Case Report

Effectiveness of the EMDR Therapy on Specific Phobia in Young Children

Deepak Gupta¹, Neha Gupta², Tripti Choudhary³
Centre for Child & Adolescent Wellbeing (CCAW)¹,³ and
Sir Ganga Ram Hospital (SGRH)³ New Delhi, India
Contact: Deepak Gupta. E-mail:deegupta_2000@yahoo.com

Introduction

Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 2001) is a comprehensive, integrative psychotherapeutic approach. It contains elements of a number of effective psychotherapies in structured protocols that are designed to maximize treatment effects. These include psychodynamic, cognitive behavioural, interpersonal, experiential, and body-centred therapies (Shapiro, 2002). EMDR psychotherapy is an information processing therapy and uses an eight phase approach to address the experiential contributors of a wide range of pathologies. It attends to the past experiences that have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviours and mental health. During treatment, various procedures and protocols are used to address the entire clinical picture. One of the procedural elements is “maintain dual awareness using bilateral stimulation” using bilateral eye movements, tones or taps. During the reprocessing phases the client attends momentarily to past memories, present triggers, or anticipated future experiences while simultaneously focusing on a set of external stimulus. During that time, clients generally experience the emergence of insight, changes in memories, or new associations. The clinician assists the client to focus on appropriate material before initiation of each subsequent set. In our experience EMDR has proved helpful in many childhood psychological and psychiatric disorders (Gupta & Choudhary, 2012, 2013). When applied to children, EMDR can often be used in conjunction with some innovative Cognitive Based therapeutic techniques to elicit better results (Rachamim et al, 2009).

Aim

A case conceptualization highlights sudden onset specific phobia and its treatment through EMDR in children.

Case Conceptualization

A 9 year old, school going boy from Agra, without any preceding history of neurological or psychological disorder experienced a sudden onset of specific phobia in October 2013. Four days prior to coming in for consultation, he developed a severe fear towards a song that was sung by a peer on stage at school. On hearing the song, his instant reaction was breaking into tears and remembering his mother. After that incident, he continued to miss her even though she would be around him at all times. He also refused to go to school for the next few days till his parents decided to bring him to the clinic for consultation.

Session 1

Phase 1: Patient history and treatment planning

The patient was a young, well turned out boy and did not look very apprehensive about being in the clinic. Since he was young, the case history was given by the parents in his presence. He seemed comfortable and safe around his parents. The patient had an elder sister, who was 20 years of age, but wasn’t present during the session.
The case history revealed that, at the age of 8 months, the patient’s mother injured herself and had to stay away from him for a period of 3 to 4 months where she could not play with him or spend much time with him. According to his mother, his childhood fears mainly related to ghosts and the whistle of the pressure cooker. Academically, he did well in school and his parents never received any complaints regarding his behaviour.

On asking the child why his parents have brought him to the clinic, he replied by saying that he was scared ever since he heard ‘the song’ and because he does not want to go to school. He was further asked what parts in the song disturbed him the most. The patient appeared to be afraid of specific stanza’s in the song and those lines made him remember his mother even more. Further, the child was asked whether he wanted this fear to go away and he answered by saying: “I want the song to get out of my head.”

**Phase 2: Preparation Phase**

Being an outstation patient, the child and his family were only in the city for two days. Therefore Phase 2 of the EMDR protocol was conducted on the same day. The Preparation Phase began by installing the ‘safe place’ as a protocol of the EMDR therapy. A safe place or a calm place refers to any experience, place, situation that relieves the patient. This place along with its specific associated features (sounds, smell, and visual imagery) is imagined by the client and strengthened using bilateral stimulation. It can be used any time during the session where the therapist feels it is required to calm the client down. Before beginning the same, the patient’s father was asked to be seated outside and only his mother along with the patient continued to be in the room. The child was asked what he liked doing the most that gave him happiness and joy. He answered by saying that he enjoyed playing cricket and he feels safest in his house. Therefore, he chose his ‘home’ as the calm/safe place. Utilizing the language uniqueland comfortable to the child, the mechanics for Bilateral Stimulation (BLS) was practiced. The child preferred tapping to eye movement. He was asked to think about his calm/safe place and say the word ‘home’ aloud. On asking him how he felt, the child replied by saying that he felt good and comfortable.

Thereafter, the container exercise was introduced to the patient. Containers are used to assist children to close incomplete sessions and as a source for affect management, especially between sessions. The patient was asked to imagine a box of his preferred shape, dimensions, material and colour. At each step he was asked to describe the box and was told the use of the box.

