

## EMDR & Intellectual Disabilities

[Summary White Paper Developed by Louisiana OCDD Clinical Services Team]

### Overview of EMDR and IDD

IDD clinicians and researchers have shown that **EMDR is possible, effective, and likely desirable** for a significant number of folks with IDD. You know that EMDR is a form of therapy designed for people who have experienced **trauma**. And, you are aware of the significant frequency of Adverse Childhood Experiences (ACEs). We add that this occurrence of ACEs is greater for those with IDD<sup>1</sup>, meaning that they too need trauma therapy.

The features of EMDR make it well-suited for folks with IDD. As you know, EMDR is recognized as a therapy **not** heavily dependent on **verbal expression**, talking about **distressing/painful experiences**, completing **homework**, or **sustaining periods of attention**. In addition to decreasing or resolving this groups' PTSD symptoms<sup>2-7</sup>, EMDR may also decrease or resolve anxiety<sup>7</sup>, depression<sup>5-7</sup> and OCD<sup>7</sup>. More importantly, EMDR researchers and clinicians have evidenced its effectiveness in areas important and meaningful to people with IDD. For example, giving a **treatment approach** to address their trauma<sup>2-7</sup> them a sense of **mastery**<sup>8</sup>, the ability to **calm** when distressed<sup>2</sup>, improve **social** and **adaptive skills**<sup>5-6</sup>, decrease **physical complaints**<sup>5-6</sup> and decrease a sense of **worthlessness**<sup>4</sup>.

### How EMDR and IDD Work Together

EMDR's mechanism of action depends on two brain functions<sup>4</sup>. First, alternating bilateral stimulation (BLS) eye movements is effective/works when eye movements and visual imagery are both overwhelmed/compete for the same resources of the **visuospatial and central executive working memory**. Here the dual tasks impairs imagery so that the images become less emotional and vivid which is well suited for those who experience deficits in these types of working memory, deficits included in IDD. Second, degradation of working memory helps individuals with re-experiencing the trauma. The **distancing effect** caused by the degradation of working memory enables the individual to distance/"stand back" from the trauma allowing for a re-evaluation and new understanding of the trauma by re-experiencing the trauma and not feeling overwhelmed by it. Therefore, EMDR may be particularly effective for individuals with IDD who experience deficits in this type of working memory too. So, in the case of EMDR, it is not just **possible and effective** for those with IDD but something more interesting; they may benefit from it more than the general population given the current understanding of how EMDR works.

### Adaptions to EMDR for individuals with IDD

What we have come to understand about EMDR for those with IDD is empirically derived<sup>2</sup>. For example, successful treatment was provided using EMDR with a group of individuals with mild to severe ID whose expressive communication ability ranged from "very articulate" to "not articulate". These individuals presented with ASD, anxiety, and or bipolar disorder. The adaptions were individualized and included **EMDR, bilateral stimulation, auditory bilateral stimulation, visualization/mental movie, pictures/graphics** to represent concepts, **breathing exercises**, and the use of **metaphor**. The authors found that for those individuals with **greater**

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**expressive communication, minimal adaption was needed.** For individuals with **poorer expressive communication bilateral stimulation was the most helpful**, used to calm the individual when upset.

Other researchers<sup>6</sup> treated the PTSD of people with severe intellectual disabilities and an accompanying syndrome/disorder. This group of folks had significant impairment and relating the details of the trauma was difficult. Therefore, an adaption was made called **the Story Telling Method**. This was used to help the person understand the series of events that happened to cause the trauma memory. The trauma story was constructed and narrated by a loved-one, minding EMDR principles, i.e., begin with a safe place/positive beginning, then gradually adding emotionally and somatically charged details (e.g., physical sensations such as noises and smells using verbal description, photos, drawing, or physical objects) of the upsetting events/targets to desensitize and reprocess, then provide trauma re-framing and resolution, and end the story with positive cognitions. While these folks were significantly impacted by their disability, efficacy was found in adaptations made to the instructions and delivery of EMDR that matched the emotional and cognitive level of the person receiving therapy.

