EMDR supervision handout 16.3 **© Tom Cloyd 2013**

The following supervision handout concerns questions that arise from time to time about conducting EMDR with pregnant women and is for clinician information purposes.

Tom Cloyd's article appears in full at:

http://www.tomcloyd.com/lib_iudb06261-PTSD-pregnancy.html

Tom advice can be summarised as follows:

a) He highlights that although in EMDR trainings the clinician is cautioned about using EMDR in pregnancy, postponement may be a more difficult decision to make.

b) Trauma-treatment may cause prenatal and postnatal harm.

Tom details various studies showing that stress hormones produced when experiencing or re-experiencing trauma can have a directly negative effect on a range of issues related to foetal development. In addition post natal characteristics may also be stress-sensitive.

c) However, not treating trauma may cause greater harm.

Tom asks the question: "How does one make a probabilistic calculation to estimate the degree to which psychotherapy, whose duration can only be estimated at best, will stress the mother LESS than leaving her to experience her pre-intervention PTSD symptoms?" Tom admits he doesn't know, or how to know. In the past he has not done any trauma therapy with pregnant clients, however it is an unsatisfying choice of action, but trauma treatment is not our only option, with EMDR.

d) Tom's conclusion is that "Supportive EMDR is safe." The following two strategies are recommended:

i) **Resource Installation** may have a stress-buffering effect. Tom points out that there is anecdotal clinical evidence that people with greater personal resources respond less adversely to trauma symptoms, and he advises that in all cases where Resource Installation might strengthen a pregnant individual, it should be done.

ii) If **Phase 5 Installation (but not Phase 4)** can be used, due to its focus on targets with positive affect. Should EMDR processing take a negative turn, which certainly can happen, processing can be quickly shut down in the standard manner taught in EMDR training and discussed in Shapiro (2001).

e) Choose to minimise harm.

i) Tom reports that many things one might experience during pregnancy have not been proven safe--including riding a bus! He also reports that a medically-trained EMDR clinician who provided EMDR did so whilst the pregnant patient was attached to a foetal monitor. No foetal distress was

observed at all during the EMDR processing. It appears that the use of a foetal monitor seems to be relatively popular in the USA. All cases Tom has heard of, EMDR did not appear to distress the foetus and he is unaware of any reports of adverse outcomes from use of EMDR during pregnancy.

ii) If EMDR *does* proceed during pregnancy, Tom advises it would certainly seem wise to give attention to the practices EMDR clinicians make use of to keep the client from re-experiencing the trauma **excessively** (e.g. emotional containment metaphors such as Shapiro's 'train', viewing the trauma as if on a television, Safe Place exercise, and so on).

iii) Tom reports: "If, say, two or three sessions of EMDR would bring an end to flashbacks that occur even once a week, there would be a clear net gain, over the period of a full-term pregnancy. Thus use of EMDR would seem to be indicated and easily defensible. If EMDR has no effect, then the net increase in trauma-related hormones would still be very small, over a nine month pregnancy." He also highlights the 'highly undesirable risks' to pregnancy such as drug overdoses: Tom reports a number of clinicians have used EMDR with such pregnant clients, and there has been a clear reduction in frequency of high-risk behaviour(s)…"

f) <u>EMDR can reduce pregnancy-related anxiety</u>

Many clinicians have appreciated the usefulness of EMDR in addressing anticipatory anxiety experienced during pregnancy. This would include such things as concerns about birthing itself, about the health of the newborn, about birth defects, about the development of the child, about the reaction of other children in the family to the child, about the adequacy of the husband to father, about the mother's own maternal skills, and so on. Not only might EMDR resolve these anxieties, it could also be used to install positive expectations. Tom concludes the net result being that an overall decrease in the anxiety experienced by the pregnant mother, and physical concomitants that might adversely affect the foetus, are likely to prove beneficial.

Conclusion: Taking all of the above into consideration:

a) It is clear that safety, as one would expect, is paramount

b) EMDR can be used to be supportive

c) There can be no 'one-size fits all' guideline

d) Each case should be considered on its merits

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