

## Program Overview: Eye Movement Desensitization Reprocessing

Please note that the accuracy of the contents of this inventory cannot be guaranteed until the program director has reviewed this summary for accuracy. Changes may be pending.

Category	Other Therapy Programs	Definitions/ Notes
<b>Program Name</b>	Eye Movement Desensitization Reprocessing	
<b>History of Program</b>	EMDR (Shapiro, 1995) was originally developed to help adult trauma survivors with PTSD process traumatic memories using a manualized series of steps to reactivate memories and correct unhelpful cognitions about the trauma. It involves pairing thoughts, emotions, and bodily sensations with eye movements accompanied by relaxation. Since its inception, it has been expanded and explained using the Adaptive Information Processing (AIP) model, which hypothesizes that successful alleviation of PTSD symptoms requires de-conditioning and unpacking distorted, confusing, and re-triggering memories which are made up of information processed at the time of the stressful event or trauma, including bodily sensations, perceptions, emotions, and cognitions. Shapiro (1989) cautions that EMDR "serves to desensitize the anxiety related to traumatic memories, not [ameliorate] all PTSD-symptomatology and complications."	rank
<b>Description of Program as it Relates to addressing Children's Exposure to Violence</b>	Use and systematic evaluation of EMDR with children and adolescents is fairly new. Adaptations for children have followed the manualized treatment protocol for adults. Adaptations include using age-appropriate strategies (e.g., tapping, inclusion of pictorial examples of emotions and cognitions for illustration, and some homework), modifications to assessments measuring	For specific information about adaptation, see Ahmad, A. & Sundelin-Wahlsten, V. (2008). <i>Applying EMDR on children with PTSD</i> . <i>European Child &amp; Adolescent Psychiatry</i> , 17, 127-132.  Ahmad, A., Larsson, B., & Sundelin-Wahlsten, V., (2007). EMDR treatment for children with PTSD: Results of a randomized controlled trial. <i>Nord Journal of Psychiatry</i> ,

Highlighted text indicates program components are currently under review. Changes may be pending.

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	subjective distress and validity of thoughts related to the traumatic event, allowing caregivers to be present if needed, and adjusting the session time. The effects of EMDR with CEV occur after there has been some time to stabilize and is therefore not intended as a crisis response.	61, 349-354.
<b>Service Continuum</b>	Tertiary/Targeted Intervention	
<b>Primary Exposure Type</b>	Maltreatment (non-specific) Refugee/Immigration/War/ Political	
<b>Target Population</b>	Individual Children/ Youth	
<b>Target Age</b>	Middle Childhood (6 - 12) Adolescence (13-21)	
<b>Target Gender</b>	Both	Most studies of CEV have included females.
<b>Appropriate for Unique Ethnic, Cultural, or Linguistic Populations?</b>	Has this program been used or evaluated with minority, cultural, or linguistically diverse groups? Yes If yes, please indicate: Latino/Hispanic African American Indian American Caucasian	Evaluations of EMDR have been based in the US, Sweden, and Iran.
<b>What Adaptations have been made?</b>	Adaptations for implementation with children have included translation of assessments into Persian.	
<b>Primary Settings</b>	Mental Health Community Agency Mental Health Hospital/Inpatient	
<b>Persons or</b>	Mental Health Providers (e.g., Social	

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<b>Entities in charge of delivering Program</b>	Workers, Therapists)	
<b>Primary Components</b>	Child Individual Therapy Parent Training/Therapy	

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## Resource & Capacity Planning

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<b>Length/ Duration of Program</b>	After baseline assessments, EMDR for children has been delivered in 2-8, 90- or 45-minute sessions.	
<b>Required Materials</b>	Manuals/Program materials Fidelity Checklists/Assessments	Manual for Adults: Shapiro, F., (2001). <i>Eye movement desensitization and reprocessing: Basic principles, protocols and procedures (2nd ed.)</i> . New York: Guilford Press  Protocol Adaptations for children: Ahmad, A. & Sundelin-Wahlsten, V. (2008). <i>Applying EMDR on children with PTSD</i> . <i>European Child &amp; Adolescent Psychiatry</i> , 17, 127-132.
<b>Are Materials Available in Multiple Languages?</b>	Assessments are available in Persian	
<b>Training Requirements</b>	Face-to-face training Supervision Consultation	Standard US training provided by EMDR Institute for practice with adults follows this sequence:  1. Attendance and completion of 2 face-to-face weekend trainings 2. Read manual (Shapiro, 2001) 3. 10 hours of case consultation 4. 10 additional hours of supervised practice (5 before and 5 after second training)
<b>Provider Certification/ Training/ Requirements</b>	Program Specific Certification/Training Required  Special Service Area Required (e.g., Social Worker, Doctor)	

