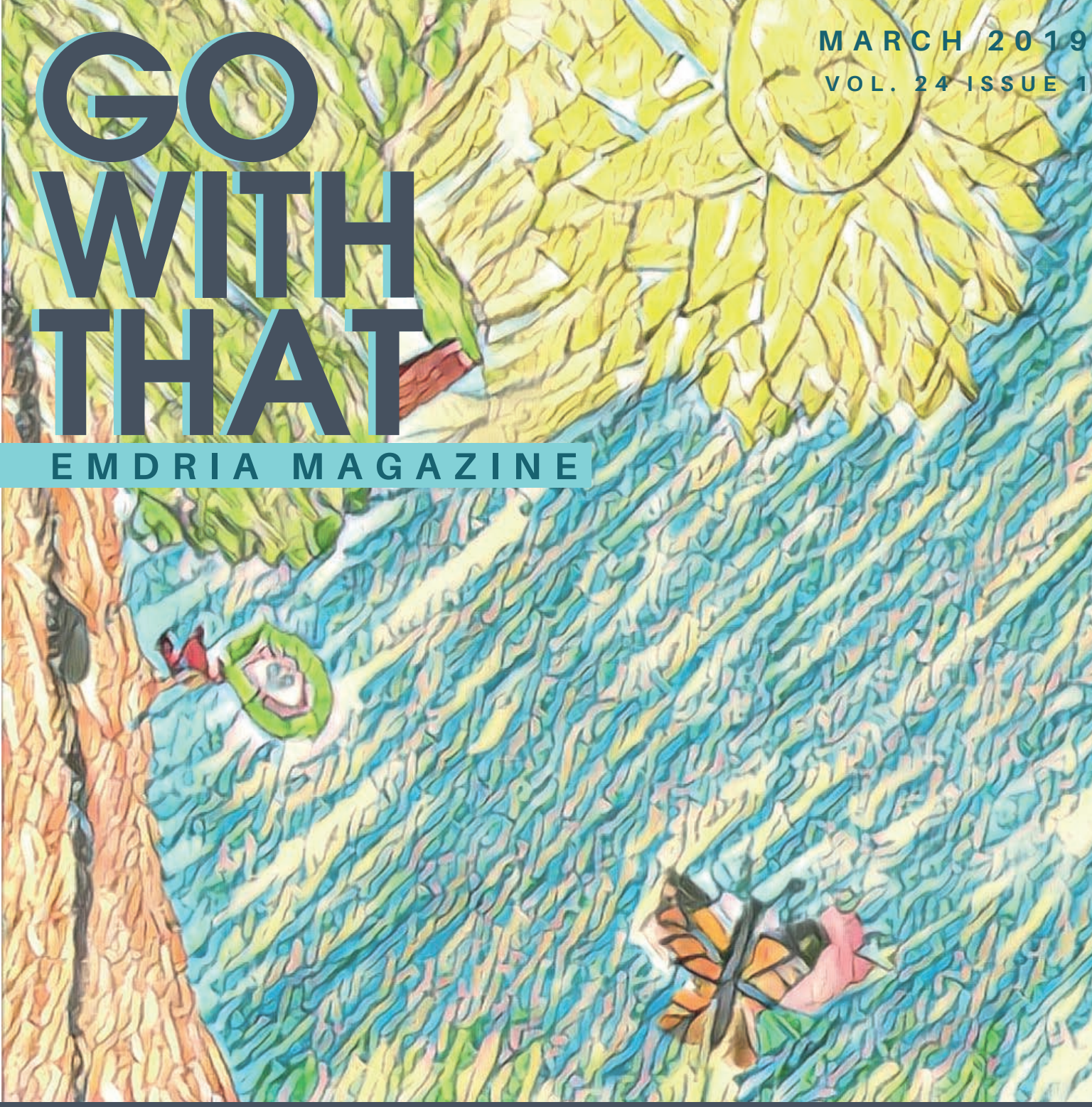
MARCH 2019
VOL. 24 ISSUE 1

GO WITH THAT

EMDRIA MAGAZINE



EMDR THERAPY WITH CHILDREN & ADOLESCENTS

emdria
EMDR International Association
CREATING GLOBAL HEALING, HEALTH & HOPE

Executive Director
Michael Bowers, MA
mbowers@emdria.org

Editor
Sara Sturtevant
ssturtevant@emdria.org

"Go With That" is the quarterly magazine of the **EMDR International Association (EMDRIA)**, and is copyrighted by EMDRIA. No reproduction, republication, or other use of the content herein is authorized without explicit permission from EMDRIA. For permission, please write the Editor at **ssturtevant@emdria.org**.

Letters to the Editor should be addressed to the Editor. Any letters submitted are subject to review and approval by EMDRIA and will be published at EMDRIA's sole discretion. Letters to the Editor should not exceed 250 words.

The views expressed in this publication do not necessarily represent the official positions or views of EMDRIA and should not be construed as such.

Contents

Departments

In this issue

Executive Director's Message

Beginner's Mind

MICHAEL BOWERS, MA

A big part of the wonder of childhood is the ability maintain a beginner's mind without embarrassment or hesitation. Children can marvel at a mudpuddle (and love jumping in it) or stare at the Milky Way. They can express themselves in art or music without concern as to whether they are, or ever will be the next Picasso. Learning, and doing new things for the sheer experience or joy of it is part of the journey. In fact, it is a large part of the work of childhood.

Perhaps for therapists, part of our journey to excellence involves embracing those parts of ourselves that allow us to experience wonder and creativity. Adopting and maintaining a beginner's mind can help us stay fresh and open to learning. I believe, in fact, that being able to adopt a beginner's mind and hold it offers great potential for those who wish to excel in their work of giving care to others. We hope that this issue on working with children and adolescents will give you some opportunity to practice a beginner's mind.

In the same way that children and therapists can cultivate and grow from a beginner's mind, so can organizations. This year EMDRIA is trying several things it has never done before. The EMDRIA Board is practicing a new method and commitment to governance. Every single member of the EMDRIA staff is assigned some project or program that is new to them—that they haven't done before. In these instances, the beginner's mind is forced by circumstance. And like all of us at some point, we must adopt a posture to that new thing—whether to struggle with it, avoid it, or embrace it and learn.

We invite you on that journey with us. As this magazine is evolving from a newsletter to a feature-based publication, we welcome your feedback. We will also be revising and publishing a new consultation packet/manual, creating resources to help market and integrate EMDR into clinical practice, especially for those who are newly trained EMDR practitioners, and convening a Symposium of almost three dozen scholars and thought leaders from around the world to help chart the future of EMDR. We hope to see you at the conference in California this September, where many of these initiatives will be presented.

EMDRIA is focused on learning, growing, and maintaining a beginner's mind. What is your beginner's mind task this year? What are you learning or doing that you've never done before?

A Word from the President

CAROL MILES, LCSW

In the spirit of this quarter's Go With That magazine theme, I thought that the people on our board might have some good childhood stories, so I asked them to tell me a little about their youth. Interestingly, these stories really ring a bell in the adults we now know! I hope these stories help you get to know our board a little better as people as well as help you get ready to read this kid-focused issue of our magazine.

Wendy Byrd, LPC, LMFT
I grew up on the coast of Texas, loving to run barefoot on the beach. As a result, I hated wearing shoes other places. I refused to put my shoes on, to the utter frustration of my mom. I still love the smell of the ocean and the feel of sand between my toes. Even now I rebel against wearing shoes!

Candida Condor, Psy.D.
As a girl, I was fond of the Mickey Mouse Club TV show, and especially enjoyed watching Darlene's introduction to being an air hostess. Years later, I followed Darlene's footsteps on to a Pan Am 747 wearing that blue uniform and jaunty hat!

Marisol Erlacher, LPC
When I was in Middle School, I was certain I wanted to be a Peace Corp volunteer. I wanted to work in Swaziland (currently eSwatini) to easily get to South Africa to work toward the end of apartheid.

Kriss Jarecki, LDCSW-R
In 8th grade I sat in front of my caseworker at the commission for the blind, a very nice man but a bit lazy with crumbs in his beard. I told him I wanted to be a social worker. He said, "great because I want to retire from social work." I still wonder if he decided to retire after an hour with me!

Lori Kucharski, LMFT, LPC
I loved playing school long before I ever considered becoming a therapist, so it is not surprising that I ended up in some form of education (Counselor Education and Supervision and EMDR Training) after all.

Carol Miles LCSW
I was painfully shy as a child, "slow to warm up". Changing schools frequently (12 schools in 12 years) may have helped but I still often take some time to feel accepted in new situations.

Mark Nickerson, LICSW
When I was a kid, I learned that if I wanted to play baseball in the neighborhood, I had to go door to door to get kids to come out. Then I had to make sure everyone had fun so they'd play the next day.

Mischa Cohen Peck, MA, MSW, PhD
I'm a second-generation survivor of the Nazi Holocaust. My father was born in Belgium. Because of his life experience, and emotional characteristics of his survival, it was determined epigenetically that I would be a therapist (see the research of Rachel Yehuda).

Sharon Rollins, MS-LPC, NCC
I was the Quarterback for the family football team. I threw passes to my three brothers which rivaled those of the Dallas Cowboy's superstar, Roger Staubach.

Evelyn Wright, LCSW
My childhood was a VERY long time ago...I'm truly the American multicultural living experience of the "Heinz 57" variety with about 7 ethnicities in my family background.

I hope this trip down memory lane with our board was fun for you and that you learned a little bit about each of us! We work for you. Thanks for allowing us to be in this role.

Carol Miles, President
EMDRIA Board of Directors

News & Announcements

EMDRIA'S EMDR Certification & Approved Consultant renewal process is changing!
We have moved to an audit-based system for our credential renewal process. If you are an EMDR Certified Therapist or Approved Consultant with us, you will still need to renew for your credential every two years, however, you will only have to turn in your EMDRIA Credit certificates if your renewal is chosen in an audit. We began implementation this change as of January 1, 2019. For more information, please review the Certification Renewal page on our website.

Position Statement on Sexual Orientation Change Efforts
The EMDRIA Board of Directors recently passed a new policy regarding reparative therapy and other efforts to change or modify sexual orientation and/or gender identity. For more information, visit the EMDRIA Policies page on our website.

2019 EMDRIA Conference - Book Your Hotel Room Now!
The 2019 EMDRIA Conference, taking place in Orange County, CA, will be here before you know it! Reserve your hotel room at our special rate! Hotel rooms get booked quickly so be sure to book your hotel room today!
https://www.hyatt.com/en-US/group-booking/ALICA/G-IEMD

2020 EMDR Asia Conference
EMDR Asia warmly welcomes you to the 4th EMDR Asia Conference on January 3-5, 2020 in Bangkok. EMDR Asia is also accepting Call for Abstracts until June 30, 2019. For more information, visit https://emdrasia.org/

A special thank you

to **10-year-old Lauren Cooper** from Greenville, South Carolina for originating and inspiring this issue's front cover! Entitled "Half Sunny Half Night," she created this work using her color pencils and sketch pad. Her mom, Amy Cromer, reports that Lauren is a wonderful artist who "draws everything." Be sure to observe the fun details throughout the drawing.

Cover Artist: Lauren Cooper

Play is often talked about as if it were a relief from serious learning. But for children play is serious learning. Play is really the work of childhood.

Fred Rogers

Exploring the Intersection of EMDR and Play Therapy

ANN BECKLEY-FOREST, LCSW-R, RPT-S

American psychologist, educator, and founder of EMDR, Francine Shapiro's adaptive information processing (AIP) model proposes that the integration of both positive and negative experiences into our nervous system is the healthy process by which we grow. When an acutely negative or traumatic event occurs, our own neurobiological effort to cope with the trauma sabotages this information processing by isolating the related associations, images, feelings, etc. (Shapiro, 2017).

EMDR's potency in entering this isolated memory network and enabling the client to begin the adaptive process of integration is well established. In the field, professionals are now looking into the intriguing question of how EMDR does its work and, often the more complicated question, how can EMDR professionals best get each client to do it?

Making safe therapeutic space for the activation and the adaptive processing of traumatic memories has long been a central theme in play therapy literature.

Basis for Integration

Since the field's earliest days, practitioners have attempted to extend the benefits of EMDR to children (Greenwald, 1999), which has a growing body of evidence in support of it (Adler-Tapia & Settle, 2009). However, therapists trained in EMDR often have great difficulty getting children to participate in EMDR activities in clinical settings.

In considering what AIP looks like in children versus adults, it is essential to recognize that children do the majority of their learning through action and imaginative experimentation, not through the verbal reflection or even the visual imagery that is the primary portal of processing for most adults using EMDR.

An all-too-typical clinical situation that an EMDR therapist might encounter in a younger child follows along these lines: the therapist brings up the target memory verbally and follows up by using "feelings faces," or a cut-out of the body, for the assessment of the memory target. These props are definitely useful in translating the language of the standard protocol – and the child answers but appears bored or detached. The therapist uses bilateral stimulation (BLS) for a few sets and checks in with the child. The child either reports that it's fine now, asks to stop, or becomes disruptive and refuses to continue.

While children with strong verbal capacities do participate in child-friendly standard protocol approaches, such as the one described above, this processing often feels superficial in practice. The therapist may wonder if the child is just going through the motions and may be unsure if the neural nets are activated to the extent needed for processing to occur. If child therapists want to be effective in extending the benefits of EMDR to more children, they will need to bring all of their creativity, playfulness and co-regulation to make these moments a possibility.

Power of Play Therapy Settings

Making safe therapeutic space for the activation and the adaptive processing of traumatic memories has long been a central theme in play therapy literature. This foundation should be the basis of the intersection between these two approaches to helping children heal. The significance of adding EMDR to the digestion of engaging experiences that children are already having in the play therapy room has been driving many trained play therapists to seek EMDR training. This trend holds the promise of moving beyond merely making EMDR more palatable to children toward a model that fully integrates both approaches.

A prescriptive approach to play therapy is quite compatible with integration of the eight phases of EMDR.

In moments of play, neural networks activate more fully and offer opportunities for more adaptive information to enter those networks. The elements of adult neutrality and acceptance, child agency, and what play therapist and author Terry Kottman calls the "egalitarian relationship between therapist and child" (2015) are critical to the construction of emotional safety in the play therapy room. The neutrality of tracking the child's own play and being fully present to the child in traditional Child-Centered Play Therapy (CCPT) constitutes the foundation for a unique relationship between the therapist and the child.

Practicing Neutral Engagement

This relationship expands the possibility for the child's own resolution of disruptions (for a thorough grounding on the theory and methodology of Child Centered Play Therapy, see Landreth,

2012). The therapist stays connected by neutrally following and reflecting the child's actions and consistently noticing the child's own agency in the play room, using phrases such as, "In here, you can decide," or "You are thinking of what you want to do now."

Clinical wisdom regarding trauma therapy with young children forces us to recognize how easily the therapeutic alliance is compromised by a child's adult-pleasing or adult-defying behaviors. Therapist neutrality, in particular the intentional creation of the play therapy space as described by CCPT, increases the projective power of the space to hold the experience of the child authentically, without the distraction of trying to please or oppose the adult. This kind of neutral engagement is a rare experience in the lives of children. In traditional or pure CCPT and its companion approaches with families, filial play therapy and Child Parent Relationship Therapy, experts believe the child's own system is able to heal itself if the therapist can sufficiently hold the therapeutic space.

Flexibility of Prescriptive Approaches

In current play therapy practice, many play therapists have turned to a more prescriptive approach. They borrow from CCPT but may choose to direct some activities based on the need of the child, especially in light of trauma research about the avoidance of trauma memory networks.

Prescriptive play therapy approaches are flexible. They use a mixture of child-centered play time, as described above, along with child-responsive interventions from the therapist, such as adding adaptive information or options when the post-traumatic play appears stuck. Play therapy training encourages the therapist to use the lightest touch possible with these insertions, such as wondering aloud, "I wonder what would happen if…."

These kinds of observations can help shifts in thinking to be more congruent, much like the gentle language that EMDR therapists use along with interweaves in EMDR processing. In ad-

On A Personal Note: Post-Trauma Play in My Practice

In my clinical practice, I have found the possibility of approaching the trauma network gradually through play extends beyond the sand tray to many of the imaginative role-playing activities in the play room that many children favor, such as the baby play that younger children with insecure attachment often present in the play room.

A young client, with insecure attachment stemming from her addicted mother's inconsistent care in infancy, used the child-centered play therapy time to again and again re-enact a similar story with herself. As a baby figure, she is alternately cared for and threatened by the imaginary characters in the room, played by the therapist and various stuffed animals and toys at her direction.

Over time, the therapist allows the client to be in charge of the play as its director. The client adds more and more elements of her ambivalent attachment into the play. For example, the client has the therapist act as the mother figure ("Mother") in the dramatic play, while the client plays the role of the baby ("Baby"). Sometimes Mother takes care of Baby and feeds Baby in this drama. (This client began bringing snacks into the session for this purpose. At times, she used a water bottle as the prop.)

At other times, the client directs Mother to tell Baby that Baby is lying, that Baby cannot have the things Baby wants. The client also directs Mother to tell Baby that Baby cannot sleep or be distracted when a dangerous third character, "X," in the form of a seen or unseen presence, comes into the room and threatens Baby in the drama.

This drama had many of the qualities of dynamic post-traumatic play, including urgency to the child, a sense of felt reality and emotional intensity as well as thematic parallels to the child's own experience. In this setting, she was able to convey to me the negative beliefs and emotions experienced by the baby. During brief sets of BLS (in this case most often tactile BLS with Patty Cake type of hand claps bilaterally across the line of sight), she was able to notice the distress in her own body. Gradually the self was brought more explicitly into this processing using the bridge of this play, initially quite simply by noticing, in statements such as, "You were a once a baby who knows what that lonely feeling is like."

This child could not have tolerated a standard protocol approach and, as much of the trauma was preverbal, she would not have had the words to convey the magnitude of her experience. Through the play, she was able to activate that memory network and use the opportunity to digest her anger and fear in an embodied way (sometimes by throwing the stuffed animals or using other active means). By using the BLS to focus her moments of noticing, we were able to begin to shift the play with the slow introduction of adaptive information.

