharing a common traumatic event. Due to the need for trauma treatment during disaster situations with high numbers of victims and limited resources, the EMDR Group Protocol has been studied in the field as therapists have attempted to aid victims and reduce the impact of trauma especially on groups of children who have experienced the same natural or manmade disaster situation and/or shared a traumatic event. The field studies that have been conducted have occurred internationally in disaster areas where resources are limited and there are many child victims. In the five published studies of the EMDR group protocol with children, 342 children participated in one to six group sessions lasting from 50 minutes to 3.5 hours. Outcome measures and posttreatment follow-up assessments from these studies note that children have reduced symptoms and show resilience (Zaghrout-Hodali et al., in press).

As of the publication of this book, the 16 studies on EMDR with children suggest that EMDR with children is promising practice.

As with any treatment modality, the efficacy of the treatment intervention must be supported by research to justify the treatment modality as best practice. The 16 studies on EMDR with children suggest that EMDR is a promising practice in psychotherapy with children; however, the robustness of the methodology in these studies has come under scrutiny. Because of this, we have struggled to get EMDR authorized for children and have had grant applications denied. Not only is it difficult to get services authorized for children, but even when services are authorized, there are not many therapists trained to use EMDR with children. Many clinicians experience frustration and even abandon the use of EMDR because they lack confidence and support in successfully integrating EMDR with children into their clinical work. This is a travesty. But

how do two clinicians convince the professional community that EMDR should be the treatment of choice for traumatized children?

Our First Research Study

Why would two clinicians pursue research? We have often asked ourselves this question. Ultimately, the reason we started using EMDR with children and why we are conducting research on EMDR with children is simple: We want EMDR to be available to all children. We began a fidelity research study at Childhelp (a national nonprofit for children who are victims of crime) and provided biweekly consultation for the therapists at Childhelp who were using EMDR with children. This research consultation group identified many training and clinical variables necessary to improve therapists' success in maintaining fidelity to the EMDR protocol in psychotherapy with young children. These findings are necessary in supporting and guiding therapists in using EMDR with even the youngest clients. The following conclusions are taken from the clinical experiences of the researchers, individual consultation with therapists who participated in the study, review of videotapes of therapy sessions, and documentation from research consultation group meetings.

Themes That Arose From the Qualitative Data. From this qualitative data, eight overarching themes emerged regarding using EMDR with children aged 2–10 years. Of these themes, five will be discussed including therapist-specific variables; variables specific to the unique characteristics of the individual child; variables specific to EMDR treatment with children; variables related to the treatment environment, including the therapist's office; and variables related to the parents of child clients and the home environment.

The following discussion will describe the initial conclusions about the variables that affected the therapists' ability to demonstrate fidelity to the EMDR protocol.

Therapist-Specific Variables. Therapist-specific variables include training and experience in working with young children; knowledge of child development; training and experience with using the EMDR protocol; confidence in the efficacy of EMDR; patience and creativity in teasing out the pieces of the EMDR protocol; and skill at developing rapport and attunement with the client.

In this study, all the therapists had at least Part-2 training in EMDR and had participated in biweekly consultation groups with feedback from Eye Movement Desensitization and Reprocessing International Association (EMDRIA)-Approved Consultants in EMDR. The consultants reviewed tapes and responded to questions from therapists regarding fidelity. Responses

from the therapists were documented by the researchers and included in this study.

Therapists experienced in treating young children with training in child development and play therapy found it easier to adhere to the EMDR protocol with young children.

In addition to training and experience working with young children, therapists needed training in EMDR and experience using the eight-phase EMDR protocol. After Part 1 training in EMDR, therapists can practice using the EMDR protocol with children with minor traumas (Shapiro, 2001); however, the therapists in this study who were Part 2 trained struggled to use EMDR with highly traumatized children without additional consultation, training, encouragement, and experience. As therapists in the study practiced using the EMDR protocol, therapists reported greater success adhering to the EMDR protocol.