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	Professional Licensure Required	
<b>System or Agency Recommendations for Serving CEV Populations</b>	None Specified	
<b>Costs of Implementation</b>	Training & Consultation: \$765-925/weekend  Materials/Manuals: Est. \$119 for required materials; supplemental materials range from \$14- \$99.	

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## Evidence for CEV

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<b>Evidence for Preventing or Addressing Violence Exposure among Children</b>	<p>In general, when implemented with <i>minimal</i> fidelity this program demonstrates <i>promising (perhaps inconsistent)</i> empirical findings showing reductions in risk of exposure or ameliorating the effects of exposure using a <i>reasonable conceptual framework</i> and a <i>limited evaluation</i> design (single group pre- post-test) that requires causal confirmation using more appropriate experimental techniques.</p>	
<b>Evaluation Design of Studies with Children Exposed to Violence</b>	<p>Randomized, control experimental design Waitlist control (randomized or pseudo randomized)</p> <p>Other (describe): Evaluation data at this point are based on exploratory and pilot studies. Further replication with larger controlled trials is warranted. Limitations include small sample sizes, limited scope of measures and follow-up assessments, and few controlled studies with children with multiple exposure types. It is not known if CEV without PTSD benefit from EMDR.</p>	
<b>Violence Exposure-Related Outcomes</b>	<p><b>Child</b> (Briefly Describe) When compared to children receiving no treatment (waitlist) or standard care (control group), children and adolescents receiving EMDR showed greater improvements in PTSD-related symptoms, depression, and anxiety. Greatest gains appear to be in improving symptoms related to re-experiencing traumatic events. Youth receiving a range of 4-8 sessions of EMDR showed comparable improvements in traumatic stress and behavioral functioning (e.g., antisocial behaviors) to CBT. Initial studies of EMDR show low to moderately large treatment effects, promising levels of acceptability and treatment efficiency based</p>	

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	<p>on number of sessions required to achieve desired outcomes.</p> <p>Child-adjusted adaptations of EMDR suggest that children require more assistance recalling traumatic events, explaining and differentiating between negative feelings and cognitions, and identifying positive alternative thoughts for coping.</p>	
<p><b>Additional Research Information</b></p>	<p><b>Study 1:</b></p> <p><b>Design, Setting, Participants:</b> 60 late adolescent females (ages 16-25; average age of 20) with histories of behavioral dysfunction (running away, sexual promiscuity, substance abuse) and physical or emotional abuse (90%) were randomly assigned to EMDR (n = 30) or Active Listening (placebo/control, n = 30). All participants completed baseline assessments, two 90-minute treatment sessions and post-test assessments. 3-month follow-up assessments included 32 participants who completed phone, mail, or in-person interviews and who had not received additional therapy between post-test and follow-up. Therapists in both groups received training or supervision.</p> <p><b>Outcome Measures:</b></p> <p>Posttraumatic stress disorder and symptomatology, including avoidance and re-experiencing, were assessed using the Posttraumatic Stress Disorder Interview (PTSD-I), a semi-structured interview as used to estimate the presences of a PTSD diagnosis, the Penn Inventory of Posttraumatic Stress Disorder (PENN), and the Impact of Events Scale. (The PTSD-I was adjusted to account for changes in the DSM-III-R and DSM-IV.) Women's levels of depression and anxiety were assessed using the Beck Depression Inventory and the State-Trait Anxiety Inventory (STATE). Young women's beliefs about themselves were obtained using the total positive score on the Tennessee Self-Concept Scale (TSCS). All measures were completed by the participants.</p>	<p><b>Reference Study 1:</b></p> <p>Scheck, M. M., Schaeffer, J. A., &amp; Gillette, C. (1998). Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. <i>Journal of Traumatic Stress, 11 (1),</i></p>