This flexible approach to desensitization and reprocessing must be grounded in all the elements of the standard protocol, with attention paid to the images, emotions, negative beliefs, and body sensations, but the process is more spontaneous and driven by the narrative of the play.

dition, prescriptive play therapists use information gained through tracking child-centered play to develop a menu of play-based skill building activities for the child and family to complement the play in which the child is already engaging. A prescriptive approach to play therapy is quite compatible with integration of the eight phases of EMDR.

Author-Expert Support of Play Therapy

In her book, Play Therapy with Traumatized Children (2010), licensed clinical social worker and registered play therapist-supervisor Paris Goodyear-Brown proposes a model for Flexibly Sequential Play Therapy, a phase model which she now calls TraumaPlay. Her model is an integration of directive and non-directive play therapy activities prescribed to 1) develop emotional safety, 2) promote physiological soothing and emotional modulation, 3) allow for gradual exposure to the traumatic material in order to re-order negative beliefs, and 4) make sense of the self in light of the trauma.

Eliana Gil, another play therapy author, lecturer, and clinician of marriage, family, and children, describes post-traumatic play as a repetitive and often rigid type of play initiated by children who are trying to "expose themselves to the literal aspects of the trauma which cause them despair" (2012, p.184). In the AIP model, therapists would describe these elements in the play as connected to the memory node, which holds the trauma, thus offering a possible pathway into the associated neural net. If the child is able to gradually move in and out of this processing in a dynamic way, the brain's own drive toward integration will promote healing.

Gil's work within play therapy has been significant in helping play therapists with the complexities of recognizing and supporting dynamic play, which may be post-traumatic in nature, providing options for intervening to prevent the play from becoming static and potentially re-traumatizing, as well as using play to ground children who begin to dissociate (Gil, 2016).

The autonomy of the child in the rich sensory environment of the playroom helps to mitigate the risk of children becoming overwhelmed and dissociating during post-traumatic play. In the presence of play that suggests post-traumatic content, a play therapist also trained in EMDR may be able to accelerate this processing with the child.

How-Tos of Integration

In her book, EMDR Therapy and Adjunct Approaches with Children: Complex Trauma, Attachment and Dissociation, psychotherapist and international lecturer Ana Gomez presents one of the best published examples of how to fully integrate EMDR into a play therapy setting in her development of a protocol for using EMDR in the context of the sandtray (Gomez, 2012). A sandtray and a collection of miniature figures chosen deliberately for their projective possibilities are standard materials available in a play therapy room. Children gravitate toward these as a place of both active and dynamic play as well as the setting for intentional creation of scenes with symbolic power for the child (Homeyer & Sweeney, 2011).

Gomez describes how invitations to children to create stories in the sand tray help to more gradually approach the traumatic memory networks available in imaginative play. The therapist might begin some initial processing along the networks that the child is not yet ready to explicitly approach in metaphor of the play (Gomez, 193-196) by wondering about the thoughts, feelings, body sensations of the central character, or self-object, in the play, and asking the child to notice these along with BLS.

Summarizing the Essentials

If therapists want to make space for EMDR in the context of prescriptive play therapy, here are several key considerations:

1. An initial phase of child-centered play helps to establish the egalitarian relationship. It allows the emergence of play, which may already activate the trauma memory network and provide information to the therapist about the child's experiences of the trauma, especially when verbal disclosure may be difficult if not impossible. The therapist allows this material to emerge congruently, without activating the child's defenses.

2. The distancing of the play allows the child to stay more present, even as traumatic intensity emerges, especially when the child has a lot of fear of the memory or the memory is beyond the child's current awareness.

3. Use gradual, play-based introduction of eye movements, BLS, EMDR tools, and vocabulary, initially for installing and noticing positive moments and associated body sensations.

4. Before or after the child-centered play time, introduce more directive activities, which promote state change from distress to calm. In addition, introduce generally developing resources as preparation for approaching the trauma. Play therapy literature, including material referenced below, offers many options compatible with these goals including Theraplay, and other directive approaches (Schaefer & Cangelosi, 2016).

5. Initial EMDR processing of trauma content can occur in the context of the play metaphor using the characters in the story for the initial assessment of the target and beginning reprocessing.

6. Build bridges from the play to the child's own experiences. Use short episodes of EMDR processing with BLS to notice the upsetting body responses or beliefs in a child-responsive but not highly directive way.

7. Parents and caregivers must be involved for support and as a resource.

8. Because it is quite challenging for young children to use the SUDS scale accurately (they tend to report everything as either a 10 or 0), Annie Monaco, LCSWR, an international specialist in trauma resolution methods, promotes the use of caregiver interviews for Phase 8 re-evaluation of targets (Monaco & Beckley-Forest, 2016). It is important to continue to return to processing in small chunks as needed as well as to attending to the shifts in the child's play themes as a clue about

the remaining distress.

Next Steps

One of the compelling reasons for encouraging more cross-training for EMDR trauma therapists as play therapists is the number of children who are the hardest to reach in therapy – those with complex trauma, especially resulting from maltreatment by caregivers. Attachment trauma presents the most challenges in establishing a window in which children are able to digest and accept adaptive information into the memory network and then begin to heal.

Child-centered play therapy approaches are not easy to master, especially with children who have attachment trauma. Its aftermath and attempts to prematurely initiate a directive therapy are often doomed before they begin. Advanced training in play therapy prepares the trauma therapist to stay grounded themselves and hold open the space in which the child can begin to show their wounded self in the play.

Licensed professional counselor and registered play therapy supervisor Lisa Dion electrified the play therapy community in her recent work. She applied recent advances in neurobiology to further develop the idea that the therapist's ability to recognize and resonate – and even exaggerate – the emotional landscape that the child is projecting in the play is the agent of change in play therapy (2018, p 105). Ultimately the attunement of the therapist makes the success of efforts to promote digestion of the trauma with EMDR more likely to succeed, and the dance that is established between therapist and client in play therapy helps keep the child within the neurobiological window of tolerance and not dissociating or overwhelmed.

Those trained in both approaches promote the idea that play therapists benefit from using EMDR therapy as a way to navigate the process of drawing children into first-person trauma work to heal more quickly, even when the child's own nervous system is organized around walling off those experiences.

With increasing numbers of therapists credentialed as both play therapists and EMDR therapists comes the possibility of more training and research focused on the efficacy and benefits of EMDR for our youngest clients. Of the need to offer healing to children as early in life as possible there can be no doubt.

Ann Beckley-Forest (annbeckleyforest.com) is a licensed clinical social worker and registered play therapist.

References and Additional Resources

EMDR and Play Therapy Integration Resources

Banbury, N. (2016). Case study: Play therapy and eye movement desensitization and reprocessing for pediatric single incident posttraumatic stress disorder and developmental regression. International Journal of Play Therapy, Vol 25(3), Jul 2016, 166-174.

Beckley-Forest, A. (2015). Play Therapy and EMDR: A conversation. Play Therapy, 10 (3), 10-14.

McGuinness, V. (2001). Integrating play therapy and EMDR with children. Author House.

Monaco, A., & Beckley-Forest, A. (2016). Teaching Kids to Play EMDR Therapy. Presentation at 2016 EMDR International Association Conference. Audio recording available at https://secure.icohere.com/registration/register.cfm?reg=3731&evt=Beckley-Forest1&t=1547761700319

Sullivan, K. & Thompson, G. (2016). Eye movement desensitization and reprocessing and play therapy. Leggett, E.S. & Boswell, J.N., eds.(2018). Directive play therapy (pp. 81-104). New York, New York: Springer.

EMDR Resources

Adler-Tapia, R. & Settle, C. (2009). Evidence of the efficacy of EMDR with children and adolescents in individual psychotherapy: A review of the research published in peer-reviewed journals. Journal of EMDR Practice and Research, 3(4). 232-247.

Adler-Tapia, R. & Settle, C. (2008). EMDR & the art of psychotherapy with children: Treatment manual and text. NY: Springer Publishing.

Gomez, A. (2012). EMDR Therapy and adjunct approaches with children:

An Example of Bridge Building

A child witness of domestic violence develops a drama in the dollhouse, using superheroes and villain figures. On the surface, it might seem like a fairly simplistic replay of action scenes from superhero movies. However, his persistence in returning to this when supported with child-centered play therapy allows the narrative to unfold and begin to carry meaning and content from his trauma experiences. He eventually expands the story to include a helpless younger sister figure, whom his hero character needs to rescue from bullying by the villain over and over again. Recognition of how this narrative carries the trauma content of standing helpless while his mother is beaten and wishing to be strong enough to protect and defend her, helps to create opportunities to bridge from the play into explicit trauma work. In these moments, using BLS helps his therapist notice the boy's own intolerance of bullying, his physical desire to defend the helpless, and only gradually approaches the explicit memory of wanting to save his mother. The boy's therapist used BLS with foam swords and drums to embody the intensity of this processing.

Complex trauma, attachment and dissociation. NY: Springer Publishing.
Greenwald, R. (1999). EMDR in child and adolescent psychotherapy. Northvale,
NJ: Jason Aronson.
Shapiro, F. (2017). Eye movement desensitization and reprocessing: Basic principles, protocols and procedures, 3rd ed. New York: Guilford.
Thaxton, S. (2007, June). Star wars therapy: Integrating EMDR with children. Presentation at the 8th EMDR Europe Association Conference, Paris, France. A summary is available at https://emdria.omeka.net/items/show/18075

Play Therapy Resources

Baggerly, J. Ray, D. & Bratton, S. (2010). Child centered play therapy research: The evidence base for effective practice. Hoboken, NY: Wiley.
Bratton, S. et al. (2005). The efficacy of play therapy with children: A meta-analytic review of the outcome research. Professional Psychology Research and Practice, 36 (4)37-390.
Dion, L. (2018). Aggression in play therapy. New York: Norton.
Gil, E. (2006). Helping abused and traumatized children: Integrating directive and non-directive approaches. New York: Guilford Press.
Gil, E. (2016). Posttraumatic play in children: What clinicians need to know. New York: Guilford Press.
Goodyear-Brown, P. (2010). Play therapy with traumatized children: A prescriptive approach. Hoboken, New Jersey: Wiley Publishing.
Homeyer, L.E. & Sweeney, D.S (2011). Sandtray therapy: A practical manual (2nd ed). New York: Routledge.
Kottman, T. & Meany-Whalen, , K. (2015). Partners in play: An Adlerian approach to play therapy, 3rd ed. American Counseling Association.
Schaefer, C. and Cangelosi, D. (2016). Essential play therapy techniques: Time-tested approaches, New York: Guilford.


When I approach a child, he inspires in me two sentiments — tenderness for what he is and respect for what he may become.
Louis Pasteur

Flip the Script: Messaging to Heal the Parent-Child Connection

DEBRA WESSELMANN, MS, LIMHP, CATHY SCHWEITZER, MS, LIMHP, STEFANI ARMSTRONG, MS, LIMHP

Children develop their earliest sense of self when they begin seeing themselves as reflected through their parents' eyes. Children develop a positive self-view in supportive and nurturing environments and a poor or unclear sense of self in neglectful and critical environments. Some children are highly sensitive. They take to heart even mild corrections or redirections with a negative interpretation that is not intended by their parents.

When they experience physical affection and emotional attunement, shared pleasure and play, and a safe environment, they see a positive reflection of themselves through their parents' eyes and learn to trust and connect in their future relationships.

Sense of self is often transmitted generationally. Parents who were raised in a highly critical environment may internalize and pass along the same judgements that they heard from their parents, leaving their children with a negative view of themselves. Emotional distance and low self-worth is the norm for parents who experienced emotional deprivation, and they may pass along a poor self-concept and avoidant patterns to their children.

Children whose parents suffer from mental illness, addictions, or PTSD may experience anxiety and fear with their attachment figures, which leads to a negative self-view and mistrust of others. Children who are removed from their parents' care due to maltreatment typically associate relationships with trauma and loss. They may fear closeness and blame themselves for past loss and abuse.

Security and Positive Reflections

Children are happiest and most confident when they have a secure base in their relationship with their parents, from which they can move out into the world and explore, learn, and grow. Attachment security develops when children feel seen and heard by their parents. When parents are emotionally present and sensitive to their children's cues, children learn that they can rely on their parents for comfort. When they experience physical affection and emotional attunement, shared pleasure and play, and a safe environment, they see a positive reflection of themselves through their parents' eyes and learn to trust and connect in their future relationships.

Parents who struggle with providing an emotionally secure and supportive environment are often good, likeable people who happen to have blind spots in relationships due to their own challenging past. Negative dynamics between parents and children can obscure a clinician's view early in therapy. The evidence may emerge incrementally through comments and interactions in the therapy office.

The negative cognition (NC), "I am not good enough," may shift to the positive cognition (PC), "I am good enough," during EMDR therapy. It won't hold if the child returns to a highly critical home. Similarly, the NC, "I am unsafe," may shift to the PC, "I am safe," in the EMDR therapy setting. It won't hold, either, if the child returns to an unsafe household.

Most parents want to do right by their children. Their negative habits are engrained from their own early experiences.

Interactions and Interventions

By integrating EMDR therapy with family therapy, clinicians may observe the interactions and intervene in the family system. They are able to provide parent education and give parents appropriate referrals, thereby replacing negative patterns of interaction with more positive patterns of interaction in the home. EMDR child therapists have an opportunity to stop negative generational attachment patterns in their tracks. Most parents want to do right by their children. Their negative habits are engrained from their own early experiences. When we integrate EMDR with family therapy, we increase the potential for healing the past and bringing positive patterns of interaction to present and future interactions.

A rule of thumb when involving parents in the therapy? Any discussion of the problematic behaviors of children and teens should take place out of earshot of the child or teen client. Therapists may invite parents to share behavioral information privately with

the clinician before the child enters the room or by phone or other electronic communication prior to the session. During private time with parents, the clinician also may provide instruction in integrative parenting methods that encourage parents to shift from a punitive approach to a more patient, attuned approach, incorporating play and intentional experiences of connection (Wesselmann, Schweitzer, & Armstrong, 2014a).

RDI and ARD

Resource Development and Installation (RDI) is one EMDR preparation activity taught in the EMDR basic course (Korn & Leeds, 2002). During RDI, a positive resource or state – such as confidence, assertiveness, or patience – is accessed and installed. One way this is accomplished is through a memory of mastery. When parents are included in the child's therapy, the clinician can utilize them by asking them to describe moments in which they felt proud of the child. The identified positive state is then resourced with slow, bilateral stimulation. This strengthens the positive quality, creates a positive self-view, and strengthens the child's sense of connection with the parent.

Another form of resource development work is Attachment Resource Development (ARD). ARD consists of several EMDR preparation phase activities that utilize parents to create a positive sense of self for the child as seen through the parents' eyes. It also creates an experience of closeness and connection for children with their parents (Wesselmann, Schweitzer, & Armstrong, 2014; Wesselmann, Armstrong, Schweitzer, Potter, & Davidson, 2018). ARD can be utilized with children who have experienced severe attachment trauma. It can also be implemented in families where the environment is either critical or distant or in families affected by medical issues, divorces, deaths, parental depression, or addictions.

One ARD activity is called "Messages of Love." Clinicians should prepare parents for this activity ahead of time. The clinician can explain the activity by saying, "I have a fun activity that is designed to help your child [teen] feel closer to you and give him a positive perception of himself as viewed through your eyes. Your words are powerful because you are the most important influence in your child's life. By increasing your child's sense of secure connection with you and by creating a new, more positive self-view, we can help stabilize your child and provide a secure base from which he [she] can participate in trauma work. Each of these questions are designed to elicit the most positive, loving messages possible for your child to hear."

Questions and Communication

Clinicians ask the parent(s) to reflect upon the following questions. They use these questions to prompt the parent to talk in a way that brings feelings of closeness and positive self-view to the child or teen during the activity:

- What are characteristics that you enjoy about your child/teen?
- What activities do you most enjoy about your child/teen?
- What do you remember about the experience of first falling in love with your child/teen?
- What are your favorite early memories of your child/teen?
- What characteristics do you share with your child/teen?
- What are your hopes and dreams for your future relationship with your child/teen?

The clinician may need to brainstorm answers to the questions with the parent. It may be helpful to type or write down the parent's ideas so the parent may easily reference a simple bulleted list once the session begins. If the parent is too uncomfortable for this activity, individual parent work is recommended. Otherwise, after preparing the parent, the child/teen can be invited into the session.

Ideally, the parent and their child or teen sit close to one another. Some children – even teens – may be willing to snuggle with the parent during the

Debra Wesselmann on Lessons Learned:

There were two mistakes I made as a young therapist. One mistake was bringing parents into the therapy office and allowing the parents to discuss problems with the child in front of the child. This is a very disheartening experience for children or teens and reinforces negative beliefs, such as "I am bad," "I can't do anything right," and "I'm not good enough." Another mistake I made early in my career was assuming that the family system was healthy because the parents were friendly, and I often worked without adequately addressing the parents and the family system.

exercise; others are able to sit nearby. The activity is usually conducted with one parent at a time.

To reduce resistance, the clinician introduces the activity to the child/teen by saying (with humor), "You get to sit back and relax. Mom [Dad] will be doing all the work today!" Clinicians may give a paradoxical instruction: "You can listen, but you don't have to listen. It's entirely up to you." Even when children and teens look like they are not listening, they are listening.

Ask the child's permission to provide bilateral stimulation during the activity. Most children do very well when holding alternating tactile pulsars or placing them in their shoes, socks, or pockets. Other children and teens prefer when clinicians tap them with hands on knees, feet, or hands. Tactile stimulation appears to be most calming and also allows the child to snuggle with the parent and even with eyes closed.

The clinician prompts the parent by asking one of the above questions at a time. As the parent answers, the clinician adds bilateral stimulation. This happens slowly during the parent's dialogue to deepen the positive effect on the child or teen. Bilateral stimulation can be applied throughout the parent's dialogue because the parent is guiding the child's thoughts, which keeps the child in a positive state. Once the parent is finished and before asking the next question, the clinician may say to the child or teen, "Just notice how good it feels to relax here with your mom [dad] today," adding a very slow, short set.