Additional adaptations made<sup>2 & 6</sup>;

### Adaptions to the Protocol

1. **More time** may be needed in the **preparation** phase, i.e., resources and skill development
2. More time may be needed to develop **rapport** and gather client/family history
3. More **time** may be needed to
  - a. Develop self and other awareness, management/self-soothing **skills**, focusing skills, psychosocial skills, and development of internal/external resources
4. More **attention** may be needed to the **education** and **support** of the family and direct care staff
5. More **directive intervention** may be needed during the processing of painful events, including
  - a. More **frequent checking** on the internal status of disturbance/**SUDs** level
  - b. More **frequent directing client** away from dysfunctional material and toward positive resources, as a means to reduce painful/intense material
  - c. **Reducing painful/intense events** by breaking them into **smaller parts/sub-events** and use of intentional distancing from the events
    - i. Sub-events may be drawn out on paper and **made into puzzle pieces**. The idea is that as each sub-event is addressed the puzzle is completed
  - d. **Greater verbal** involvement by the therapist **during trauma processing** to help the individual maintain focus
  - e. **Imagery** maybe helpful to explain abstract concepts
6. Use of a **numeric scale or physical gestures** or concrete visual representation of **magnitude** using **facial images** may be helpful to make the **SUD** and **VOC** understandable
7. Some individuals may have **difficulty following hand movements**,
  - a. **Stickers** on the therapist finger's may make tracking easier

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- b. When **tactile** bilateral stimulation is preferred
  - i. “**Buzzers**” are placed in either hand to give alternating tactile sensations
  - ii. Or, **tapping** on either side of the body, e.g., on hands or knees
- c. When **auditory** bilateral stimulation is preferred, alternating tones are played through headphones.
8. **Abstract concepts** like positive and negative language may need to be **adapted** to the individual’s cognitive level
9. It may be helpful to **check for memory processing** by asking the individual to imagine a sequential “**movie**” of the traumatic event and then check for any **overlooked disturbances**
10. **Target selection** may be limited to the immediate present/**here-and-now** experiences, due to limited ability to relate to the past
11. It may be helpful to **process emotional and somatic material**, regardless if the individual is able to relate to the cognitive/narrative content
12. It may be helpful to **emphasize** to the family/care givers the importance of **data** collection

### REFS

<sup>1</sup>Baladerian, N.J., Coleman, T. F., & Stream, J. (2013). Victims and their families speak out. A report on the 2012 national survey of people with disabilities. Spectrum Institute Disability and Abuse Project.

<sup>2</sup> Barol, B. I., & Seubert, A. (2010). Stepping stones: EMDR treatment of individuals with intellectual and developmental disabilities and challenging behavior. *Journal of EMDR Practice and Research*, 4(4), 156-169.

<sup>3</sup>Barrowcliff, A. L., & Evans, G. A. (2015). EMDR treatment for PTSD and Intellectual Disability: a case study. *Advances in Mental Health and Intellectual Disabilities*.

<sup>4</sup>Logie, R. (2014). EMDR—more than just a therapy for PTSD. *The Psychologist*, 27(7), 512-516.<sup>5</sup>Mevisen, L., Lievegoed, R., & De Jongh, A. (2011). EMDR treatment in people with mild ID and PTSD: 4 cases. *Psychiatric Quarterly*, 82(1), 43-57.

<sup>6</sup>Mevisen, L., Lievegoed, R., Seubert, A., & De Jongh, A. (2012). Treatment of PTSD in people with severe intellectual disabilities: A case series. *Developmental Neurorehabilitation*, 15(3), 223-232.

<sup>7</sup>Shaddel, F. (2016, December). EMDR for Treatment of Anxiety Disorder in a Patient with Intellectual Disability. In *The Open Conference Proceedings Journal* (Vol. 7, No. 1).<sup>8</sup>Oren, E. & Solomon, R. (2012). EMDR therapy: An overview of its development and mechanisms of action. *European Review of Applied Psychology*, 62, 197–203.