In a study on the effectiveness of EMDR with adult clients, Edmond, Sloan, and McCarty (2004) reported that "one of the therapists was positively biased toward the method, one was extremely skeptical to the point of being negatively biased against the method and the other two therapists were viewed as neutral" (p. 262). Therapists' bias toward the EMDR methodology also was evident in the data collected from research group meetings at Childhelp. The therapists' bias toward the EMDR methodology strongly contributed to the therapists' willingness to use EMDR with children. Therapists with a positive bias to EMDR were more likely to incorporate play therapy, art therapy, and other nondirective techniques in using EMDR with young children. Therapists who had been using play therapy, art therapy, and other nondirective therapeutic techniques prior to being trained in EMDR presented with a neutral or more cautious use of EMDR with children. This made it more difficult for some therapists to transition to the more directive procedures included in the EMDR protocol. However, when therapists used play therapy, art therapy, and child therapy techniques to elicit aspects of the EMDR procedural steps, therapists became more easily acclimated and then reported greater success in eliciting all phases of the protocol.

In addition, fidelity to the protocol was significantly affected by the therapists' confidence in their own clinical skills in treating young children, along with the therapists' confidence in their own skills adhering to the EMDR protocol. The most effective therapists had excellent clinical skills, especially with young children, had in-depth understanding of child development, and felt confident using the EMDR protocol. Therapists who read from the manual when they were first learning the EMDR protocol struggled to use the manual in therapy sessions. Once the therapist gained confidence in his or her own skills at using the EMDR protocol and knew the protocol without using the treatment manual, the therapist

had greater opportunity to use play therapy, art therapy techniques, and creative tools in eliciting the steps of the EMDR protocol with young children. Discussion of the specific techniques and tools therapists created to elicit the steps of the protocol with young children is beyond the scope of this book. In general, therapists who used techniques beyond traditional talk therapy were most successful in eliciting all the steps of the EMDR protocol with children 2–10 years of age. For example, therapists often struggled to elicit negative and positive cognitions with children. Instead of using the language written in the adult treatment manuals, therapists in this study asked children to identify bad thoughts and good thoughts.

Rapport building and relationship development are foundations for any successful treatment (Dworkin, 2005). These variables became even more significant with the application of the EMDR protocol to severely traumatized children. In fact, the rapport and relationship between the therapist and the child were significant predictors of the ability of the therapist to engage the child in the reprocessing that occurs during the Desensitization Phase of EMDR. The relationship between the therapist and the child client was also affected by the attunement of the therapist to the child and by attachment issues.

Variables Specific to the Unique Characteristics of the Individual Child. Besides therapists' specific variables, the individual child client also brought unique challenges to the treatment provided in this study. The children in this initial fidelity study were all clients of Childhelp, USA, where the children are all identified victims of crime. In addition to experiencing significant trauma, the children's unique personalities and life experiences affected this study. The children ranged in age from 3 to 10 years, and many children were bilingual in Spanish and English.

In addition, the children were from various cultural and religious backgrounds. Therapists had to incorporate issues related to the child's culture into therapy. The specific religious affiliations of several children required adjustments to the therapeutic environment. For instance, one child belonged to a religious organization that did not allow certain holidays and figures; therefore the therapist had to move to a different office because certain figures in the office were disturbing to the child because of her religion.

Furthermore, children in this study were often involved in the legal process of prosecuting adults; therefore the therapist had to assess current stressors and provide resourcing to the child before proceeding with reprocessing targets.

Finally, the therapist had to assess the distress in the child's family environment as well as in his or her home and school settings to most effectively use psychotherapy with EMDR.

Variables Specific to EMDR Treatment With Children. As EMDR was originally designed as a treatment protocol for adult clients, translating EMDR into language children can understand is even more complicated with severely and chronically traumatized children. Because of this, the severity of trauma experienced by the child obviously has a significant impact on the child's willingness to participate in treatment. Therapists in this study often reported experiencing clients' resistance or avoidance of reprocessing. It was necessary to explore factors that were contributing to clients' avoidance. As cases were staffed and videos reviewed, factors were identified as fueling resistance. Variables that emerged included engaging the child in the treatment process; improving the child's ability to tolerate intense affect; child developmental tasks, including children's current focus and emotional literacy; the impact of child languaging, including translation of the EMDR protocol into terms appropriate for children; and the use of BLS with young children.