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	<p>3-month follow-up interviews (phone, mail, in-person) included asking about current health and social status, as well as the re-administration of the BECK and IES to examine maintenance of treatment on levels of depression and posttraumatic stress symptoms.</p> <p><b>Study 2:</b>  <b>Design, Setting, Participants:</b>  33 children (6-16 years old) with PTSD were randomly assigned to receive 8 weekly EMDR sessions (n =17) or to a wait-list control group (n = 16). Children had been referred from welfare system, child care &amp; school health care centers, pediatric hospital. The mean number of completed sessions was approximately 6 (range = 1-8 sessions). Children were seen at a child psychiatric outpatient clinic and most had been exposed to violence (maltreatment, witnessing a violent death) and met criteria for another psychological disorder (depression, ADHD, conduct disorder). All children completed baseline assessments and 32 were included in post-test assessments conducted two months after the last session.</p> <p><b>Outcome Measures:</b> Children and/or caregivers were interviewed using a Swedish version of the Diagnostic Interview for children and Adolescents (DICA) and the Posttraumatic stress symptom scale for children (PTSS-C Scale) to assess children's severity of traumatic stress symptoms (i.e., re-experiencing, avoidance, and hyperarousal) as well as non-PTSD-related stress.</p> <p><b>Study 3:</b>  <b>Design, Setting, Participants:</b> 6th grade girls (ages 12-13) were assigned to EMDR (n= 7) and trauma-related CBT (n = 7) by random or quasi-random design. Participants were recruited through several screenings conducted at an urban Iranian school. All had been sexually abused according to data gathered in screening interviews. Participants received up to 12, 45-</p>	<p><b>Study 2:</b> Ahmad, A., Larsson, B., &amp; Sundelin-Wahlsten, V., (2007). EMDR treatment for children with PTSD: Results of a randomized controlled trial. <i>Nord Journal of Psychiatry, 61</i>, 349-354.</p> <p><b>Study 3:</b>  Aberghaderi, N., Greenwald, R., Rubin, A., Dolatabadim, S., &amp; Zand, S. O. (2004). <i>Clinical Psychology and Psychotherapy 11</i>, 358-368.</p>

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	<p>minute sessions of EMDR (4-8 sessions) or CBT (10-12 sessions). Treatment was terminated when subjective levels of distress had reached minimal levels. All participants completed post-test assessments two weeks after the final session. Therapists trained and experienced in the respective therapies delivered the treatment.</p> <p><b>Outcome Measures:</b> Children completed the Child-Report of Post-traumatic Symptoms (CROPS) (translated into Persian and back translated into English) to assess thoughts and feelings related to experiencing traumatic events. Caregivers completed the Parent Report of Post-traumatic Stress (PROPS) and asked to rate the intensity of observable problematic behaviors of their children. Teachers completed the Rutter Teacher Scale to assess children's social, emotional, and behavioral problems in school (e.g., antisocial behaviors, internalizing).</p>	
<p><b>Is this Program an Evidence-Based Practice in other Family/ Youth Development Areas?</b></p>	<p>Yes California Clearing House Rated: Promising</p>	<p><b>Please briefly describe:</b> Several evaluations of EMDR with children have shown promising effects at improving PTSD, anxiety, and depression related to experiencing natural disasters and mass trauma not due to violence.</p>
<p><b>Evaluation Designs of other evaluations</b></p>	<p>Waitlist control (randomized or pseudo randomized) Pre- and post-test (no comparison group) Other (describe): Case Studies</p>	
<p><b>Sources</b></p>	<p>Empirical Studies (peer-reviewed journal) Evaluation Conducted by Program California Clearing House</p>	

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## Selected References

**Website:** <http://www.emdr.com>

Ahmad, A. & Sundelin-Wahlsten, V. (2008). Applying EMDR on children with PTSD. *European Child & Adolescent Psychiatry, 17*, 127-132.

Ahmad, A., Larsson, B., & Sundelin-Wahlsten, V., (2007). EMDR treatment for children with PTSD: Results of a randomized controlled trial. *Nord Journal of Psychiatry, 61*, 349-354.

Scheck, M. M., Schaeffer, J. A., & Gillette, C. (1998). Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. *Journal of Traumatic Stress, 11* (1),25-44.

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Shapiro, F. (1989b). Eye movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 20*, 211-217.