Words and Actions: Tools for Healing

Messages of Love is usually the first Attachment Resource Development activity to implement with children, teens, and their parents, as there is nothing more powerful than positive words spoken by the parent. It is important to let parents know that because the child may be experiencing a closeness that has not been felt in a very long time, the child may go home feeling more vulnerable, more sensitive, and a little fearful that this will be the last time he or she will have such a positive experience of closeness with the parent.

Therefore, it is especially important that, following the activity, clinicians instruct each parent to spend extra positive time during the week with the child or teen. Suggest the parent take additional time – at bedtime, during dinner, after school – to check in with the child, give hugs, and provide positive affirmations. In this way, the parent carries the activity forward into new, positive interactions in the home. The parent's words and actions thus become important and powerful tools for healing.

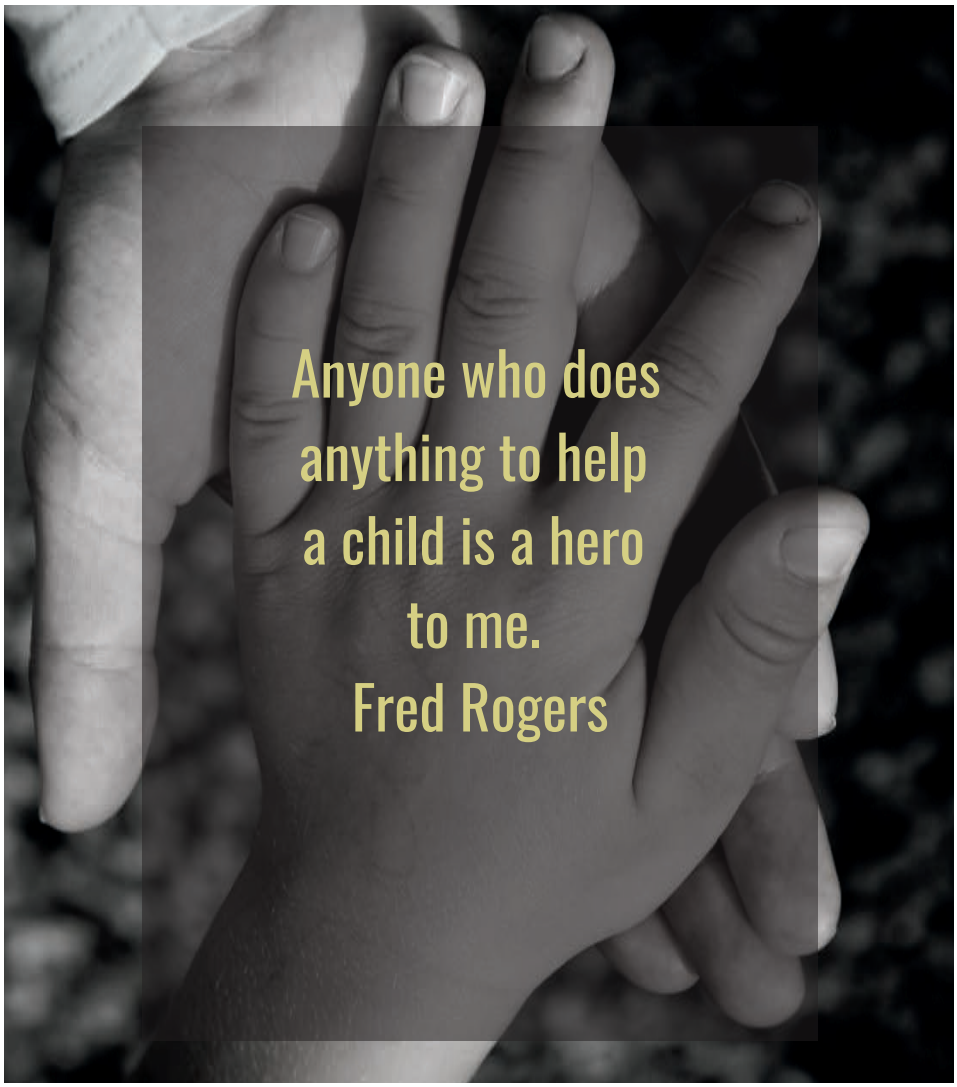
References

Korn, D. L. & Leeds, A. M. (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex post-traumatic stress disorder. Journal of Clinical Psychology, 58, 1465-1487.

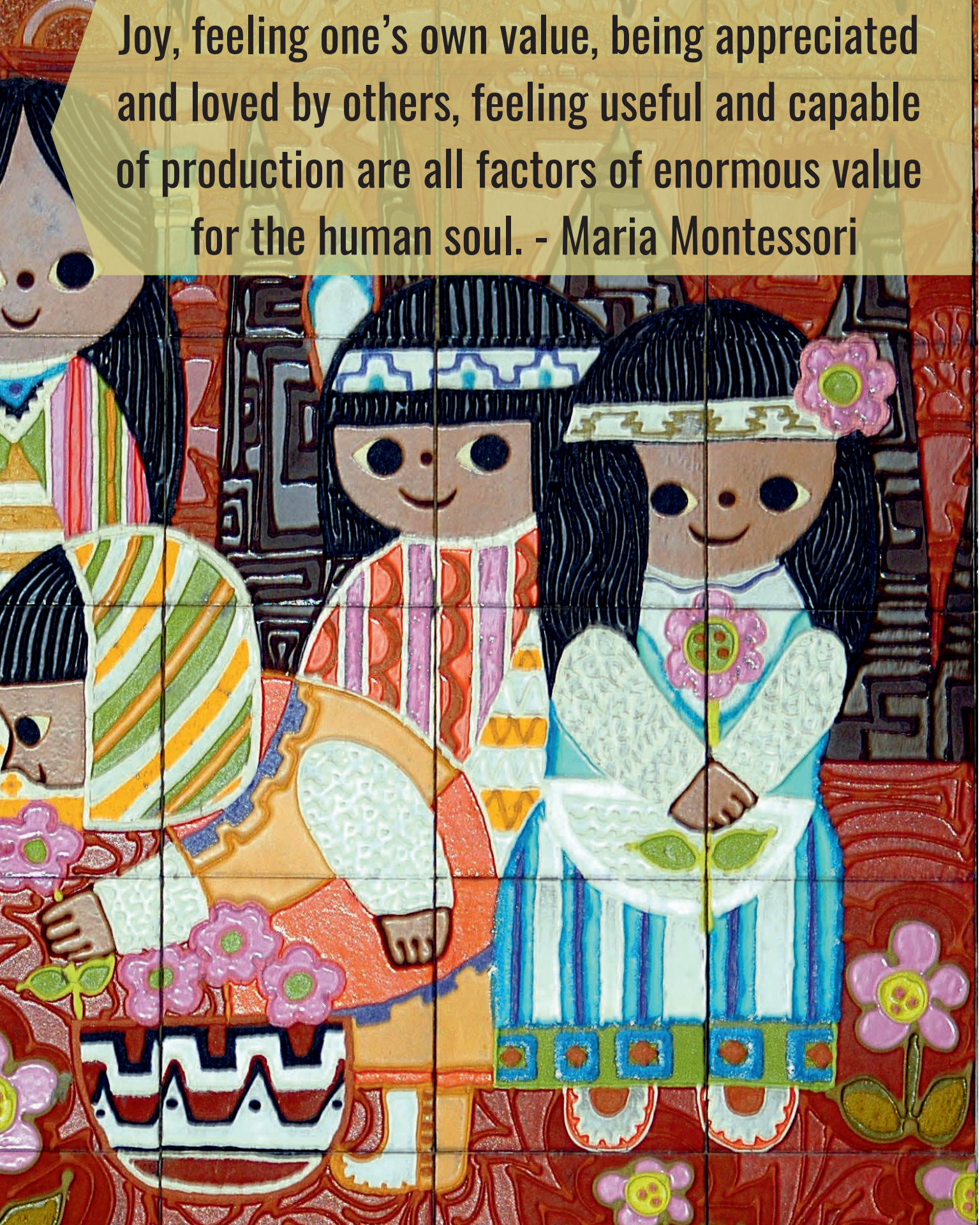
Wesselmann, D., Armstrong, S., Schweitzer, C., Davidson, M., & Potter, A. (2018). An integrative EMDR and family therapy model for treating attachment trauma in children: A case series. Journal of EMDR Practice and Research, 12(4) 196-207.

Wesselmann, D., Schweitzer, C., & Armstrong, S. (2014). Integrative team treatment for attachment trauma: Family therapy and EMDR. New York, NY: W.W. Norton.

Wesselmann, D., Schweitzer, C., & Armstrong, S. (2014a). Integrative parenting: Strategies for raising children affected by attachment trauma. New York, NY: W.W. Norton.



Joy, feeling one's own value, being appreciated and loved by others, feeling useful and capable of production are all factors of enormous value for the human soul. - Maria Montessori



Perspectives In Practice

Navigating the Child Welfare System as an EMDR Therapist

MARSHALL LYLES, LPC-S, LMFT-S, RPT-S, EMDRIA APPROVED CONSULTANT AND ANNE-MARIE BROWN, LCSW, MCAP, CIP, ICADC

EMDR offers hope and healing to trauma victims of all ages and from all walks of life. Some situations, such as treating children in a child welfare system, however, can complicate EMDR treatment. While working within a child welfare system may seem daunting, several characteristics and skills will improve an EMDR clinician's success and therapeutic outcomes.

Install qualities in yourself that facilitate safety.

At the top of the list, clinicians can help themselves by possessing a flexible personality and ability to swiftly adjust to changes. Unfortunately, children in the child welfare system often experience placement disruptions. Case managers may be frequently replaced. Group homes may be inflexible in their scheduling. Court hearings can occur with little notice. While keep boundaries firm is imperative, child welfare can be fluid. As a therapist, adapting to sudden changes is vital and can serve to maintain relationships with those in the dependency system as well as reduce the therapist's anxiety.

Being flexible feels more possible when a clinician possesses a solid foundation in EMDR/AIP theory and treatment planning. Staying flexible may require reviewing EMDR basic training with regularity as well as seeking advanced EMDR continuing education. When therapists are solidly grounded, they can more easily know when to adapt and when to advocate. And flexing with the system keeps therapists less stressed, which then translates as safety to the clients.

Second, tremendous help comes from understanding each player involved in a child welfare case as many roles exist, and each role often has different goals and agendas related to the case. In order to influence the system to be a safer place for the child to heal, the EMDR therapist needs to stay mindful of those differing agendas. For example, while a clinician may need to share concerns related to a child's sexualized behavior with a caregiver or case manager, providing that information to a juvenile probation officer may not always be in the child's best interests. Similarly, although a judge or magistrate may request details about the clinical work accomplished in session, clinicians know that clients need the stories of their traumas guarded. Enough detail should be disclosed to serve the client's needs and meet legal obligations, but boundaries are often easier when pre-contemplated.

Children in the child welfare system have suffered a significant loss of power, which adds to the complexity of their traumas. EMDR clinicians can return some of that power by knowing how to prepare a client when spoken or written disclosures to other adults are required and by being concise with those disclosures. Knowing the roles of the parties involved informs the structure needed for communication, which helps clients feel safer about addressing the hard parts of their stories.

Another ideal quality to possess as an EMDR clinician working within child welfare is the ability to collaborate and communicate without bias. EMDR treatment planning emphasizes the establishment of safe resources. For example, children who have been traumatized prior to, and oftentimes within, the child welfare system typically have quite different lived experiences from their therapists. Part of establishing safety requires the EMDR clinician to maintain awareness of when differences or biases affect felt safety. Then, they must have the ability to admit when a mistake is made, to ask for help or feedback, or refer out for additional services when in the best interest of the client.

Also, bias and judgment can more easily sneak into a therapist's frame of mind when burnout or vicarious traumatization become a factor. Increasing self-compassion aids a therapist in speaking compassion to clients. While often difficult to internally monitor, clients from the child welfare system need their EMDR therapists to care about their trauma, help organize their experiences, and believe in their innate healing potential. These clients do not need their therapists to judge, aloud or silently, the members of the their system. Staying aware of person-of-the-therapist dynamics represents one important aspect of keeping felt safety an option in therapeutic relationships.

Remember the ENTIRE system.

Even when in full possession of strong EMDR clinical skills and relational attributes, clinicians can have difficulty navigating the number of individuals involved in a child welfare case and, oftentimes, they can forget to communicate with key people. In order to provide the most appropriate trauma-informed care, clinicians should familiarize themselves with the child's system, remembering that every case has its own nuances. Here are some questions on which to reflect when considering needed systemic involvement:

- Where are the biological parents? Have their rights been terminated?
- Do they still have any contact with the child? Is it appropriate, or is clinical assistance needed?

Look for registration information in the next issue of the EMDRIA Magazine!

EARN CEs

HEAR THE LATEST RESEARCH

NETWORKING OPPORTUNITIES

2019 EMDRIA CONFERENCE

SEPTEMBER 12-15 | ORANGE COUNTY, CA

- Does a child have both biological family and a foster family?
- Does the foster family hope to adopt?
- Who does the child perceive as their support system?
- Who is named in existing child welfare documents as involved parties?
- Have requirements about goals or communication of therapeutic progress been set by other parties involved?

During the often-experienced chaotic moments of seeing clients from a child welfare system, such as trying to find a private space for a school-based appointment or having a client brought late because multiple individuals were involved in scheduling and transportation, it can become easy to overlook what a healing child is needing from their parenting subsystem. Caregivers, relative or non-relative, living with the child or not, need to know how to speak safety after EMDR appointments. Biological parents are often left out of therapy or updates on the child's progress simply because the child is no longer in their custody. However, being left out detracts from their role as parent and neglects the development of the parents as an eventual safer place. Whatever the reason for child welfare involvement, the clinician's assumption should be that many case outcomes are possible. This means that multiple caregivers may need education and support for continuing the child's healing journey. A village mentality is needed.

Clinicians working with children and families in the child welfare system should also be apprised of the various other systems playing a role for the child or family. Each of these systems may carry different sets of requirements and expectations that could impact therapy. For example, a child with delinquency charges may have a certain treatment plan via juvenile justice. The clinician needs an awareness of these goals so that the child does not seek termination of probation, only to discover that they have not yet completed their court-ordered 12 weeks of anger management.

Even the most effective of EMDR treatment can be problematically impacted when clients feel let down by the adults involved in their case are not communicating – school staff, medical providers, for starters, and the list goes on. Due to the complexity of cases in the child welfare system, much of the EMDR clinician's treatment must consider the other moving parts in the client's life.

Oftentimes, however, key players within both the judiciary and the child welfare system may make clinical recommendations that are not EMDR (or even trauma) informed. As a result, the clinician must establish and maintain their role as clinician. Also, many members of these systems may not be knowledgeable about the help EMDR offers. A therapist needs to perfect an elevator pitch that can be customized

Experience Speaks

Marshall Lyles has been navigating the child welfare system for 18 years as:

- case manager in a child placement facility
- therapist in a residential treatment center with children from his caseload
- contract therapist for Child Protective Services
- child and Family Services Director at a nonprofit that frequently treated foster/adoptive families
- foster and adoptive parent

The lessons Lyles has learned have been accumulating over the course of his career. By 2011, special education in attachment trauma became prominent in his work.

He was fortunate to have leaders who were supportive of his early career, but he had no one to mentor him in the hard lessons he had while navigating a chaotic, though often well-intended, system that was meant to protect the voiceless. He was chronically overwhelmed. His mind began to calm when a trusted colleague said, "Just know your role and only respond from that lane." From this perspective, Lyles found the freedom to be an EMDR therapist who treated the client but was intentionally aware of how the client's involvement in the system interacted with the treatment plan.

Lyles finds a sense of urgency in the message of working within the Foster Care System. "Due to a combination of low-pay, high-stress trauma exposure and frequently sad outcomes, experienced EMDR therapists are less and less open to child welfare agency-related jobs," he says. "I don't judge that because I have walked away for seasons as well. However, we are at crisis levels in some places, and we need to re-introduce experienced EMDR voices into this therapeutic work.

"Anne and I wrote this article as a how-to conversation starter with a focus on being effective and feeling empowered as therapists doing this work. We hope it encourages Go With That readers who are in the middle of the same hard work now."

Lyles believes most everyone is doing the best they can with what they have been given. "Resources are often inadequate, and lack of resources cause people to be hurt," Lyles explains, "but EMDR therapists practice from an approach that encourages us to be regulated and present witnesses of hard things. We can have hard conversations with other professionals in the system, with caregivers of all varieties, and with child clients in clear, honest, and compassionate ways."

Lyles has published on clinical work with adoptive families, presented on trauma work with kids in the system, and is writing a dissertation with related information. This is his first article about navigating the system.

Anne-Marie Brown spent more than 10 years working with adults with co-occurring disorders who had experienced childhood trauma. She has been working as a trauma therapist in the child welfare system for 5 years.

Brown has been collecting tips and pointers on working in child welfare and navigating the child welfare system ever since, which she utilizes in her own practice and shares with the student interns and therapists she supervises. While working with adults with substance use disorder, Brown found significantly high rates of childhood trauma, specifically, sexual abuse and child welfare involvement. She wanted to make more of a difference in reducing adult substance use, so she switched to working with children and began to learn everything she could about child welfare. Many of these lessons learned have been gathered from her own experiences, trial and error, as well as building a close working relationship with her local child welfare agencies.

"Marshall and I believe that the information in this piece on the child welfare system is important to share because many trauma therapists don't have much experience either working with children or working with children in the child welfare system," Brown says. She has seen a great deal of burnout and high turnover in her local child trauma therapist community and, at times, it seems due to a lack of understanding how to navigate this tremendously large and complicated system.

"The most important takeaway I have related to working with the child welfare system," Brown continues, "is to have open and honest communication with everyone involved in a case, even if you disagree."

Brown has facilitated over a dozen workshops and training events on the topics of childhood adversity, sexual abuse, and the treatment of childhood trauma.

for a variety of non-therapeutic professionals. Know what EMDR research offers so that information can be delivered and boundaries can be set with conviction and clarity.