Variables Related to the Treatment Environment, Including the Therapist's Office. The therapist needed to invest time, especially during the Preparation Phase of EMDR, to successfully engage the child in the clinical process and ultimately convince the child that participating in therapy would be valuable to the child. One variable unique to this study was location. At a large facility like the Childhelp, USA, Children's Center, therapists needed to understand that children needed time to play, explore, and ultimately trust the therapist to be convinced that reprocessing trauma would lead to positive and desirable outcomes. Because the Childhelp, USA, Children's Center is an advocacy center that includes law enforcement, forensic interviewers, forensic medical facilities, and the clinical environment, the children in this study had been interviewed by detectives and often had participated in medical assessments prior to being referred for therapy. Unlike children participating in therapy in a private office or community mental health center, children in therapy at Childhelp, USA, had already associated stressful experiences with the facility prior to being referred for therapy. This required therapists to desensitize the child to the therapy environment for treatment with EMDR to proceed. Once the therapist recognized that the child's reticence to participate in therapy with EMDR sometimes was due to contamination of the facility environment, rather than difficulties with the EMDR protocol, the therapeutic process continued more successfully.

Variables Related to the Parents of Child Clients and the Home Environment. These variables included the parents' current emotional functioning, the stability of the home and school environments, the recency of the trauma, and unfolding secondary traumas such as changes to the family and home environment and forensic involvement. The emotional functioning of the child's parents often had a direct impact on treatment

outcomes for children. The parents' own anxiety and trauma history had to be assessed and treated to improve the child's success in treatment. It was evident that the stability of the home and school environments posed significant challenges to EMDR with children. Often, when the home environment was destabilized or had been dysfunctional when the crisis/trauma occurred, the child's progress in therapy was stymied or halted. When this occurred, the therapist needed to stabilize the home and school environments for progress in therapy to continue. In addition, the recency of the trauma and co-occurring or secondary trauma to parents often contributed to the parents' own mental health issues and tendency to become more protective of the children. With several clients, the perpetrator was a sibling or parent, which profoundly destabilized the child's environment. Progress in treatment was prolonged and required patience and commitment from the therapist. In these cases, the child's participation in the EMDR fidelity study was difficult because therapists had to spend a significant amount of time during the Preparation Phase with the child and his or her family. This issue also delayed data collection for the fidelity study as therapy became lengthy. Several clients had to withdraw from the study because of new allegations that required forensic or legal involvement.

The research conducted on EMDR with children (Chemtob et al., 2002; Cocco & Sharpe, 1993; Fernandez et al., 2004; Greenwald, 1994; Jaberghaderi et al., 2002; Jarero et al., 2006; Korkmazlar-Oral & Pamuk, 2002; Muris et al., 1998; Oras et al., 2004; Puffer et al., 1997; Rubin et al., 2001; Soberman et al., 2002; Tufnell, 2005; Wilson et al., 2000), along with the fidelity study that we have conducted, form the foundation for documenting EMDR with children as a promising practice.

Of the eleven studies published on EMDR in individual therapy with children, a total of 185 children aged 4–17 years were reportedly provided from 1 to 12 sessions of EMDR (mean 3.8 sessions). Eight studies reported that therapists offered six or less sessions of EMDR. The EMDR treatment in all of these studies ranged from ½ hour to 1-hour sessions provided by therapists fully trained in EMDR in all but three of the studies, where the therapists had not completed basic training in EMDR.

SUMMARY

As with any treatment modality, the efficacy of the treatment intervention must be supported by research to justify the treatment modality as best practice. Conducting research on therapeutic processes is challenging and requires that specific criteria be met to establish the methodological

robustness of the research study. More research studies need to be conducted on using EMDR to treat young children, yet how do you conduct studies if there are few therapists specifically trained to use EMDR with young children? What a difficult predicament. Where do you start? To demonstrate fidelity to the EMDR protocol, therapists must first receive standardized training in using EMDR and then advanced training in using EMDR with young children. This training starts with a written manual, with directions for the therapist to adhere to the protocol. In addition to using a manual, the therapists still need ongoing consultation and skill development to effectively implement the EMDR protocol. The purpose of this book is to document and attempt to standardize the use of EMDR with young children in an effort to provide a document that will assist educators and researchers in standardizing the EMDR protocol for use with young children.

The book began with a review of the theoretical underpinnings from the AIP Model and a brief summary of the published studies on EMDR with children. In this chapter, we also reviewed the research on EMDR in general, with a focus on the current research on EMDR with children. The next chapters of the book provide specific written instructions for therapists to use EMDR with children, with explanations for using each piece of EMDR protocol with even the youngest client.

We then provide specialty protocols for using EMDR with children with symptom presentations and diagnoses.

Future studies on EMDR with children are necessary to assess the efficacy of using EMDR to treat children. Currently, EMDR with children has the foundation for a promising practice, and with additional studies, EMDR with children can become recognized as evidence-based practice.