**Phase 3 and 4: Assessment & Desensitization Phase**

Since there weren’t adequate days with the patient for therapy, phase 3 was incorporated in the same session as well. The target memory was chosen as the song since that was the clients triggering traumatic event. Subjective Unit of Disturbance Scale (SUDS) was rated as 9 on a scale of 0 to 10. On identifying where he felt maximum discomfort in his body, the patient replied by saying that he felt uneasy in his chest. On being asked to think about the song along with Bilateral Stimulation (BLS), which in his case was tapping, the child felt extremely ‘scared’. After a few more sets of BLS, the particular song was played aloud, to which he immediately reacted with tears and more anxiety. The song was stopped thereafter and the child was asked to think about his calm/safe place (his ‘home’). Sets of BLS continued and holding onto the feeling that absorbed the client when he thought of the song. Eye movement stimulation replaced tapping after seeking his consent if he was comfortable with the change. The reason for the shift from tapping to eye movement was because he appeared to be dissociating. He was also asked to open his eyes during the stimulation to sustain his attention which was getting diverted.

The child reported positive feelings as sets of BLS went on. He continued to say that he was feeling good. His positivity was further reiterated by telling him that he has control over his mind and which thoughts enter it. This sense of power that was induced into him strengthened more as the therapy went on. EMDR with children has to be innovatively changed according to each child and the situation, specifically in cases of phobias (Jongh et al. 1999). On that note, the child was asked to write the line that disturbs him most in the song, on the whiteboard. As BLS took place, he gradually kept erasing the words on the whiteboard. He felt
better each time he did so. Finally he was asked to report SUD once again. This time it went down from 9 to 1 on the scale. After a few more sets of BLS, the child was asked if he could sing the song aloud. He expressed distress and did not want to sing it. After restoring the calm/safe place to stabilize the child, BLS continued along with assuring the child that he himself has left the song back in the clinic by erasing it on the board and therefore will not take it along with him. Thereafter, the patient spoke out the lyrics of the song that disturbed him most.

Before ending the session, the container exercise was conducted by asking the child to imagine that he locked in all of his thoughts and fears in the box (that he had earlier created) and left the box in the clinic itself.

The session lasted about an hour and ended on a positive response from the child which was that he would resume going to school from the coming Monday. The patients’ mother who was seated in the room all along and his father who was called in at the end were both asked to make the patient enjoy the rest of the day in the city and not bring up anything that related to the fear. As a part of the day’s home task they were told to behave as normally as any other usual day with the patient.

Session 2

The successive session was held on the next day itself as the family was departing for Agra in the evening. In order to slowly prepare the child for reprocessing, the session began with the child singing his favourite song, after which he was asked to shut his eyes and think about the song he sang. He reported SUD of 0 out of 10. Thereafter, the he was asked if he could sing the song he feared. After initial hesitation, he sang the first line thrice. This was being recorded so that he could be shown the recordings later. After a few rounds of BLS, he was made to hear his own recording. He noticed that he was not getting anxious when he heard himself. As sets of BLS continued, the child felt better and reported a SUD of 0. Although he wasn’t ready to hear the original track at that moment, he did say that he will go to school from Monday and that he felt better. The metaphor about the remote control and television were used in the patients’ case where he was told that his thoughts were in his hands just like the remote control of the television is in the hands of the user. When a channel gets disinteresting the user changes it by using the remote control. Just the same way, the patient has the power to control his thoughts and fears.

The 45 minute long session ended on the above positive note with the container exercise as closure, where he was asked to take the empty imaginary box back to his house in Agra. His home task entailed that he would put all his fears and worries in the box and locks it as and when he felt the need to. At the same time, the patient should also empty the box when his fears and thoughts would go away in order to make room for new thoughts.

The child’s parents were emailed the recordings of the song so that they could show him the video to slowly take away the little fear that remained. The sessions were recorded because it was observed that the child responded well to visual assurance (Blackboard erasing of words) and as he was from Agra and would not be able to come in for a follow up. According to the telephonic conversation with the parents of the child, he resumed school from Monday and has been going regularly along with no reports of fear ever since.

Conclusion

The above case substantiates research that now recommends EMDR as a treatment for specific phobias and problems other than PTSD (Marquis, 1991; Shapiro, 1995; Renssen, 1999). The three pronged approach was followed in the case study as well and by the end of the second session, the child was slowly getting desensitized to the stimuli (song) and also getting prepared for future confrontation. However, the breakthrough occurred when the child himself, was ready to go to school from the next day. Ost (1991), conducted research that highlighted how a single treatment session of 2.5 hours is successful in about 90% patients with specific phobias. EMDR works extremely well on children and a Meta-analysis by Rodenburg.et.al, (2009) reiterates the same. There are many advantages of using EMDR therapy with children, adolescents and young people who might be suffering from traumatic experience and phobias. The effectiveness of EMDR can be ascertained after a few sessions itself (rapid onset of improvement). Also, the EMDR is quite a simple
task for the child. Since the changes occur automatically, and in a non volitional manner, it makes it comparatively easier to use with children (child friendly), as compared to other therapies. But at the same time using EMDR with children requires constant innovation and creativity in technique that suits the child and situation well.

References
6. Gupta D, Choudhary T. EMDR Psychotherapy in Children and Adolescents, Poster presented at 7th Congress of Asian Society for Child and Adolescent Psychiatry and Allied Professionals (ASCAPAP), and the 12th Biennial Conference of Indian Association for Child and Adolescent Mental Health (IACAM), New Delhi 2013.