Bring power back to the child.
One of the most important aspects of working with children and families involved in the child welfare system is empowering the child. Too often a child is removed from their caregiver without explanation, moved to a new home, enrolled in a new school, in a new neighborhood, with few belongings, no friends, and little to no contact with their natural support system. How frightening this must be.

One of the clinician's primary roles is to engage the child and establish a sense of safety while developing their locus of control. In the course of an EMDR treatment plan, this likely means returning to Phase 2 with frequency. Be prepared to offer touchstones to security and to handle contaminations in previously-identified safety resources. The process is required for a child who may have less internalized co-regulation and multiple experiences of powerlessness.

In general, children often have minimal control over their lives. However, children in the child welfare system have even less control. Simple tactics to utilize when working with children include keeping them apprised of treatment team outcomes in a developmentally appropriate manner, inquiring what they know about their removal and why they were removed, and validating their emotions.

It is also crucial that clinicians not demonize biological caregivers. They can simply state, "Your mommy and daddy love you so much, but they didn't always know how to be safe mommies and daddies. Sometimes, they didn't know how to keep you safe, and this was scary. A lot of people want to help make sure you and your parents are always safe. It's scary to not know what will happen next, but I'm here with you now, and we can learn to feel safe together."

When reprocessing traumas, trust the child's perspective. Allow the child's mind to lead in the healing. The therapist is tasked with cultivating and continually monitoring the proper relational context but not with making meaning for the client.

Even EMDR clinicians who believe in the "stay of the way of healing" principle can fall into a rescuer stance in the presence of these tragic stories. And, as controversial as it may be to other voices involved in a child welfare case, the client needs choice in the pacing of their EMDR work. The ultimate responsibility is to the client. Safety can be compromised when a therapist becomes overly preoccupied with the expectations of therapeutic outcomes from others.

Closing thoughts
Serving clients involved in the child welfare system can be complicated, overwhelming, and time-consuming. This is true, but it is not the only thing that is true. EMDR offers a perspective on healing traumas that can empower all involved to retake some control in making meaning of the hard moments in life. For those in the system, EMDR therapy can change their lives and the lives of their future generations. The child welfare system needs informed EMDR therapists to help make healing a possibility for far too many children who did not choose to be where life has brought them.

Marshall Lyles, an EMDRIA Approved Consultant, has over 15 years of practice in family and play therapy. He regularly teaches on trauma, expressive therapies, and attachment-informed family work around the globe. Anne-Marie Brown is Director of the Childhood Trauma Response Program at the Center for Child Counseling in South Florida. She is an EMDRIA and TF-CBT Certified Therapist, EMDR Consultant in Training, and Qualified Supervisor for addiction professional candidates.

Authors' Recommended Readings:

Lyles and Brown recommend the following resources to any clinicians seeking additional information on working with children in the child welfare system:

Adler-Tapia, R. (2012). EMDR for the treatment of children in the child welfare system who have been traumatized by abuse and neglect. In A. Rubin, (Ed.), Programs and interventions for maltreated children and families at risk, The clinician's guide to evidence-based practice series (pp. 141-160). Hoboken, N.J.: John Wiley & Sons, Inc.

Eldridge, S. (2005). Twenty things adopted kids wish their adoptive parents knew. New York: Random House.

Greenwald, R. (2015). Treating problem behaviors. Routledge.

McGuinness, V. (2003). Integrating play therapy and EMDR with children. Bloomington, IN: 1st Books Library.

Pickover, S., & Brown, H. (2016). Therapeutic interventions for families and children in the child welfare system. New York: Springer Publishing Company.

Ungar, M. (2005, December). Pathways to resilience among children in child welfare, corrections, mental health and educational settings: Navigation and negotiation. In Child and youth care forum (Vol. 34, No. 6, pp. 423-444). Kluwer Academic Publishers-Human Sciences Press.

Waldon, A. P. (2015). Goodbye Yucky Thoughts and Feelings: An EMDR Workbook for Children. Lulu.com.

Webb, N. B. (2006). Working with traumatized youth in child welfare. New York: Guilford Press.

Wesselmann, D., Schweitzer, C., & Armstrong, S. (2014). Integrative team treatment for attachment trauma in children: Family therapy and EMDR. WW Norton & Company.

http://www.txsystemofcare.org/

Using EMDR Therapy With Suicidal Children and Adolescents

CAROLYN SETTLE, MSW, LCSW

Who can deny the sadness and shock upon hearing the news that a nine-year-old girl died by suicide after suffering racial taunts and bullying (Rosenblatt & Burke, 2018)? How can this happen? She was so young. What were the signs? Did anyone notice?

Child and adolescent therapists try to navigate the complexities of our child and adolescent clients' lives and try to prevent such tragedies. Suicide is the second cause of death for young people between the ages of 10 and 24 years old. And, while death by suicide in younger children is rare, it has increased significantly in the last few years and has increased for adolescents as well. Much has been written about teen suicide, but little is known about younger children and suicide (Centers for Disease Control and Prevention (CDC), 2018), and even less has been written about using EMDR with suicidal children and teenagers.

EMDR therapy is known as an effective therapy for addressing trauma but EMDR therapists are often uncomfortable using it with our suicidal clients. In trainings, EMDR therapists are discouraged to do reprocessing with clients if they are unstable or suicidal (Shapiro, 2018). This leaves EMDR therapists feeling unsure and with few guidelines on how to move forward with high-risk child and adolescent clients.

- What are child therapists to do if a client is chronically suicidal?
- At what point, if ever, can child therapists use EMDR reprocessing with suicidal clients to help stabilize them?
- How do the protocols differ developmentally for children and adolescents?

Defining "Des-pair vs. Re-pair"

When working with suicidal children and teens, it's helpful to have a framework for thinking about the contributing factors influencing suicidal thoughts and behaviors. However, as research shows, the causes for suicidal behavior are complex, which makes it difficult for therapists to determine a standard treatment (Oquendo & Mann, 2008). One helpful model psychiatrist Dr. Mark Goulston (2018) introduced is "des-pair vs. re-pair."

Goulston (2018) states that suicidal thoughts and actions are impacted by a person feeling des-pair, not feeling paired with anything. They are unpaired from the future, themselves, friends, and family, which leads them to feel hope-less, power-less, useless, worth-less and meaning-less. Dr. Goulston talks about these as "lesses." When clients are attached to nothing, they are unmoored, which leads to pain that causes des-pair. He recommends therapists help re-pair the dis-connect by assisting the client to "feel felt"— to feel truly heard and to use the therapeutic relationship for attachment.

EMDR is helpful because it is client-centered and about listening, not advice giving. EMDR addresses the trauma that is impacting the dis-connect and provides young people with the ability to re-connect with themselves and integrate who they are on an emotional and physical level. From an Adaptive Information Processing (AIP) perspective, traumatic events actually un-pair or separate people from their positive memories and experiences and, therefore, to their future. Processing through traumatic events can help children and teens experience their sense of connectedness and assist in re-pairing them with themselves, other people, and their lives in the future.

Treatment Considerations

When considering use of EMDR Therapy with a suicidal client, the two primary courses of action are 1) to stay in the History-Taking and Preparation phases and focus only on stabilization, resourcing, and containment, or 2) to apply all of the above and begin moving forward with target identification and reprocessing.

Often therapists feel the only thing they can do when a client is suicidal is to stabilize the client. Of course, stabilization is necessary. However, there are ways to focus on stabilization and resourcing while still moving forward with processing targets that are contributing to suicidal thoughts and behaviors.

History-Taking

When obtaining the history from suicidal clients and their families, assessing risk is the first order of business: determine safety and evaluate active suicidal thoughts versus passive suicidal thoughts. Active thoughts entail a plan, with an intent and a means to commit the act of suicide. Passive suicidal thoughts are less specific and without a specific plan or intent such as, "If I died tomorrow, I wouldn't care." Both types of suicidal thoughts should be taken seriously. The National Suicide Prevention website (SuicidePreventionLifeline.org) has several helpful tools for lay people and professionals (ASIST, 2018).

Risk assessment should include questions about self-harm and delineate between self-harm and suicidal thoughts and behaviors. Many children and teens exhibit self-harming behav-

iors but are not suicidal. They use self-harm as an unhealthy coping mechanism to deal with emotional pain.

The difference between self-harm and suicidality is that a client with suicide attempt has an intent to die rather than release emotional pain. Children and teens demonstrating both behaviors require careful questioning on the part of the therapist in order to determine appropriate treatment (Mosquera, 2017).

Along with risk assessment, therapists need to conduct a standard psycho-social history. This is an on-going process and may take time as the therapist learns more from the client and the family and as the therapeutic relationship develops (Adler-Tapia & Settle, 2017, p. 29-54).

Throughout history-taking, the EMDR therapist is listening for the following (Settle, 2018a):

- Targets
- Negative/positive cognitions (NC/PC)
- External/internal resources
- Possible roadblocks
  - o avoidance
  - o distractions
  - o intellectualization
  - o minimization
  - o blocking beliefs

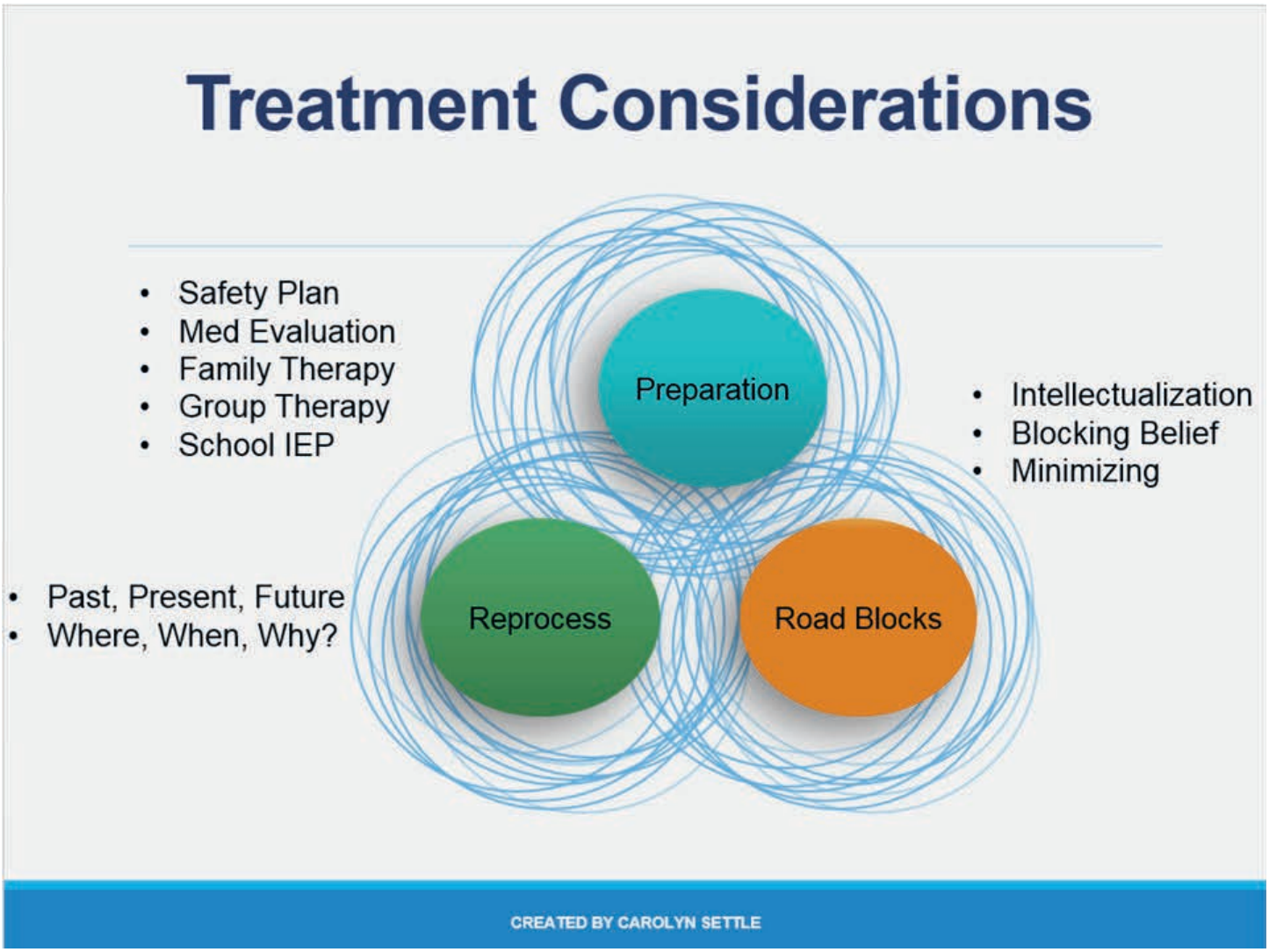
Treatment Planning

When thinking about integrating EMDR into the treatment plan for a suicidal youth, a multi-modal approach is best. This includes treatment options, such as Intensive Out-Patient Program (IOP), Residential Treatment Center (RTC), or out-patient therapy sessions 2-3 times a week. Also, recommended: a medication evaluation, family therapy, and group therapy. When working with challenging cases, experts strongly advise having consultation-supervision and/or having a therapeutic team (Hogberg & Hallstrom, 2008). A multi-modal approach promotes safety and enables the therapist to begin Resource Development Installation (RDI) and reprocessing to assist in stabilizing the client.

Preparation Phase

When working with complex cases, therapists should consider beginning with the Preparation Phase before moving to Target Selection. First, discuss a safety plan with the client and their client's parents or caregivers. This requires removal of anything in the environment that could be used for self-harm.

Parents and caregivers – or the therapeutic team – need to provide



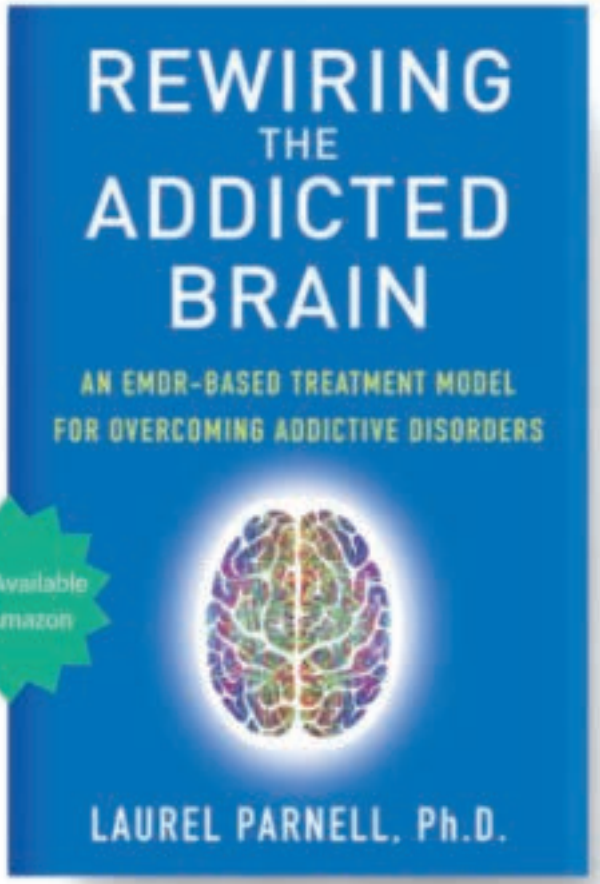
JUST RELEASED

FROM DR. LAUREL PARNELL

In this newly recorded workshop, Dr. Parnell integrates her innovative Attachment-Focused EMDR into the treatment of addiction – one of the most clinically challenging therapeutic issues practitioners face.

She's developed techniques that are brain-wise, resource-based, trauma-informed, and attachment-focused that you can use to help clients break the addiction cycle.

Based on her newest book, *Rewiring the Addicted Brain*, Dr. Parnell will show you how to apply EMDR-based techniques in a holistic, integrative approach to the treatment of addictions and dysfunctional behaviors.



Home study course available with 6 CEs & EMDRIA credits!


Dr. Laurel Parnell

For more information about this workshop, please visit Dr. Parnell's website at DrLaurelParnell.com.

Laurel Parnell, PhD is recognized worldwide as a clinical psychologist, author, consultant and EMDR trainer.

24-hour support and a watchful eye with a suicidal client. Then, the therapist needs to contract with the client to affirm that they will notify parents or caregivers and therapist and/or use the national teen suicide hotline (SuicidePreventionLifeline.org) if they feel like harming themselves. During reprocessing the therapist needs to seek feedback in every session and reinforce this plan with both the client, parents and caregivers as well as with the therapeutic team.

To create a sense of belonging and connection for a child or teen, the therapist should consider involving the parents or caregivers and the school in treatment and have the client participate in group therapy. The therapist can then move forward with addressing anything that is causing the unpairing and dis-connect, such as drug and alcohol abuse, social media and technology addiction, and bullying and abuse at home or school.

Often preteens and teens think the thing that makes them feel connected, such as social media or drugs/alcohol, is the very thing that un-pairs them from themselves and others. For clients with substance abuse and addiction issues, therapists may want to use the addiction protocol developed by EMDR Institute founding member and psychotherapist A. J. Popky, known as the Desensitization of Triggers and Urges (DeTUR) model (Popky, 2005).

Teaching emotional-regulation, grounding, breathing, and mindfulness are all part of stabilization and resourcing. Eye Movement Desensitization (EMD) can be used to assist with emotional regulation. EMD is EMDR originator Francine Shapiro's original protocol for desensitizing a disturbing event by returning to the target after every set of bi-lateral stimulation (BLS) (Shapiro, 2018.). When using EMD for emotional regulation, the emotion needing to be modulated is the target (Settle, 2018b).

Various apps are available for mindfulness, self-soothing, and calming self-harm. The Calm app is a meditation and mindfulness. The Calm Harm app teaches children and adolescents techniques for managing and resisting self-harm. By adding a few sets of BLS to resource the positive experience, these apps can be used for containment of emotions or self-soothing.

