Improving Lives:
EMDR Psychotherapy for People with I/DD Experiencing Trauma and Distress

EMDR Humanitarian Assistance Programs, Inc. (EMDR HAP)  www.emdrhap.org

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EMDR (HAP)  
Humanitarian Assistance Programs

- Mission is to build capacity for effective treatment of traumatic stress disorders in underserved communities anywhere in the world
- People with I/DD are an underserved community
- The I/DD community can benefit by working with practitioners who specialize in treating trauma with EMDR
• Trauma is a subjective experience interpreted through the lens of the individual
• Symptoms of psychiatric disorders are often expressed differently in persons with ID
• Events not typically considered traumatic can be traumatic for certain people with ID
• Individuals with ID are more likely to experience traumatic events, especially sexual and physical abuse
• Practitioners often attribute severe behavior disturbances to the disability (overshadowing)
Assessment of Trauma/PTSD in people with ID

- Important and often under diagnosed – PTSD is included in a chapter in the DM-ID (Fletcher et al 2007)
- PTSD symptoms in adults often appear more like those in children when lower intellectual levels are present
- Self-injurious behaviors can be a symptom of PTSD in people with a lower level of ID
- Caregivers often don’t recognize or understand symptoms associated with PTSD
- Trauma/PTSD can co-occur with
  - Autism
  - ADHD
  - Depression
  - Phobias
  - General anxiety disorder
Recognizing the trauma history

- Paul, age 55, mild to moderate ID
- Diagnosis of bipolar disorder, generalized anxiety disorder
- Labeled as a sex offender because he stares at children and talks about not wanting to touch children
- Was sexually abused by his father as a child
- Required line of sight supervision at all times; inside his own home and in the community
- Attended a sex offenders support group, but did not receive individual therapy to treat his trauma
What if Paul’s symptoms had been treated with EMDR?
- Could we have avoided the label as a sex offender?
- Could the “line of sight” staffing been lifted – allowing him more freedom and privacy?
- Could we have saved him from his intense anxiety and depression?
- Could he have had more self-esteem?
- Could he have been happier?
- Could his quality of life have been improved?
- Could the cost of his support been lowered?
What is trauma?

- An actual or **perceived** threat to the safety/integrity of self or others.
- Intense fear or helplessness in response to an event. Research suggests powerless in the face of an event often is what cause the client to experience the event as traumatic.
- Stress that exceeds the normal coping capacity for the person. It is the capacity to manage perceived threat that is compromised with individuals with I/DD.
- Can be a major event or a series of distressing life events over time, which can lead to a diagnosis of Type I or Type II PTSD.
A major trauma could be:

- Sexual Assault/Physical Assault
- Natural or Manmade Disasters
- Catastrophic Illness
- Loss of a loved one
- Humiliation
- Bullying
- Moving to a new home or significant change
- Deprivation and powerlessness to act on one’s own behalf
“ Ordinary” life event trauma could be:

- Feeling different
- Not being accepted
- Not being able to do what others do
- Knowing that one has a disability and is “different” than others
- Not being listened to
- Being misunderstood
- Failing at a task
- Getting confused and overwhelmed
Symptoms of trauma/PTSD in people with I/DD include (but not limited to):

- New, disruptive behaviors that appear suddenly
- Reoccurrence of previously displayed disruptive behaviors, or an increase in frequency of these behaviors
- Attention seeking behaviors
- Self-injury
- Inappropriate sexual behavior
- A decline in skill development where there were prior gains including self care, sleeping, and eating
Additional symptoms of trauma and PTSD in people with I/DD include:

- New mental health symptoms including depression & anxiety
- Questions about sexuality or reproduction that seem to come from nowhere
- Difficulty modulating anger
- Excessive fear of others, worries about which staff is working on what shift
- Irritability and new expression of dysregulation
- Onset of bedwetting or bowel accidents
- Increased difficulty transitioning
And even more symptoms of trauma/PTSD in people with I/DD:

- Changes in sleep and eating habits – increase or decrease of sleep and eating
- Lack of energy and enthusiasm for doing things typically enjoyed; social isolation
- Irritability, appearance of being distracted, confused, or preoccupied
- Nightmares and flashbacks
- Hyperactivity
- Headaches, stomachaches, back pain and other somatic complaints
Important Considerations

- Between 60% and 100% (depending on sample) of individuals with developmental disabilities have experienced trauma, usually repeated incidents of abuse (Sobsey, 1994).