Target Selection

The standard three-pronged EMDR protocol, targeting past, present, and future, is an effective treatment approach for processing suicide trauma and assisting stabilization. Not only can therapists target and reprocess the triggering incident(s) that have contributed to their client's suicide attempt, the therapist can separately target their suicidal thoughts, their suicide attempt, and any intrusive suicidal imagery (van Bentum, et al., 2017). These aspects of the suicidal sequelae can be traumatizing to a child or teen and so can the responses and actions or non-responses and non-actions of family, friends, and medical personnel. All of these incidents are possible targets.

Before moving forward in reprocessing suicide targets, consider the client's ability to maintain dual awareness (i.e., "One foot in the present and one in the past") and the strength of the therapeutic relationship. If the client does not have these elements in place, the therapist needs to spend time teaching those skills and building those resources in the Preparation Phase. Or, if the therapist is hesitant in targeting past or present triggers, the therapist can first install a Future Template (FT). A suicidal child or teen sees no future and envisioning a possible positive future and installing an FT is both stabilizing and preparatory for future reprocessing (Greenwald, 1999). An FT encourages resiliency and can be reinforced in every session.

Mapping

One of the most helpful tools for developing a treatment/target selection plan and for getting the child or teen's buy-in to therapy is drawing a Worries and Bothers Map. Children and teens often don't want to directly address issues bringing them into therapy. They don't want to talk about what an adult sees as the problem. The Map is made up of the child or teen's worries, bothers, problems, and issues. Mapping is a creative and effective way to gather information on triggers contributing to their suicidal ideation and/or attempt.

The Map can include descriptions of situations (i.e., "Kids are mean to me."), emotion (i.e., anxiety), sensory issues (i.e., fear of the dark or of medical shots), or disturbing statements/expressions (i.e., "I want to kill this boring life."). Once the child or teen chooses a target from the Map, the therapist is able to explore past, present, and future events related to the target.

For example, the therapist may begin by asking, "When's the first time you remember thinking or feeling 'I'm stupid to not have taken enough pills. I want to kill this boring life'?" Then, inquiring about the current trigger(s), ask, "When is the most recent time you wanted to 'kill this boring life'?" The therapist may then move to the future template by asking, "How would you like your life to be?" The therapist targets and reprocesses the first time the client believed the negative thought, followed by the most recent trigger(s), and then the FT. (Adler-Tapia & Settle, 2017, p.108-112).

Tools for Roadblocks

Working with actively suicidal youth can present unique challenges as the child or teen may be resistant to treatment. They may not want to talk about their struggles, depression, self-harm, or being suicidal. The child or teen may avoid addressing their issues by complaining about everything, minimizing, distracting, or intellectualizing their issues and, underneath it all, they are des-pairing and hopeless. Utilizing creative Cognitive Interweaves and targeting the child or teen's blocking beliefs (BB) are a helpful way to tackle these obstacles.

Blocking Beliefs (BBs)

Common child and teen blocking beliefs a therapist can target directly are:

- "This won't work. You are my fourth therapist."
- "Why am I here (alive)? I don't think I should be here."

- "If things matter, then they hurt."
- "This is not a big deal. I don't want to change."
- "I don't choose to like myself. Hating myself makes me do better."

The Child and Adolescent Blocking Belief Questionnaire assists therapists to quickly identify BBs to reprocess (Adler-Tapia & Settle, 2017). After identifying the BB, the therapist can ask questions to target the past incidents, present triggers and FT (i.e., "When was the first time you thought, 'Hating myself makes me do better'? "When was the most recent?" "How would you like to be next year?").

Cognitive Interweaves

Applying CIs more quickly and more often helps suicidal clients access internal and external resources and facilitates reprocessing (Spector & Kremer, 2009). Here are two creative cognitive interweaves (CIs) that the therapist can use with children and teens:

- "If this were your friend, what would you say?" This CI helps the client connect with their inner wisdom.
- "Let me hold the hope. I'll hold the hope and you do the work." This CI, originated by licensed psychologist Dr. Robbie Adler-Tapia, is surprisingly useful with hopeless children and teens.

Therapists can also use a CI to target the child or teen's inner critic. Their inner critic causes shame, humiliation, and self-loathing. First, the therapist instructs the client to objectify their inner critic by asking, "Who [or what] in your head is saying those mean things to you?" Secondly, the therapist asks the child or teen to draw a picture of their inner critic. Next, the therapist asks the client to identify a friend or a character in a movie or book who has the positive quality that the child or teen needs to challenge the mean, hateful inner critic part. The therapist then installs the positive quality of a friend or character with the RDI protocol. And, finally, while applying BLS, the therapist directs the client to have the positive friend or character dialogue with the inner critic for the purpose of both parts collaborating toward a positive resolution (Settle, 2018c).

Parent and Caregiver Considerations

Working with families of suicidal children and adolescents presents several difficulties. One challenge is when parents or caregivers see suicidal statements as attention seeking behavior. Younger children in particular may verbalize frustrations by saying, "I want to die." This causes the parents or caregivers to not take the child's comments seriously. Even if these are attention-seeking statements, the child is crying for help. The therapist needs to focus on keeping the client safe and teaching the child emotional regulation skills.

Another challenge is when parents and caregivers are uncomfortable talking about suicidality. They are fearful of directly asking if their child or teen is suicidal. They are also uncomfortable with the therapist asking about it directly. Parents and caregivers worry that asking children and teens this question will "give them ideas." And, while children and adolescents can use suicidal statements for attention-seeking or manipulation, studies show the more that people are aware and ask questions about self-harm, the more therapists and families can identify at-risk youth and intervene (ASIST, 2018). Children and teenagers often will tell friends about their suicidal thoughts before telling adults. Educating children, adolescents, parents, caregivers, and society about seeking help when they hear a suicidal statement is an important intervention.

Developmental Considerations

Children under 14 years old are more likely to attempt suicide if they experience:

- cognitive immaturity
- lack of judgement
- impulsivity
- method availability
- high-risk circumstances
    - o poverty
    - o abuse

Understanding and addressing these risks in therapy is a priority. When applying EMDR protocol with younger children, the therapist needs to translate EMDR into child language while

playing, drawing, and using clay, Sandtray and Mapping. (Adler-Tapia & Settle, 2017) The standard EMDR protocol can be used with young children if the therapist has tools to bridge the protocol language.

Adolescents are vulnerable to suicidal acts when they hear of the suicides of

- someone they know
- others in their local area
- suicidal peers
- suicides in the media

Therapists can use EMDR with any of these situations and to process through the trauma of hearing of others suicides. EMDR therapy-processing can be suicide prevention. Both children and teens have a stronger risk of suicide if they struggle with depression and aggressive, disruptive behavior, so an EMDR therapist can keep these vulnerabilities in mind and look for targets that may be related.

Contraindications and Cautions

Contraindications for not proceeding with reprocessing immediately include

- a very recent suicide attempt
- medical instability
- active psychosis
- drug/alcohol abuse (address with EMDR drug/alcohol protocols first)
- moderate to severe dissociation
- a currently abusive environment

The therapist needs to apply resourcing, containment, and safe-place exercises until an appropriate time to move forward with reprocessing. All therapists should seek regular consultation-supervision when treating high risk clients.

Call to Action

EMDR child and adolescent therapists, are on the front line for treating trauma and suicidal behaviors and need to be well-educated in dealing with these issues. EMDR therapy can be used as an early intervention and to help stabilize clients with suicidal thoughts and behaviors through reprocessing. Utilizing resources like the National Suicide Prevention website and the ASIST program can hone therapist's skills when combining them with EMDR therapy.

Working as a team with other clinicians in a multi-modal approach benefits our clients in moving toward health. Most importantly, therapists must take care of themselves when working with complex, high-risk populations.

In private practice in Scottsdale, Arizona, author and international speaker Carolyn Settle (carolynsettle.com) has over 40 years of experience working with children, adolescents, and adults who have experienced abuse, trauma, and loss. She is an EMDRIA-Approved Consultant, an EMDR Institute facilitator, and a trainer for the Trauma Recovery-HAP Program.

References

Adler-Tapia, R. L. & Settle, C. S., (2008) EMDR and the Art of Psychotherapy with Children. New York, NY: Springer Publishing.

Adler-Tapia, R. L. & Settle, C. S., (2017) EMDR and the Art of Psychotherapy with Children: Infants To Adolescents. New York, NY: Springer Publishing.

ASIST, LivingWorks.net (2018). ASIST two-day training. https://www.livingworks.net/programs/asist/

Centers for Disease Control and Prevention (CDC). (2018). Data and Statistics on Children's Mental Health. https://www.cdc.gov/childrensmentalhealth/data.html

Goulston, M. (2018). Why people kill themselves (and others) – Part 1 (of 8) "I'm going to kill myself." Retrieved from https://medium.com/@mgoulston/why-people-kill-themselves-and-others-part-1-of-7-im-going-to-kill-myself-312c35599382

Greenwald, R. (1999). Eye Movement Desensitization Reprocessing (EMDR) in Child and Adolescent Psychotherapy. Lanham, MD: Rowman & Littlefield Publishers, Inc.

Hogberg, G., Hallstrom, T. (2008). Active multimodal psychotherapy in children and adolescents with suicidality: description, evaluation and clinical profile. Clinical Child Psychology and Psychiatry, Vol. 13(3), 435-448.

Mosquera, D. (2017). EMDR therapy for suicidal clients and self-harming behaviors. In EMDR models/theory/techniques/strategies. Presentation at the 3rd EMDR Asia International Conference, Shanghai, China.

Oquendo, M. A., & Mann, J. (2008). Suicidal Behavior: A Developmental Perspective. Psychiatric Clinics of North America, 31(2), xiii-xvi. Popky, A. J. (2005). DeTUR, an Urge Reduction Protocol for Addictions and Dysfunctional Behaviors. In R. Shapiro (Ed.), EMDR Solutions: Pathways to Healing (Chap.7). New York, London: W.W. Norton & Company.

Rosenblatt, K. & Burke, M. (2018, December 11). Alabama 9-year old's family says bullying drove her to suicide, officials are investigating. NBC News. Retrieved from https://www.nbcnews.com/news/us-news/alabama-9-year-old-dies-suicide-after-racist-taunts-bullying-n946411

Settle, C. S., (2018a). "Uh-0h, I'm Stuck…Tools for Blocked Processing" [On-demand webinar]. Retrieved from http://trainingcenter.carolynsettle.com/

Settle, C. S., (2018b). "EMDR with Preteens and Adolescents" [On-demand webinar]. Retrieved from http://trainingcenter.carolynsettle.com/

Settle, C. S., (2018c). Strategies for healing suicidal and high-risk youth in the 21st century, presented at EMDRIA conference.

Shapiro, F. (2018). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures (3rd ed.). New York, NY: Guilford.

Spector, J., & Kremer, S. (2009). Can I use EMDR with clients who report suicidal ideation? Journal of EMDR Practice and Research, 3(2), 107-108.

van Bentum, J., Sijbrandij, M., Huibers, M., Huisman, A., Arntz, A., Holmes, E., & Kerkhof, A. (2017). Treatment of intrusive suicidal imagery using eye movements. International Journal of Environmental Research and Public Health, 14, 714.

Parents As Partners: Enhancing Co-Regulation and Coherence Through An Integration of Play Therapy and EMDR

PARIS GOODYEAR-BROWN, MSSW, LCSW, RPT-S

When a traumatic event occurs, parents can serve as partners in the reprocessing and integration of trauma content. Self-regulation develops as an outgrowth of co-regulation as attuned caregivers raise children. Practitioners of both play therapy and EMDR talk about the work as metaphorically chewing up or digesting trauma (Gomez, 2007; Goodyear-Brown, 2010) and both models are treatments of choice for traumatized children (Adler-Tapia, 2009; Bratton et. al, 2005; Gil, 2012; Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009).

Much as a meal shared with family is more enjoyable than a meal eaten in isolation, the process of anchoring trauma work in the parent/child dyad can provide more enjoyment of the process, a faster sense of felt safety for children, and a deeper sense of shared ownership of the trauma narrative. This ensures that long after the therapist has said goodbye to the family, the story of the scary thing that happened is still held by the most important story keepers: the parents.

Through the thousands of repetitions of this kind of nurturing care, the baby learns that he has a voice and that his voice matters...

Parents who function as comforting attachment figures for their children in day-to-day caregiving situations can be enlisted during the preparation phase of EMDR to bring in vivo experiences of comfort during session that can be further enhanced through BLS. For example, if the smell of a parent's hair as a child is snuggled on her lap is comforting, this experience can be recreated in the session and further installed or expanded through Bilateral Stimulation (BLS). Parents often underestimate the importance of what they can bring to treatment when they are enlisted to operate in two primary roles: co-regulators and story keepers. In models, such as Theraplay (Booth & Jernberg, 2009); Filial Therapy (Ryan, 2005), CPRT (Landreth, Bratton, Kellam, & Blackard, 2006), and TraumaPlay (Goodyear-Brown, 2019), play therapists integrate parents into the work of co-regulation, the provision of structure and nurture, and the holding of the story. There are also EMDR protocols in which parents participate fully in sessions and serve in these roles (Wesselmann et al., 2012; Wesselmann, Schweitzer, & Armstong, 2014).

Recapitulating Natural Rhythms: Combining EMDR and Play Therapy

The newborn comes into the world with many needs and amazing capacities to bring caregivers to them to get needs met. The familiar signal of a baby waking from a nap hungry (a full-body feeling of discomfort for the baby) is intense crying. The parent bounds up the stairs, picks up the baby, rocking and soothing until they hear the sigh that signals relaxation and settling for the baby.

This happens thousands of time over the first year of life. The baby is cold, and the parent warms him. The baby is hungry, and the parent feeds him. Through the thousands of repetitions of this kind of nurturing care, the baby learns that he has a voice and that his voice matters, that he can get needs met, and that his caregivers will help. This baby has a rich neural network of positive associations with caregivers and has been set up, neurobiologically, as scaffolding for eventual self-regulation.

The profound truth of development is that the other must first wholly soothe the baby in order for the baby to eventually internalize an ability to self-soothe and become autonomous. For the first several months, the baby continues to cry as the parent bounds up the steps but, around the six-month mark, the baby hears the parent's footsteps on the stairs and stops crying, anticipating that the soothing is coming. In a healthy caregiving setting, self-regulation develops slowly and after untold repetitions of co-regulation by a caregiver.

What if no one comes when the baby cries? This baby first tries harder and then gives up (Tronick, Als, Adamson, Wise, & Brazelton, 1978). Instead of developing a trust foundation, the baby develops a control foundation. A deep river of anxiety runs beneath the controlling behavior. Tied to it is the unspoken core belief, "I must control everything at all costs because I can't trust anyone else to meet my needs." For the child who spent months or years in an institution, the core belief is even simpler: "I must control everything at all costs or I'll die."

When children have experienced significant neglect, maltreatment or abuse, the foundational task of learning to trust becomes seemingly impos-

sible. Maltreated children face the predicament of having the person to whom they would normally turn for comfort be the source of terror. This powerful paradox can manifest as paralysis, collapse, or dissociation. The somatic encoding of these states can become prime EMDR targets for the perceptive therapist.

Once a child is removed or rescued from that environment, there is no magical re-programming. The unfortunate truth is that trust is hard earned. Trust is built with each new experience of contingently responsive, attuned caregiving between a good enough parent (Winicott, 1960) and the hurt child. EMDR therapists can amplify these effects by capturing moments of connection, delight, and need-meeting between parent and child. Therapists can further enhance these experiences through BLS. Further installation of somatic, emotional, and cognitive experience can lay down new wiring that anticipates enjoyment, comfort, and help.

Surprising are the profound gains a child can make in self-regulation after an EMDR-enhanced experience of playful delight between a parent and child.

Building trust with new attachment figures requires both the installation and enhancement of new experiences and the chewing up of previous trauma. Play therapists commonly refer to this as leaching the emotional toxicity out of an event. Traditional EMDR strategies, such as changing the image in your mind from a full color image to a black-and-white image, serve a similar function. Play therapy activities can lay the groundwork for this new wiring and pack a powerful punch when coupled with EMDR.

The Playroom:
A Neurochemical Boxing Ring

Traumatized children have a great deal of difficulty remaining within their optimal arousal zone. For many traumatized children, excitement and aggression balance neurophysiologically on the head of a pin. Oxytocin, the bonding chemical, and dopamine, sometimes referred to as the joy chemical, can greatly mitigate the cortisol stress hormones that release in massive amounts during their neglect or maltreatment experiences. These neurochemical interactions are sparked interpersonally and begin in the earliest moments of parent/child interactions.

Oxytocin is released in the brains of both mother and baby when baby is nursing and serves to bond them closer together (Uvnäs-Moberg & Francis (2003). Other forms of nurturing touch, humor, and play are powerful mediums for the release of this "delighting-in" hormone. Dopamine is released as a child experiences the "other" delighting in his preciousness.

Surprising are the profound gains a child can make in self-regulation after an EMDR-enhanced experience of playful delight between a parent and child. From an attachment lens, the parent is, in good caregiving systems, the first and most important playmate: the source of comfort, the first mirror in which the child sees himself, the first conveyor of delight in the child. The attuned responsive care of the parent helps the child to rebuild the trust foundation. This happens slowly over time. Nurturing dyadic games can recapitulate the early "delighting-in environment" for children and parents.

A game as simple as having a parent blow a bubble and hold it on the end of a wand while the therapist helps the child wait on the playful cue of a parent to pop it (a seemingly simple circle of communication) can result in numerous therapeutic benefits. The child learns, experientially, that it is OK to give up tiny bits of control to the parent, that following the parent's lead can result in the powerful payoff of making something happen. This is sometimes called the "I Can Do It" effect and builds the traumatized child's positive neural network through new adaptive experiences of shared power with the parent.

Healing neurochemicals are also released during a child's mastery experiences. When a child suddenly is able to surpass the third rung of the monkey bars for the fourth rung, he expe-

riences a sense of mastery. This competency surge often mitigates a child's approach to hard content (Goodyear-Brown, 2019). Using the EMDR lens, the AIP model honors the importance of building positive neural networks for the hurt child prior to attempting to reprocess traumatic content.

Newly Shared Experiences, New Neural Networks

The length of time that a traumatized child may need to spend building neural networks of positive associations to the caregiver may be directly proportional to the amount of betrayal they have experienced by attachment figures to date. The length of time that a traumatized child may need to spend building neural networks of positive associations to the self, believing that they are competent, masterful, and able to handle hard things may be directly proportional to the level of disempowerment they have experienced to date.

Offering newly shared experiences to the dyad that establish or deepen new neural pathways of connection and co-regulation may be the most efficient way to move forward in treatment. To this end, families with adoptive children may spend time in each session playing delighting-in games, while BLS is employed to further install the feelings of joy, safety, or mastery that are being experienced somatically. For example, Nurture House (nurturehouse.org), which this author founded and directs, has a slack line in its backyard space with no additional handhold above. Children wanting to balance on the slack line must risk trusting their caregiver to hold their hands and help them balance. When the child crosses the slackline, and has joyous somatic reinforcement that trusting the caregiver equals success and accomplishment (a rush of oxytocin and or dopamine to the brain as the parent and therapist cheer), the buzzers (placed in the child's shoes or pockets) turn on in slow sets, which further installs the shared somatic experience of trust leading to achievement.

The combined effects of play therapy and EMDR can help concretize the growth of trust in the parent as an upregulator (i.e., clinicians invite dyads to dance together to a boisterous piece of music), and the growth of the child's capacity to rest in the parent by having them experience the parent as a downregulator (i.e., the parent collapses into a bean bag and the child sits on her lap while the parent reads a book to a child). BLS can aid the installation of both states as a child learns how to upregulate and downregulate with his or her parent's guidance in order to remain more often within their window of tolerance while simultaneously stretching it.

Many adoptive children find a state of calm to be scary – it feels too much like the loneliness of the institutional crib. Powerful cognitions, such as "We can rest together" and "My mom will help," begin to mitigate this fear. Therapists do play-based mindfulness work with parent and child and further install with EMDR (Beckley-Forest, 2015; Sullivan & Thompson, 2016).

Sieves and Other Play Sessions

The parents of adoptive children often express bewilderment at their children's inability to hold onto nurturing experiences, to have their own love tanks filled, and to have this lead to a sense of satisfaction or satiation. In my practice at Nurture House, this author keeps a sieve in the playroom and invites the child to play with it in the sand tray. As the child fills the sieve with sand, the sand slowly runs out of the holes. As we talk about ways to offer reinforcement for the holes, so that the sand cannot slip out, we introduce various colors of duct tape. By adding duct tape to hold the sand in, we are then able to compare the use of EMDR to holding in the nurturing experiences with the parent.

Clinicians at Nurture House habitually offer two activities to dyads. In one, parent and child nestle together on the snuggle spot in the upstairs loft while the parent reads the book, The Invisible String. We then offer fishing wire and pipe cleaners, have parent and child create matching pipe cleaner bracelets that we call "Love Connectors," and then reinforce their connectedness through EMDR.

The focus of another session involves the parent reading the book Beautiful Hands, in which many beautiful shapes, such as butterflies and birds, are made using painted hands,

big and small, and individual fingers. Parent and child each paint each other's hands and press them down on paper (which requires gentle touch). Once they create the final, colorful image, the somatic satisfaction of having created something beautiful together is further installed with EMDR as well as any identified positive cognitions, such as "We can make beautiful things when we stick together." (Figures 1 and 2)

Humor, nurture, delight, and gentle touch are all conduits to increase co-regulation and connection and help harness the power of parent as partner. Therapists can further install almost any play-based activity that invites these kinds of interactions through EMDR. Once co-regulation and connection have been enhanced using EMDR, therapists can pursue reprocessing of traumatic events and coherent narrative building.

Case #1: Sally Can't Swallow

Sally's mother calls this therapist in a panic. Sally was having a playdate with a friend when she choked on a piece of food while laughing hard at something her friend had said. Mom's panic stemmed from the fear that this event would become a repeat of Sally's first traumatic choking moment.

Two years prior, Sally had choked on a piece of bacon while strapped down in the car, had been unable to ask for help, had tried to crawl out of the car windows, stopped eating for 10 days, was hospitalized, and was in danger of having a feeding tube put in if she didn't eat. This therapist went to the hospital and worked with Sally there until she began eating again. Once she was released from the hospital, this therapist invited Sally and her mom to create a sandtray about what happened.

Mom set up a hospital bed. Sally chose a beetle to represent herself and placed it on the bed. Sally then chose a wire tornado and a set of chattering teeth. She set up a scene in which the mouth was being swept away in the funnel, representing the vortex of fear that overtook her when she could not speak or breathe. (Figure 3)

Sally had the EMDR buzzies in her shoes and was listening to Mom's narration. She would stop to add or change things in the sand. She eventually went and got the adhesive bandage (bottom, Figure 3), put it on the hospital bed. A short while later, she put it on the beetle itself, and said, "And then she was all better." Immediately after this session, she began eating several foods she had previously avoided.

Fast-forward to present day. Sally is back in the playroom, having severely restricted her eating after the choking incident with her friend, triggering a trauma response in both mom and client. This therapist offers buzzies to Sally, who puts them in her pockets and grabs some veggie straws. As her mom tells the story of what happened, this therapist makes several out loud connections between the client's recent experience and the one two years ago.

As the client eats, and this therapist looks steadily at Mom so that Sally can hear the connections, she blurts out, "I feel like I have a slice in my throat." Another time Sally says, "It smells like the hospital smell in here." Mom helps the therapist with this somatic reprocessing of the earlier event by offering details and staying present as Sally's history keepers. The role of parent as history keeper cannot be overstated.

Case #2: Nurturing Narration to Connect the Dots

As parents are matter-of-factly able to give details or provide structured narratives, behavioral, cognitive, emotional and somatic symptoms can be extinguished quickly. Dots get connected for the child between their unconscious responses and their earlier experiences. Figures 4-6 illustrate this journey for Johnny, an eight-year-old boy adopted as a one-year-old.

Johnny has spent years raging at his mother when she sets any kind of limit (when he perceives that he will not get what he needs). Johnny was 10 months old and very sick in the hospital when Mom got the call to come and get him. After several sessions of nurturing interactions being enhanced with

Figure 1: Painting Hands

Figure 2: Shared Hope

Figure 3: World in Chaos

Figure 4: Johnny naked in the hospital bed

Figure 5: Mom rushing Johnny away from the hospital

Figure 6: Mom and Dad wrapping Johnny in warmth at the foot of their bed

EMDR, Mom tells the story of meeting him for the first time.

She explains that she rushed into a hospital room and saw Johnny, lying under harsh lights on a hospital bed surrounded by doctors and nurses. He only had a diaper on and was without a blanket. She saw that he was cold and uncomfortable and needed to be held. (Mom plays out the scenario in the sand as she narrates.) She scooped him up, warmed him up, rushed home with him, and wrapped him in a blanket that she had bought especially for him.

Johnny has very few words, even when regulated and crouched behind an exercise ball while holding the buzzies. (He uses the ball as a barrier between himself and the sandtray while Mom speaks.) However, when Mom gets to the point in her narration where she describes his first blanky, he leans far forward, becomes actively involved in choosing a toy to be the blanket, and listens as the therapist explains that he may have had to have been very loud to get his needs met in the hospital, but once he got home with Mom and Dad, they were right there and could hear every sound he made and meet every need as soon as he expressed it.

After this session, Johnny was able to regulate himself better when asking for help. When a child's linguistic communication is severely limited, giving words to the scary thing that happened while tying it to current symptoms, through play or expressive arts and accompanied by EMDR, can bring immediate relief. Parents can be powerful partners in the therapeutic process, giving words to the scary thing while providing a comforting anchor for traumatized children.

Paris Goodyear-Brown is a Licensed Clinical Social Worker and Registered Play Therapist-Supervisor specializing in the treatment of traumatized children and their families. She has an international reputation as an innovative and inspiring speaker and has authored numerous books and articles contributing original play theray intervenions to the field.

References

Adler-Tapia, R. L. & Settle, C. (2009). Evidence of the efficacy of EMDR with children and adolescents in individual psychotherapy: A review of the research published in peer reviewed journals. Journal of EMDR Practice and Research, 3(4), 232-247.

Beckley-Forest, A. (2015). Play therapy and EMDR: A conversation. Play Therapy, 10, 10-14.

Booth, P. B., & Jernberg, A. M. (2009). Theraplay: Helping parents and children build better relationships through attachment-based play. John Wiley & Sons.

Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. Professional Psychology: Research and Practice, 36(4), 376.

Gil, E. (2012). The healing power of play: Working with abused children. Guilford Press.

Gomez, A. (2007). Dark Bad Day Go Away. Published by the author.

Gomez, A. (2013). EMDR therapy and adjunct approaches with children: Complex trauma, attachment, and dissociation. New York, NY: Springer Publishing.

Goodyear-Brown, P. (2010). Play therapy with traumatized children: A prescriptive approach. Hoboken, NJ: Wiley Publishing.

Goodyear-Brown, P. (2019). Trauma and play therapy: Helping children heal. New York, NY: Routledge Publishing.

Landreth, G. L., Bratton, S. C., Kellam, T., & Blackard, S. (2006). Child parent relationship therapy (CPRT) treatment manual: A 10-session filial therapy model for training parents. Routledge.

Rodenburg, R., Benjamin, A., de Roos, C., Meijer, A. M., & Stams, G. J. (2009). Efficacy of EMDR in children: A meta-analysis. Clinical Psychology Review, 29(7), 599-606.

Ryan, V. (2005). Filial therapy: Helping children and new carers to form secure attachment relationships. British Journal of Social

Work, 37(4), 643-657.

Shapiro, F. (2001). Eye movement desensitization and reprocessing (EMDR): Basic principles, protocols, and procedures. Guilford Press.

Sullivan, K. & Thompson, G. (2016). Eye Movement Desensitization and Reprocessing and Play Therapy. In E.S. Leggett & J.N. Boswell (Eds.), Directive Play Therapy: Theories and Techniques.

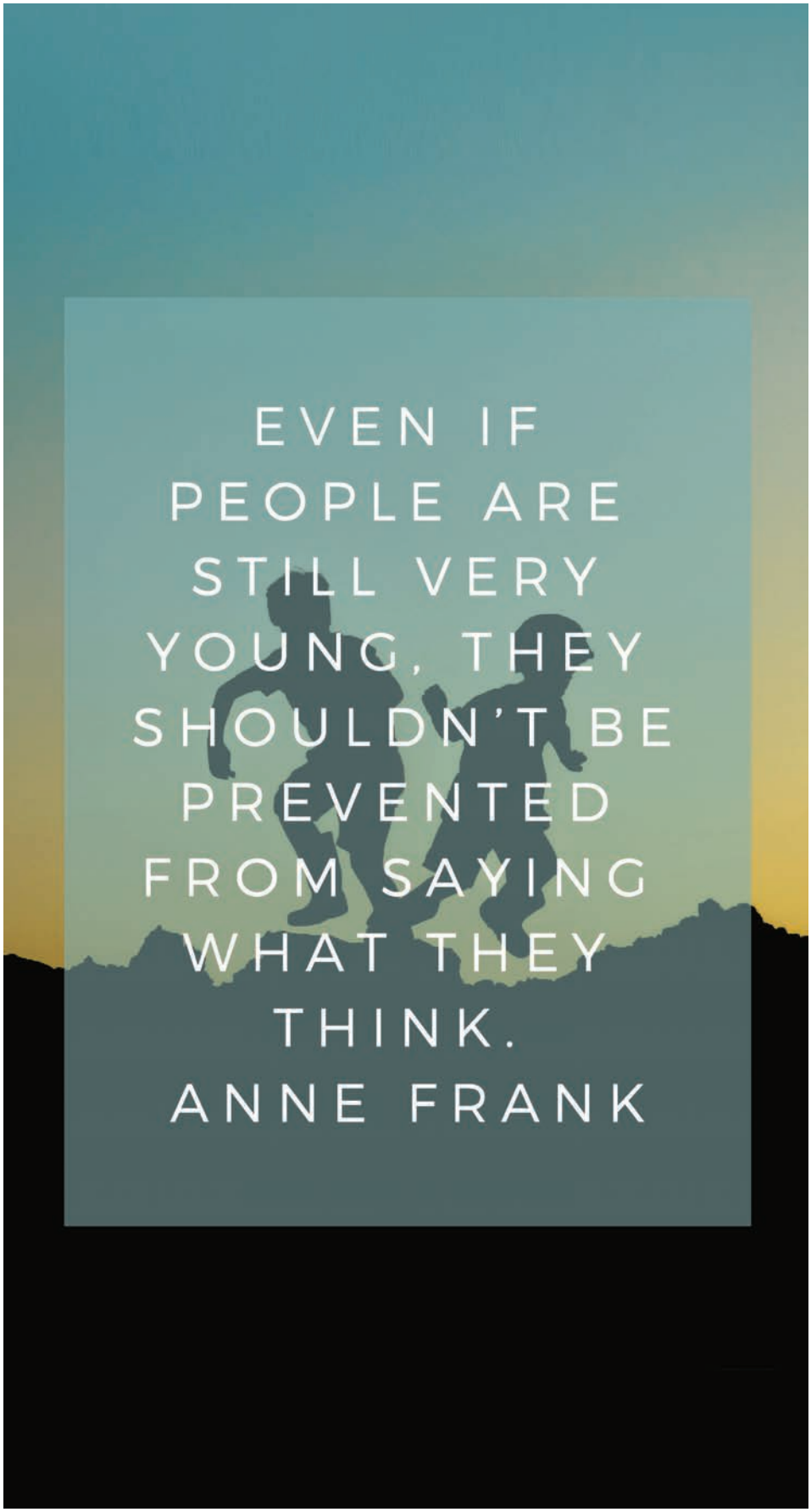
Tronick, E., Als, H., Adamson, L., Wise, S., & Brazelton, T. B. (1978). The infant's response to entrapment between contradictory messages in face-to-face interaction. Pediatrics, 62(3), 403-403.

Uvnäs-Moberg, K., & Francis, R. (2003). The oxytocin factor: Tapping the hormone of calm, love, and healing. Cambridge, MA: Da Capo Press.

Wesselmann, D., Davidson, M., Armstrong, S., Schweitzer, C., Bruckner, D., & Potter, A. E. (2012). EMDR as a treatment for improving attachment status in adults and children. Revue Européenne de Psychologie Appliquée/European Review of Applied Psychology, 62(4), 223-230.

Wesselmann, D., Schweitzer, C., & Armstrong, S. (2014). Integrative team treatment for attachment trauma in children: Family therapy and EMDR. WW Norton & Company.

Winnicott, D. W. (1960). The theory of parent-infant relationships. International Journal of Psychoanalysis, 41, 585-595.



Adults follow paths. Children explore.
Neil Gaiman

The World of Stories and Symbols: The EMDR-Sandtray Protocol

ANA M GOMEZ, MC, LPC

Children are innately drawn to play. Fred Rogers, 1968-2001 PBS television host of "Mister Rogers' Neighborhood," was a vocal advocate of play: "Play allows us a safe distance as we work on what's close to our hearts" (Rogers, 1994, p. 59). Children impacted by developmental trauma may have greater difficulties exploring, accessing, and processing memories of adversity and hardship. As a result, incorporating strategies and adjunct approaches that make EMDR therapy appealing, playful, and developmentally sound may be needed in some cases and imperative in others.

Margaret Lowenfeld, a pioneer of child psychology and play therapy, believed that language is insufficient to express the richness and abundance of human experience (Lowenfeld, 1993). Before children develop the capacity to utilize language, children think in images based on their sensory experiences (Rae, 2013). Child psychiatrist and author Daniel Siegel stated that "… only a part of memory can be translated into the language-based packets of information people use to tell their life stories to others. Learning to be open to many layers of communication is a fundamental part of getting to know another person's life." (1999, p. 43).

Traumatized children and adolescents may become physiologically activated and verbally inhibited when exploring or processing memories of trauma. Brain imaging studies show that when exposed to stimulus reminiscent of the traumatic event, people show increased activation in areas of the right brain involved in emotional processing, while simultaneously showing a decrease in oxygen utilization in the Brocca's Area (Rauch et. al., 1996). Named after physician Paul Brocca. this area of the brain is responsible for attaching words to internal experience. Traumatized children, unable to verbally tell their life stories, become entrenched in the pain, shame, and hurts embedded in such narratives. EMDR clinicians need to be open to other forms of communication in cases when the left verbal brain is silenced by trauma.

EMDR therapy, combined with Sandtray strategies, embraces the language of the right hemisphere and its ability to utilize metaphors, archetypes, symbols, and stories. Representing in the outer world what remains hidden in the inner world begins a profound and integrative dialogue that creates a solid foundation for integration to take place.

Combination of Benefits

EMDR therapy and Sandtray techniques offer a number of opportunities and benefits. Together, the combination:

1. provides distance from the traumatic event so children are able to bring up elements of what is in conflict for them within the context of a story or a world.
2. uses the child's primary language of play.
3. has the potential for accessing implicit memory and early experiences of adversity that the cognitive mind is not yet able to access and as a result, remain below awareness.
4. "physicalizes" what is conflicting and painful, so the inner world can dialogue with the outer world.
5. allows the child and clinician to initiate processing early, even when the child has not fully acknowledged the traumatic events.
6. using sand, figures (i.e., toys and miniatures) and Sandtray procedures helps the child with dissociative tendencies stay present, especially when the child is in constant movement, bringing figures in or out of the tray.
7. engages the right brain, giving children who are verbally constrained by trauma another avenue and channel of expression.
8. offers an entrance into the memories of trauma, even when the child has a phobia of the memory. The worlds and stories the child creates may become targets for processing.

In these cases, the child enters elements of the traumatic event with sufficient distance and without having to own yet what may be otherwise overwhelming. The entrance allows the child to integrate and work through conflicting areas of responsibility, safety, power, and control without becoming emotionally dysregulated or constricted, hypo-aroused, and ultimately shut down.