- Behavior support plans are often used to address symptoms of trauma and PTSD.
About all these symptoms...

- Assessment of attachment and trauma history, and PTSD should be best practice
- Effective treatment (EMDR) of trauma/PTSD could mean for the individual:
  - Better quality of life
  - Less problem behavior

- How might supports and support plans be affected?
### Brain’s response to Hyperarousal

<table>
<thead>
<tr>
<th>Hyperarousal Continuum</th>
<th>REST</th>
<th>VIGILANCE</th>
<th>RESISTANCE Crying</th>
<th>DEFIANCE Tantrums</th>
<th>AGGRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociative Continuum</td>
<td>REST</td>
<td>AVOIDANCE</td>
<td>COMPLIANCE Robotic Detached</td>
<td>DISSOCIATION Fetal Rocking</td>
<td>FAINTING</td>
</tr>
<tr>
<td>Regulating Brain Region</td>
<td>NEOCORTEX Cortex</td>
<td>CORTEX Limbic</td>
<td>LIMBIC Midbrain</td>
<td>MIDBRAIN Brainstem</td>
<td>BRAINSTEM Autonomic</td>
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<tr>
<td>Cognitive Style</td>
<td>ABSTRACT</td>
<td>CONCRETE</td>
<td>EMOTIONAL</td>
<td>REACTIVE</td>
<td>REFLEXIVE</td>
</tr>
<tr>
<td>Internal State</td>
<td>CALM</td>
<td>AROUSAL</td>
<td>ALARM</td>
<td>FEAR</td>
<td>TERROR</td>
</tr>
</tbody>
</table>

Bruce Perry-Childtraumacademy.com
Eye Movement Desensitization and Reprocessing - EMDR

- EMDR as an integrative 8 phase treatment protocol based on the Adaptive Information Processing (AIP) Theory
- EMDR integrates cognitive behavioral, affective/psychodynamic and sensory treatment modalities
- EMDR does not require verbal or intuitive abilities to progress in treatment
Adaptive Information Processing (AIP)

- AIP-Adaptive information processing model (Francine Shapiro) is the theory that drives the psychotherapeutic treatment.
- AIP hypothesizes that an innate information processing system exists and symptoms occur because this mechanism is blocked.
- Symptoms described as pathology are conceptualized as sensory information/experiences that have been retained maladaptively in the nervous system.
- EMDR assists the individual to access different aspects of the traumatic memory network and reprocess it through to an adaptive resolution.
AIP Model

• Unprocessed- maladaptively encoded memory networks consisting of the recording of earlier events containing the emotions, physical sensations, and beliefs, arise in the present when these traumatic events are triggered and then become the filter for new experiences and the etiology of current symptoms.

• The PTSD symptom clusters (intrusive, avoidant, hyperarousal) are the evidence of the retention of distressing life events that need to be accessed, activated, and reprocessed through to adaptive resolution.
Why EMDR with the I/DD Population?

- EMDR does not require insight, language, or intellect to reprocess the traumatic retained memories.
- EMDR can be implemented without language and can integrate expressive therapies including art therapy and play therapy techniques.
- EMDR is efficacious because treatment rapidly accesses the natural adaptive information processing system for healing.
Review of the 8 phases of EMDR

- Client History & Treatment Planning
- Preparation
- Assessment
- Desensitization
- Installation
- Body Scan
- Closure
- Re-evaluation
How long does EMDR take?