Creating Worlds of Their Own

The EMDR-Sandtray Protocol (Gomez, 2013, 2014) utilizes elements of Lowenfeld's World Technique (Lowenfeld, 1993), Sandplay, and Sandtray therapy. However, this protocol has its own distinctive techniques and strategies rooted in the Adaptive Information Processing (AIP) model (Shapiro, 2018) and EMDR therapy procedural steps.

Sandtray techniques are used throughout the eight phases of EMDR therapy in various ways depending on the goals of each phase. For instance, during client history and treatment planning, the child is invited to create

a "world," or story, by connecting with all the figures in the therapist's collection and to pick the ones they find attractive. Once the child has selected the figures, they are invited to create a world of their own.

The world becomes the sole creation of the child. The therapist becomes the observer, witness, and companion, learning much from the stories the child creates. Themes emerge that show the child's inner conflicts, emotions, and traumatic events as well as their mechanisms of survival. This is a way of gathering information, not only from the verbal left brain but from the emotionally-connected and symbol-driven right brain.

...the worlds and the stories created in the sand tray constitute a sacred space that the therapist witnesses in a compassionate and honoring manner.

Accessing What Words Fail to Express

The therapist's use of Sandtray strategies increases access to implicit mental processes (Rae, 2013), facilitating the exploration, processing and integration of early experiences of adversity and trauma. Memories encoded when the brain's cognitive and verbal capabilities were not well developed are often times difficult to access. However, the right brain can access what words fail to express much easier.

Therapists may also explore the parent-child relational dynamics by inviting both the parent and the child to create worlds together in the tray – and can learn from observing both caregiver and child. The themes and dynamics they exhibit as they construct stories together can be further utilized in the overall organization of the eight phases of EMDR treatment to support the healing of the child as well as the rebuilding of the caregiving system.

Therapists can explore targets by using directive and non-directive approaches. They may invite children to create a "worry world," or timeline or story, of their lives. The stories and worlds that children create can also provide information on the constellation of experiences that may be conflicting for them, ones that have not reached their conscious mind or remain hidden behind the multiple mechanisms of the child's survival- and trauma-related phobias.

Preparation Phase

During the EMDR-Sandtray protocol, therapists can use preparation strategies and procedures. They invite the child to create the calm-safe place or other resources in the sand tray. Miniatures and figures become the child's companions in expressing and physicalizing the adaptive memory networks held by the child. Children may connect with their inner or outer resources. They then have the figures express and bring into the external world such assets and inner possessions. When working with children lacking experiences of safety, another option is for the child to pick the figures that promote or awaken a felt sense of safety and then construct a safe, happy or calm place with such figures.

Children with developmental trauma present with significant deficits and unmet attachment needs – and those needs may show up organically in the stories created by the child. The clinician may also employ a more directive approach and use protocols such as the Tolerance and Amplification of Positive Affective States (TAPAS) (Gómez, 2013, 2017), which works directly on identifying and fulfilling the longings of the child or the child's wounded parts. In the sand tray, the main character or the figure representing the child can be, among other needs, nurtured, fed, loved, and protected. The process of meeting unmet needs may be initiated in the preparation phase of EMDR treatment and continue throughout the processing phases, where needs continue to be identified and addressed via the use of reparative interweaves (Gomez, 2013).

Affect tolerance is expanded as the therapist invites and encourages the child to "be with" or "sit with" whatever arises in the sand tray. Not only is the child's ability to shift states invigorated, but the child's capacity to fully accept what is unfolding in the present. Affect tolerance build in small increments, for example, as the invited child "spends some time" with the "sadness of the kitty." Therapists can also invite children to install their and their story characters' acts of triumph in the stand tray as well as the mastery experiences of both.

Assessment Phase

Therapists should follow the procedural steps of phase 3 with the main character of the story. Again, if the kitty is the central character, therapists may direct questions about the "mixed-up thought" and the "good thought," etc., toward it, but responses to questions like these come from the child:

- What is the yuckiest part of the world for the kitty?
- What is the mixed-up thought the kitty has about herself when she looks at the yuckiest part of this world?

Still, one mind and one mind only is generating and creating the information, the child's. It is important to highlight that the worlds and the stories created in the sand tray constitute a sacred space that the therapist witnesses in a compassionate and honoring manner. The child understands that in the sand tray anything can happen, giving permission to the child's mind, heart, and body to create whatever reality they wish to construct in the moment.

Processing Phases of EMDR Therapy

During the processing phases, a child may create in the sand tray a world or story about the actual traumatic event and own the cognitive, emotional, and somatic content of this event. However some children, due to their deficits,

defenses, and trauma-related phobias, lack the complete realization that these experiences happened. In these cases, the utilization of Sandtray strategies into EMDR therapy may allow the child the safe distance needed to access what otherwise would be overwhelming.

For example, Sarah, a 7-year-old girl, abandoned and abused during the first five years of life, is unable to verbalize and explicitly tell her story. However, in the sand tray, she creates worlds of kittens that are mistreated by other animals and their caregivers. Sarah is able to express the pain and anger experienced by the kittens – even their loneliness and hurt. Sarah, however, is unable to acknowledge or own her pain and past. The story, characters, and figures in the sand tray allow Sarah to both access elements of her memory networks and stay at a safe distance.

During processing sessions, the story evolves in the way it is meant to while the therapist accompanies the child, providing the safety for the stories to unfold. At times, therapists administer Dual Attentions Stimulus (DAS) as the child is constructing the world and playing with what is developing in the tray. Other times, in a more standard form, the therapist invites the child to engage in DAS and then asks the child to show whatever he or she is noticing in the sand tray and observe any new emerging information.

The child's memory network cannot completely process until the child can own, realize, and embrace the memory. However, the story created in the tray becomes an important stepping stone for the child to eventually realize and access the cognitive, emotional, and somatic components of the memory and to have a full and explicit sense of ownership.

All kinds of interweaves are possible in the sand tray that embrace the various levels of information processing. Therapists invite the body – the somatic component of the experience – as an active participant in the process as well. Some interweaves may go from character to self. In this case, the therapist may inquire:

- "As you see the kitty being chased by the lion, what happens in your body?"
- "Is there something that you find your body is wanting to do as you see the kitty being chased?"

As the child constructs various levels of meaning in the tray, therapists can watch for incredible richness and possibilities related to the stories. Emotions, cognitions, somatic responses may show up. Deep core elements of the child's pain, conflicts, and suffering may come to the surface and physicalize through the tray and the figures. Synchronically, the therapist actively accompanies the child, sometimes in silence and sometimes through the use of attuned interventions and interweaves.

Working with Dissociative Children

The sand, the miniature collection, and the active participation of the child as the creator of the world or story keep the child engaged and present more easily. For children and adolescents with failures of integration, structural dissociation, and a fragmented sense of self, the EMDR-Sandtray protocol offers multiple and abundant opportunities.

Toy figures may be used to symbolize and represent dissociative parts. For older children, adolescents, and adults, therapists may use a version of Fraser's Dissociative Table Technique (Fraser, 2012) in the sand tray. These older clients can create a conference room in the tray and assign participants. "Parts" can pick the figure that will represent each of them. Clients can resource and orient these parts in time and space using Sandtray techniques. Clients can also physicalize and address dynamics and conflicts among dissociative parts. Polarized parts can externalize their differences in the sand tray so they can dialogue and work on resolving their inner conflicts.

It is worth highlighting that the EMDR-Sandtray protocol does not modify the heart and core of EMDR therapy. Instead the combined protocol enriches the therapy for children, adolescents, and adults with complex clinical presentations. We all have a story to tell embedded in a generational story that is ultimately a part of the larger story of humankind. Sandtray techniques are a vehicle through which such stories can unfold within the framework of EMDR therapy.

Author of several books, book chapters, and articles on the use of EMDR therapy with children and adolescents, Ana M Gómez, MC, LPC (www.AnaGomez.org), is founder and director of AGATE Institute in the U.S. (www.AgateInstitute.org), and an EMDR Institute and EMDR-IBA trainer of trainers.

References

Armstrong, S. A. (2008). Sandtray therapy: A humanistic approach. Dallas, TX: Ludic Press.

Badenoch, B. (2008). Being a brain-wise therapist: A practical guide to interpersonal neurobiology. New York: W.W. Norton & Co.

Fraser, G. A. (2003). Fraser's 'Dissociative Table Technique' revisited, revised: A strategy for working with ego states in dissociative disorders and ego-state therapy. Journal of Trauma & Dissociation, 4(4), 5–28.

Gómez, A. M. (2013). EMDR therapy and adjunct approaches with children: Complex trauma, attachment and dissociation. New York: Springer.

Gómez, A.M. (2014). The world of stories and symbols: The EMDR-Sandtray Protocol.

Presentation conducted virtually by the AGATE Institute. Retrieved from https://www.anagomez.org/virtual-world-stories-and-symbols-emdr-sandtray-protocol

Gómez, A.M. (2017). EMDR therapy with children with complex trauma: New frontiers in theory, research, and clinical practice. Keynote presented at the EMDRIA annual conference. Seattle, WA.

Lowenfeld, M. (1993). Understanding children's sandplay: Lowenfeld's world technique. Cambridge, UK: Margaret Lowenfeld Trust.

Rae, R. (2013). Sandtray playing to heal, recover, and grow. New York: Jason Aronson, Inc.Rauch, S.L., van der Kolk, B.A., Fisler, R.E., Alpert, M.N., Orr, S.P., Savage, C.R., Fischman, A.J., Jenike, M.A., & Pitman, R.K. (1996). A symptom provocation study of posttraumatic stress disorder using positron emission tomography and script-driven imagery. Archives or General Psychiatry.

Rogers, F. (1994). You are special. New York, NY: Viking (Penguin Group).

Rae, R. (2013). Sandtray: Playing to heal, recover, and grow. New York: Jason Aronson

Siegel, D. (1999). The developing mind. New York: Guilford Press.

Shapiro, F. (2018). Eye movement desensitization and reprocessing. Basic principles, protocols, and procedures (3rd ed.) New York: Guilford Press.

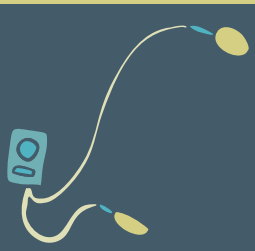
Turner, B. A. (2005). The Handbook of Sandplay Therapy. Cloverdale: Temenos Press.


Let the child be the
scriptwriter, the director and
the actor in her* own play.
Magda Gerber

EMDRIA CHILD AND ADOLESCENT SIG

12 BI-LATERAL OPTIONS WITH CHILDREN

GET CREATIVE!



TAPPERS

PLACE TAPPERS IN CHILDREN'S SHOES OR POCKETS.

HAND TOUCH

THE CHILD RESTS BOTH OF HIS HANDS ON HIS KNEES AND THE THERAPISTS ALTERNATELY TOUCHES THEM. USE ONLY IN SPECIAL CIRCUMSTANCES DUE TO BOUNDARY AND VULNERABILITY ISSUES.

MAGIC WAND

WAND BEING WAVED BACK AND FORTH OR IN CIRCLE 8 TO KEEP THE CHILD'S ATTENTION.

HAND TAPPING

THERAPISTS HOLDS HIS PALM OUT, AND THE CHILD USING ONLY ONE HAND, TAPS THE THERAPISTS PALMS ALTERNATELY. MAKE SURE THE CHILD IS MOVING THEIR EYES. KEEP YOUR HANDS MOVING SO EYES ARE MOVING ALSO.

PUPPETS

PUPPETS BEING WAVED BACK AND FORTH AND HAVE THE CHILD FOLLOW.

FINGER POPPING

HOLD A FIST UP ON EITHER END OF THE CHILD'S VISUAL RANGE, AND POP UP A FINGER ON ALTERNATING HANDS.

DRUM

BEATING A DRUM IN A BI-LATERAL WAY AFTER EACH PROCESSING. ALSO TRY THE CHILD HOLDING THE PUPPET AND THE TAPPERS TOGETHER.

ALTERNATE MOTIONS

CIRCULAR, ELLIPTICAL, DIAGONAL, BUMPY LINE OR A SIDEWAY FIGURE 8.

COMBINE SPEAKERS AND SAND TRAY

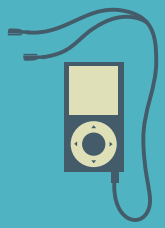
PLAY CD OF BLS THAT ALTERNATES ON SPEAKERS OVER THE SAND TRAY AS THE CHILD PLAYS. YOU CAN CHECK IN WITH THE CHILD WHEN YOU NOTICE SHIFTS OF EMOTION OR THOUGHTFULNESS.

BALL GAMES

HAVE THE CHILD THROW THE BALL BACK AND FORTH FROM ONE HAND OR UP AND DOWN TO THE OTHER AS THEY TALK ABOUT A DISTRESSING TOPIC.

MUSIC WITH TEENS

PURCHASE UNIT THAT TURNS THEIR MUSIC INTO BLS.



COLORING

HAVE A CHILD COLOR FROM ONE SIDE OF THE PAGE TO THE OTHER, WHILE FOLLOWING THEIR OWN HAND MOVEMENTS AND MARKINGS VISUALLY.

Explore More With EMDRIA's Child SIG!

Would you like to engage with a professional group of EMDR therapists who work with children and teens? Join the Child & Adolescent Special Interest Group. The Child & Adolescent SIG gives you access to the discussion board where difficult cases are discussed and trainings, research and other items of interest are posted. As a member you can post your questions and cases to the group!

The Child & Adolescent SIG:

- Promotes professional discussion of clinical cases through the community discussion board utilizing a template for case presentation. Responses are received from a wide range of experienced therapists and provides community brainstorming for dealing with challenging cases.
- Understands the need for quality, low cost training for members, especially those in agency and community nonprofit settings. SIG sponsored trainings range from webinars to face-to-face conferences. The SIG advocates for a Child & Adolescent track of training at the annual conference.
- Offers members a library of free resources that can be downloaded for presentations, finding a consultant, therapeutic interventions, and a bibliography related to EMDR with children and teens.
- Informs members of new protocols and therapeutic interventions, research findings, and encourages research by members.
- Provides a unified voice to the larger EMDRIA community in advocating for needs, concerns, and issues that therapists identify as vital to their practice as EMDR clinicians.
- Holds an annual meeting during the annual EMDRIA conference for communication and networking of members.

To join the Child & Adolescent SIG one must be a member of the EMDR International Association. EMDRIA members can log into the member site, click on the "Get Involved" tab, and choose the Special Interest Group option. On the Special Interest Group page, you will find the Child & Adolescent SIG where you can click on "Join Community" to be added to the Child & Adolescent SIG. Additional questions or concerns can be directed to the board members listed on the SIG page.

Gael Thompson, LPC, Certified EMDR therapist
Executive Chair, Child & Adolescent Special Interest Group
gaelthompsonlpc@gmail.com
832-858-0932

The Research Corner

ANDREW M. LEEDS, PH.D.

This quarter, five new controlled studies of EMDR were published covering pain from rheumatoid arthritis, child victims of domestic violence, homicidally bereaved individuals, treatment-resistant depression, and the health–economic benefits of treating trauma in those with psychosis. Two of these are discussed below. Ghanbari et al (2018) compared EMDR with guided imagery for pain management in patients with rheumatoid arthritis. Minelli et al (2019) studied trauma-focused psychotherapies in treatment-resistant depression. Readers can find abstracts for all five recent RCTs in "Recent Articles on EMDR Therapy."

Other notable recent papers include a pilot study of EMDR treatment of tinnitus (Phillips, 2019), a report on combining Emotionally Focused therapy and EMDR as treatment for the trauma of infidelity (Negash et al., 2018) and two more reports on stabilization with resourcing (and without any trauma memory confrontations) as an effective treatment for complex PTSD in Cambodia (Eichfeld, et al., 2018; Mattheß, et al., 2018). Balancing the expanding breadth of research into EMDR treatment is the continuing work maintaining and deepening the international acceptance of EMDR therapy as a frontline treatment for PTSD. Therefore, we first turn to the publication of the latest PTSD treatment guidelines update from the International Society for Traumatic Stress Studies (ISTSS; 2018).

ISTSS PTSD Prevention and Treatment Guidelines Methodology and Recommendations.

ISTSS last published guidelines on the treatment of PTSD in 2009. At that time, EMDR received the highest possible rating for the treatment of adults (Level A) and a Level B rating for the treatment of children due to the then limited published studies. The third edition of Effective Treatments for PTSD is expected to be published by the end of 2019. In the meantime, ISTSS has published basic recommendations and position papers online "to help practitioners in their work". The committee's approach was based on the question: "For adults with PTSD, do psychological treatments, when compared to treatment as usual, waiting list or no treatment [emphasis added], result in a clinically important reduction of symptoms, improved functioning/quality of life, presence of disorder, or adverse effects?" This means that some published comparison studies on EMDR treatment outcome were excluded unless EMDR therapy was compared to treatment as usual, waiting list or no treatment.

Regarding recommendations for children and adolescents there is good news at last as a result of the increased number of quality studies on EMDR treatment of children and adolescents since 2009. ISTSS gave its highest ("Strong") recommendation to EMDR. "Strong Recommendation - CBT-T (caregiver and child), CBT-T (child), and EMDR are recommended for the treatment of children and adolescents with clinically relevant post-traumatic stress symptoms." The same "Strong" recommendation was given to EMDR therapy for the treatment of adults. "Strong Recommendation - Cognitive Processing Therapy, Cognitive Therapy, EMDR, Individual CBT with a Trauma Focus (undifferentiated), and Prolonged Exposure are recommended for the treatment of adults with PTSD." In addition, EMDR received the strongest level of early intervention treatment recommendations for adults, "Group 512 PM and Single-session EMDR within the first three months of a traumatic event have emerging evidence of efficacy for the prevention and treatment of PTSD symptoms in adults." Some more details are available in the ISTSS members area of their website, but the summary report is available to all online. See the references below for the link.

Ghanbari Nia, et al. (2018). Comparing the effect of eye movement desensitization and reprocessing (EMDR) with guided imagery on pain severity in patients with rheumatoid arthritis.

Clinicians often raise questions about the efficacy of EMDR therapy in the management of chronic pain. The latest controlled study to address this question comes from an open access article by Ghanbari Nia, et al. (2018) of Iran published in the Journal of Pain Research. They examined the relative effectiveness of guided imagery and EMDR compared with an untreated control group regarding pain severity in patients with rheumatoid arthritis in remission. The authors review the challenges most of these patients face in managing arthritic pain and the risks of complications from pain medicines as well as the literature supporting both guided imagery and EMDR therapy as effective treatments to manage chronic pain. However, no previous study compared the relative effectiveness of these two treatment modalities for pain management.

Seventy-five subjects were assigned to one of three conditions. Both EMDR and guided imagery subjects receive six 75-90-minute sessions on consecutive days. Most subjects were married women from 35 to 55 years old. The Rheumatoid Arthritis Pain Scale (RAPS) was used to measure pain severity. Subjects in both EMDR and guided imagery groups had significantly lower scores for pain on four

RAPS subscales post intervention. Those in the EMDR treatment group showed greater reduction of pain than those receiving guided imagery or in the control group (P=0.001). The study has several limitations including small sample size, lack of independent assessors, blind to treatment condition and lack of follow up data. The study nevertheless is noteworthy for adding to the controlled clinical treatment literature on the management of chronic pain with EMDR therapy.

Minelli, et al. (2019). Clinical efficacy of trauma-focused psychotherapies in treatment-resistant depression (TRD) in-patients: A randomized, controlled pilot-study. As discussed in the December 2018 "Research Corner" column, several controlled treatment outcome studies have appeared in recent years examining the effectiveness of EMDR for major depressive disorder (MDD), most recently by Hase, et al. (2018) of the EDEN Project. Until now, no published studies have specifically examined EMDR therapy for treatment resistant depression (TRD). The Italian research team of Minelli et al. (2019) examined whether the two leading trauma-focused forms of psychotherapy could lessen depressive symptoms in those with treatment resistant major depressive disorder. This research was previously presented at the EMDR Europe Conference in Strasbourg, France in 2018 (Minelli, 2018). TRD is defined as a failure to respond to one or more standard antidepressant medications and occurs in up to 30% of patients with MDD. These authors hypothesized that TRD patients with traumatic experiences in their life history might experience reductions in their depressive symptoms with either trauma-focused cognitive-behavioral therapy (TF-CBT) or EMDR therapy.

Participants were randomized to TF-CBT (N=10) or EMDR (N=12) with three individual 60-minute sessions per week over an eight-week period. All subjects continued to receive drug treatment as usual (TAU). Measures included the Montgomery–Åsberg Depression Rating Scale (MADRS), the Beck Depression Inventory II (BDI-II), the Beck Anxiety Inventory (BAI), and the Pittsburgh Sleep Quality Index (PSQI). Measures were taken at baseline, after four weeks of treatment in hospital, after eight weeks of treatment at discharge from the hospital, and four weeks after treatment ended during a follow up visit to the hospital.

The results indicated that EMDR was as effective as TF-CBT in reducing depressive symptoms in TRD patients during hospitalization. Notably however, at follow-up only subjects receiving EMDR maintained their gains on their scores on both the MADRS and the BDI. In addition, the EMDR subjects show a greater improvement on neurovegetative symptoms, which the authors attributed to the reduction of hyperarousal activation among severe TRD patients reported by Pagani et al. (2017).

In their discussion, the authors emphasize the potential benefits of EMDR therapy for TRD patients. "Thus, our study supports the hypothesis that stressful events, in particular child-

hood maltreatment, can be promising targets for innovative interventions offered specifically for MDD patients with a trauma history. Indeed, our data showed that trauma-focused psychotherapy, particularly EMDR when a more rapid response is necessary, could represent a new challenge in the clinical practice setting." (p. 571)

After reviewing various limitations of their study design including the small sample size, they add that "… this study provides a 'proof of principle' that TRD patients benefit from a treatment with evidence-based trauma-focused psychotherapies, such as EMDR and TF-CBT, with a greater and more persistent amelioration in symptomatology after the EMDR intervention." (p. 573)

References

Ghanbari Nia, N., Afrasiabifar, A., & Behnammoghadam, M. (2018). Comparing the effect of eye movement desensitization and reprocessing (EMDR) with guided imagery on pain severity in patients with rheumatoid arthritis. Journal of Pain Research, Volume 11, 2107-2113.

Open Access: http://dx.doi.org/10.2147/jpr.s158981

(2018). ISTSS PTSD Prevention and Treatment Guidelines Methodology and Recommendations.

Open Access: https://www.istss.org/treating-trauma/new-istss-prevention-and-treatment-guidelines.aspx

Minelli, A., Zampieri, E., Sacco, C., Bazzanella, R., Mezzetti, N., Tessari, E., . . . Bortolomasi, M. (2019). Clinical efficacy of trauma-focused psychotherapies in treatment-resistant depression (TRD) in-patients: A randomized, controlled pilot-study. Psychiatry Research, 273, 567-574. doi:10.1016/j.psychres.2019.01.070

Minelli, A. (2018, June). EMDR therapy in treatment resistant depression (TRD) in-patients: Clinical and biomarkers efficacy. Presentation at the 19th EMDR Europe Conference, Strasbourg, France.

Pagani, M., Amann, B. L., Landin-Romero, R., & Carletto, S. (2017). Eye Movement Desensitization and Reprocessing and Slow Wave Sleep: A Putative Mechanism of Action. Front Psychol, 8, 1935. doi:10.3389/fpsyg.2017.01935

Open access: https://doi.org/10.3389/fpsyg.2017.01935

Recent Articles On EMDR

ANDREW M. LEEDS, PH.D.

This regular column appears in each quarterly issue of the EMDRIA Newsletter and the EMDR Europe Newsletter. It lists citations and preprint/reprint information—when available—on all EMDR therapy related journal articles. The listings include reviewed research reports and case studies directly related to EMDR therapy—whether favorable or not—including original studies, review articles and meta-analyses accepted for publication or that have appeared in the previous six months in scholarly journals. Authors and others aware of articles accepted for publication are invited to submit pre-press or reprint information. Listings in this column will exclude: published comments and most letters to the editor, non-peer reviewed articles, non-English articles unless the abstract is in English, dissertations, and conference presentations, as well as books, book chapters, tapes, CDs, and videos. Please send submissions and corrections to: aleeds@theLeeds.net.

Note: a comprehensive database of all EMDR therapy references from journal articles, dissertations, book chapters, and conference presentations is available in The Francine Shapiro Library hosted by the EMDR International Association at: http://emdria.omeka.net/

Previous columns from 2005 to the present are available on the EMDRIA web site at: https://www.emdria.org/page/emdrarticles

For a complete list of Recent Articles with abstracts, please visit www.emdria.org and look under the Resources tab!

Bae, H., Kim, D., Cho, Y., Kim, D., & Kim, S. H. (2018). Add-on Eye Movement Desensitization and Reprocessing (EMDR) Therapy for Adults with Post-traumatic Stress Disorder Who Failed to Respond to Initial Antidepressant Pharmacotherapy. J Korean Med Sci, 33(48), e306.

Daeho Kim, M.D., Department of Psychiatry, College of Medicine, Hanyang University, 222 Wangsimni-ro, Seongdon-gu, Seoul 04763, Korea. E-mail: dkim9289@hanyang.ac.kr

Beer, R. (2018). Efficacy of EMDR Therapy for Children With PTSD: A Review of the Literature. Journal of EMDR Practice and Research, 12(4), 177-195. doi:10.1891/1933-3196.12.4.177

Renée Beer, EMDR Europe Accredited Child & Adolescent Trainer, Gaasterlandstaat 24, 1079 RH Amsterdam, The Netherlands.
E-mail: reneebeer01@gmail.com

Brewerton, T. D. (2018). An Overview of Trauma-Informed Care and Practice for Eating Disorders. Journal of Aggression, Maltreatment & Trauma, 1-18. doi: 10.1080/10926771.2018.1532940

Timothy D. Brewerton Department of Psychiatry & Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina, USA. E-mail: drtimothybrewerton@gmail.com

Cusimano, A. (2018). EMDR in the Treatment of Adolescent Obsessive-Compulsive Disorder: A Case Study. Journal of EMDR Practice and Research, 12(4), 242-254. doi:10.1891/1933-3196.12.4.242

Angela Cusimano, PhD, Palm Beach Family Counseling, LLC, P.O. Box 742584, Boynton Beach, FL 33474. E-mail: angela@pbfamilycounseling.com

de Bont, P. A. J. M., van der Vleugel, B. M., van den Berg, D. P. G., de Roos, C., Lokkerbol, J., Smit, F., . . . van Minnen, A. (2019). Health–economic benefits of treating trauma in psychosis. European Journal of Psychotraumatology, 10(1), 1565032. doi:10.1080/20008198.2018.1565032

Open access: http://dx.doi.org/10.1080/20008198.2018.1565032

Paul A. J. M. de Bont, Postbox 103, Boxmeer 5830 AC, The Netherlands. E-mail: paj.de.bont@ggzoostbrabant.nl

Furuta, M., Horsch, A., Ng, E. S. W., Bick, D., Spain, D., & Sin, J. (2018). Effectiveness of Trauma-Focused Psychological Therapies for Treating Post-traumatic Stress Disorder Symptoms in Women Following Childbirth: A Systematic Review and Meta-Analysis. Front Psychiatry, 9, 591.

Open access: https://www.frontiersin.org/articles/10.3389/fpsyt.2018.00591/full

Marie Furuta, Institute of Higher Education in Healthcare Research, University of Lausanne and Lausanne University Hospital, Lausanne, Switzerland. E-mail: furuta.marie.8r@kyoto-u.ac.jp

Gielkens, E. M. J., Sobczak, S., Rossi, G., Rosowsky, E., & van Alphen, S. J. P. (2018). EMDR as a treatment approach of PTSD complicated by comorbid psychiatric, somatic, and cognitive disorders: A case report of an older woman with a borderline and avoidant personality disorder. Clinical Case Studies, 17(5), 328-347.

Ellen M. J. Gielkens, Clinical Center of Excellence for Older Adults With Personality Disorders, Kloosterkensweg 10 6419 PJ Heerlen, The Netherlands. Email: e.gielkens@mondriaan.eu

Hurn, R., & Barron, I. (2018). The EMDR Integrative Group Treatment Protocol in a Psychosocial Program for Refugee Children: A Qualitative Pilot Study. Journal of EMDR Practice and Research, 12(4), 208-223. doi:10.1891/1933-3196.12.4.208

Ghanbari Nia, N., Afrasiabifar, A., & Behnammoghadam, M. (2018). Comparing the effect of eye movement desensitization and reprocessing (EMDR) with guided imagery on pain severity in patients with rheumatoid arthritis. Journal of Pain Research, Volume 11, 2107-2113.

Open Access: http://dx.doi.org/10.2147/jpr.s158981

Nasrin Ghanbari Nia, Ardashir Afrasiabifar school of nursing, Yasuj University of Medical Sciences, PO Box: 2591994 Yasuj, Iran. E-mail afrasiabifar@yahoo.com

Ibadi, A., Kuntoro, I. A., & Iswardani, T. (2018). The Implementation of Resource Development and Installation (RDI) for an Adolescent with Non-Suicidal Self Injury (NSSI). Proceedings from Proceedings of the 1st International Conference on Intervention and Applied Psychology (ICIAP 2017), Paris, France.

Open access: http://dx.doi.org/10.2991/iciap-17.2018.10

Ike Anggraika Kuntoro, Developmental Psychology Department Faculty of Psychology, Universitas Indonesia Jl. Lkr. Kampus Raya, Depok, Jawa Barat Indonesia, 16424. E-mail: ike.anggraika@ui.ac.id

(2018). ISTSS PTSD Prevention and Treatment Guidelines Methodology and Recommendations.
Open Access:

https://www.istss.org/treating-trauma/new-istss-prevention-and-treatment-guidelines.aspx

Jaberghaderi, N., Rezaei, M., Kolivand, M., & Shokoohi, A. (2019). Effectiveness of Cognitive Behavioral Therapy and Eye Movement Desensitization and Reprocessing in Child Victims of Domestic Violence. Iranian Journal of Psychiatry, 14(1), 67-75.

Online access: http://ijps.tums.ac.ir/index.php/ijps/article/view/1129/836

Nasrin Jaberghaderi, Clinical Psychology Department, School of Medicine, Parastar Blv, Daneshgah street, Tagh Bostan Boulevard, Kermanshah, Iran. Postal Code: 6714415153.
Email: n_jg2004@yahoo.com

Keenan, P., Farrell, D., Keenan, L., & Ingham, C. (2018). Treating Obsessive Compulsive Disorder (OCD) using Eye Movement Desensitisation and Reprocessing (EMDR) Therapy: An Ethno-Phenomenological Case Series. International Journal of Psychotherapy, 22(3), 74-91.

Paul Keenan, Edge Hill University, Faculty of Health and Social Care, Lancashire, UK. E-mail: keenanp@edghill.ac.uk

Lewey, J. H., Smith, C. L., Burcham, B., Saunders, N. L., Elfallal, D., & O'Toole, S. K. (2018). Comparing the Effectiveness of EMDR and TF-CBT for Children and Adolescents: a Meta-Analysis. Journal of Child & Adolescent Trauma, 11(4), 457-472. doi:10.1007/s40653-018-0212-1
Jennifer H. Lewey. E-mail: jenniferhleweyphd@gmail.com

Mattheß, C., Farrell, D., Mattheß, M., Bumke, P., Sodemann, U., & Mattheß, H. (2018). The therapeutic value of trauma stabilisation in the treatment of post-traumatic stress disorder - A Southeast Asian Study. Asian J Psychiatr.

URL: https://www.ncbi.nlm.nih.gov/pubmed/30340966

Cordula Mattheß, University of Worcester, Henwick Grove, Worcester WR2 6AJ I, United Kingdom. E-mail: Cordula.eichfeld@web.de

Minelli, A., Zampieri, E., Sacco, C., Bazzanella, R., Mezzetti, N., Tessari, E., . . . Bortolomasi, M. (2019). Clinical efficacy of trauma-focused psychotherapies in treatment-resistant depression (TRD) in-patients: A randomized, controlled pilot-study. Psychiatry Research, 273, 567-574. doi:10.1016/j.psychres.2019.01.070

Alessandra Minelli, Department of Molecular and Translational Medicine, University of Brescia, Brescia, Italy. E-mail: alessandra.minelli@unibs.it

Negash, S., Carlson, S. H., & Linder, J. N. (2018). Emotionally focused therapy and eye movement desensitization and reprocessing: An integrated treatment to heal the trauma of infidelity. Couple and Family Psychology: Research and Practice. doi:10.1037/cfp0000107

Sesen Negash, Marriage and Family Therapy Program, San Diego State University, 5500 Campanile Drive, San Diego, CA 92181. E-mail: snegash@sdsu.edu

Phillips, J. S., Erskine, S., Moore, T., Nunney, I., & Wright, C. (2019). Eye movement desensitization and reprocessing as a treatment for tinnitus. The Laryngoscope, 00, 1-7. doi:10.1002/lary.27841

John S. Phillips, Department of Otolaryngology, Norfolk and Norwich University Hospital, Colney Lane, Norwich, Norfolk NR4 7UY, United Kingdom. E-mail: john.phillips@mac.com

Rathore, H. E. (2018). Trust and Attunement-Focused EMDR With a Child. Journal of EMDR Practice and Research, 12(4), 255-268. doi:10.1891/1933-3196.12.4.255

Helen E. Rathore, Southern District Health Board, Child, Adolescent, & Family Service, Invercargill, Southland, New Zealand. E-mail: helenmx5@me.com

Rousseau, P.-F., El Khoury-Malhame, M., Reynaud, E., Boukezzi, S., Cancel, A., Zendjidjian, X., . . . Khalfa, S. (2019). Fear extinction learning improvement in PTSD after EMDR therapy: an fMRI study. European Journal of Psychotraumatology, 10(1), 1568132. doi:10.1080/20008198.2019.1568132

Open access: https://doi.org/10.1080/20008198.2019.1568132

Pierre-François Rousseau, Laboratoire de Neurosciences Sensorielles et Cognitives, UMR 7260 CNRS, Fédération 3C, 3 place Victor Hugo, Marseille 13331, France. E-mail: paf.0526@gmail.com

Swimm, L. L. (2018). EMDR Intervention for a 17-Month-Old Child to Treat Attachment Trauma: Clinical Case Presentation. Journal of EMDR Practice and Research, 12(4), 269-281. doi:10.1891/1933-3196.12.4.269

Lindy Lee Swimm, Private Practice, Creative Therapy Services, 16289 Mande Lane, Culpeper, VA 22701. E-mail: lindyswimm@riverbendcounseling.net

van Denderen, M., de Keijser, J., Stewart, R., & Boelen, P. A. (2018). Treating complicated grief and posttraumatic stress in homicidally bereaved individuals: A randomized controlled trial. Clinical Psychology & Psychotherapy, 25(4), 497-508.

Mariëtte van Denderen, Department of Clinical Psychology, University of Groningen, Grote Kruisstraat 2/1, 9712 TS Groningen, The Netherlands. Email: m.van.denderen@fpcvanmesdag.nl

Wesselmann, D., Armstrong, S., Schweitzer, C., Davidson, M., & Potter, A. (2018). An Integrative EMDR and Family Therapy Model for Treating Attachment Trauma in Children: A Case Series. Journal of EMDR Practice and Research, 12(4), 196-207. doi:10.1891/1933-3196.12.4.196

Debra Wesselmann, The Attachment and Trauma Center of Nebraska, 638 N 109th Plaza, Omaha, NE 68154. E-mail: deb@atcnebraska.com

CREATING GLOBAL HEALING, HEALTH & HOPE

5806 Mesa Drive, Suite 360
Austin, TX 78731-3785

VISIT US TODAY AT EMDRIA.ORG