- Research on EMDR suggests that one session of trauma processing during phases 3-6 of EMDR rapidly improves symptom manifestation in 1-3 sessions.
- With EMDR case conceptualization, not all traumatic events need to be reprocessed because when the first and worst events are reprocessed, the system generalizes clearly other events simultaneously.
What changes after EMDR?

- EMDR focuses on more than coping and surviving, but actually healing.
- Many clients no longer have any disturbance associated with a traumatic event because the material has been reprocessed through to adaptive resolution.
- Unlike other treatment modalities focused on coping, EMDR focuses on healing.
Engaging staff/family in therapy

- Can learn to recognize symptoms
- Know history
- Provide daily support
- Trusted
- Can be “eyes and ears”
- Can note progress
An effective tool for caregivers

- **TICES:**
  - Target /trigger
  - Image (picture)
  - Cognition/thoughts
  - Emotions
  - Sensation (sensory including body sensations)

- Caregivers can help identify pieces for reprocessing with EMDR
Success story:
Aly (from her adoptive mother, Arizona)

- Diagnosis of PTSD, dissociation, intellectual disabilities (moderate) and learning disorders.
- Biological mom’s boyfriends and her step-grandfather severally sexually and physically abused until she was 8 years old when grandmother died and 3 girls removed from the home. Grandfather would lock her in a closet until her grandmother came home.
- Aly repeatedly called 911 to protect her 2 younger sisters
- Aly was placed in foster care and parental rights were severed. She had several failed adoptive placements until her successful adoption at age 14.
- Challenging behaviors included indiscreet masturbation in public, fecal digging. She would smear feces on the walls and eat it as well. She would also pee on her floor and in her closet.
- Aly was abused in foster care and in school. She was psychiatrically hospitalized multiple times.
Aly’s Progress

- Within a few weeks of EMDR treatment, the masturbation and fecal digging began to subside.
- After six months of treatment, Aly no longer masturbated or engaged in fecal digging.
- Aly has not been hospitalized since treatment with EMDR. And Aly was successfully adopted at age 13 years.
- EMDR continued to relieve anxiety, depression, anger and any confusion Aly felt. Aly also learned to have more confidence in herself.
- She now has friends, is able to participate successfully in school and in social activities.
- After EMDR Aly learned to read and has been stable at home and school.
Success story: Carol
(Andrew Seubert MA,NCC, Mansfield, PA)

- Moderate range, early 40's
- Was acting out aggressively after the death of a close friend of the family
- Was treated using EMDR
- When another family friend died shortly afterwards Carol began acting out again
- One session of EMDR resolved this issue
Success story: N.
(Karen Harvey, Ph.D., Baltimore, MD)

- N., a young man; was sexually abused by his adoptive father.
- He was in jail for 18 months for trying to choke his mother.
- No one knew about the sexual abuse – it came out in therapy after he came to our agency.
- He was very high profile and had a one on one during the day.
- After about 9 very intense EMDR sessions he was able to calm down considerably and to get past his anger.
- We did talk therapy after that and I used the EMDR for positive installations.
- N. went from a 1 on 1 during the day to a work crew of 1 to 8.
Success Story: A woman
(Karen Forte, LCSW, DCSW, Bend, OR)

• Woman in her 50's with DD - had been assaulted. She withdrew from everything and everybody and acted out with anger if anyone got near her.

• It took a lot of trust building to begin EMDR, but after several sessions her care providers reported a decrease in out of control anger response and an increase in her willingness to reconnect with those around her.
Success Story: A young man
(Karen Forte, LCSW, DCSW, Bend, OR)

- A young man with ID was referred for severe suicidal depression.
- His physician referred him as a last resort because nothing else was helping him. A few EMDR sessions later, the physician was shocked that he was doing so much better. No longer suicidal and able to be more independent in his adult daily living skills.
References

References con’t


EMDR References


Internet References

• EMDR HAP Website
  http://www.emdrhap.org/researchandresources.htm

• Website for training information on EMDR
  www.emdr.org

• EMDR International Association
  www.emdria.org