go with that magazine™

WINTER 2025
VOLUME 30 / ISSUE 1
EMDRIA.ORG

EMDR THERAPY AND NEURODIVERSITY

plus:

- Neurodiversity Affirming EMDR
- Affirming EMDR for Gender Identity & Neurodiversity
- Finding the Magic in the Neurotype
- Using EMDR to Navigate PTSD with TBIs

IN THIS ISSUE

WINTER 2025
VOLUME 30 / ISSUE 1

FEATURES

DEPARTMENTS

Go With That Magazine™ is the quarterly magazine of the EMDR International Association (EMDRIA™), and is copyrighted by EMDRIA. No reproduction, republication, or other use of the content herein is authorized without explicit permission from EMDRIA™. For permission, please write the Editor at khoward@emdria.org.

Letters to the Editor should be addressed to the Editor. Any letters submitted are subject to review and approval by EMDRIA™ and will be published at EMDRIA™'s sole discretion. Letters to the Editor should not exceed 250 words.

The views expressed in this publication do not necessarily represent the official positions or views of EMDRIA™ and should not be construed as such.

emdria™
EMDR International Association
CREATING GLOBAL HEALING, HEALTH & HOPE™

We are excited to announce a new EMDR Topic Forum called EMDR and Psychedelic-Assisted Psychotherapy. This will be a space where EMDRIA™ members can exchange ideas, share experiences, and collaborate on exploring the intersection of EMDR therapy and psychedelics, recognizing the potential synergies between these modalities for effective trauma treatment.

If you would like to participate in this new forum, log into the online community and click on "Communities" in the main navigation bar, and click on "EMDR Topic Forums" to see a list of available EMDRIA ™ communities. Click on the EMDR and Psychedelic-Assisted Psychotherapy community and click "Join," then choose a delivery option for notifications (real time, daily digest, or no email).

REC

2024 Annual Membership Meeting Recording Available

If you could not attend the 2024 Annual Membership Meeting, you can view the Zoom recording on our new Annual Membership Meeting page. The archived Annual Meetings go back to 2021. Visit and log in here www.emdria.org/about-emdria/annual-membership-meeting.

New Member Resources

EMDRIA™ just launched the Adaptive Information Processing (AIP) Model web page. This page is the latest in a series of efforts to help the public understand more about EMDR therapy. www.emdria.org/about-emdr-therapy/aip-model.

Also included in the EMDRIA Library is Appendix A: Clinical Aids from Dr. Francine Shapiro's book, *Eye Movement Desensitization, and Reprocessing Therapy: Basic Principles, Protocols, and Procedures.* We currently have English, French and Kazakh licensing rights from the publisher. We are working on obtaining licensing rights for Spanish and Russian translations. **Please do not take the resource, translate it, and use/share it, or you will breach our agreement with The Guilford Press.**

EMDRIA Foundation Bestows RESI Award on 20 New Recipients

We are excited to welcome 20 new recipients at this program's second-year anniversary. Nearly 100 therapists are now participating in the program, and more than 20 have already reached their credential goal. Congratulations to Patricia Alvarado, Katrina Blair, Lilly Alaniz, Claudia Ocampo, and Victoria Oana, all of whom reached the goal of EMDR Consultant.

The Racial Equity Support initiative, offered through the EMDRIA Foundation, provides financial support to assist BIPOC individuals in achieving the designation of EMDR Certified Therapist or EMDR Consultant. For more information about the program and becoming involved, visit the EMDRIA Foundation website:

- Donate www.emdriafoundation.org/donate
- Partner to be a consultant for recipients
- Apply to get the support at www.emdriafoundation.org/diversity/resi-application

The EMDRIA Foundation is a 501(c)3 organization established to support public-interest programming that increases access to, knowledge of, and understanding of EMDR therapy.

Q4 2024 Issue Correction

In the Q4 2024 article by Dr. Jason Linder, 29(4), p. 37, "Integrating EMDR in Emotionally-Focused EMDR Therapy" the author cited a wrong reference as Wesselmann and Potter. The citation should have been Parnell. The digital edition has been updated. We apologize for the error.

NEURODIVERSITY AFFIRMING EMDR:
Pathological Demand Avoidance

Understanding and Supporting a Unique Nervous System Response

By Christine MacInnis, MSed, MS, LMFT

The growing field of neurodiversity research is shedding light on the relationship between trauma and neurodivergent populations, and this has significant implications for therapeutic approaches like Eye Movement Desensitization and Reprocessing (EMDR). Neurodiversity-affirming (ND) EMDR aims to support individuals through a lens that respects their unique neurotypes without pathologizing them. Traditional therapeutic models often focus on conforming individuals to neuro-normed standards, which can inadvertently reinforce ableism. ND-affirming EMDR instead emphasizes that all neurotypes are valid ways of experiencing the world, challenging the notion that any specific neurotype is inherently "better" than another (Hanville et al., 2023).

This ND-Affirming approach to EMDR aligns well with the emerging understanding that trauma and negative beliefs can be deeply interwoven with a neurodivergent person's experiences as a societal misfit (Clearly et al., 2023). By reframing therapy to validate and affirm diverse neurotypes, clinicians can address trauma without adding layers of shame or pressure to conform, offering a more compassionate path to healing for neurodivergent individuals. It has been noted in other studies that up to 45 percent of autistics experience PTSD in comparison with allistic (non-autistic) individuals (Fisher et al., 2022).

This shift is particularly relevant for individuals with profiles like Pathological Demand Avoidance (PDA), who may experience heightened levels of trauma due to societal pressure to fit neuro-normative expectations. In a neurodiversity-affirming context, EMDR works to dismantle internalized ableism (the belief that they are inherently flawed) and the trauma that stems from forced conformity. Instead of viewing PDA traits as symptoms to be "fixed," this approach acknowledges them as adaptations within a neuro-normed society that often misinterprets or stigmatizes neurodivergent behaviors (Morris, 2024).

Pathological Demand Avoidance, or the term some consider more affirming, Pervasive Drive for Autonomy, is now receiving increased attention. Professor Elizabeth Newson introduced Pathological Demand Avoidance (PDA) in 1999 and formally published it in 2003, describing it as a subset within the pervasive developmental disorder spectrum. Newson suggested that PDA could relate to autism as a subgroup while also proposing it might represent a standalone profile. She illustrated this overlap with a diagram explaining the nuanced nature of PDA (Newson et al., 2003). Although professionals often diagnose clients with PDA as autistic, individuals

may present a PDA profile without an autism diagnosis (Gould, 2024). With a foundational understanding of the PDA profile and the experiences of PDA clients, we can explore how ND-Affirming EMDR can effectively support individuals with this profile. Due to the lack of research on EMDR with PDA, the author will be referring to studies regarding autism (since many consider PDA to be a profile that is part of autistic neurotype) and EMDR and the latest research on PDA to provide support for evidence-based practices. The following topics merit in-depth exploration, and the brief descriptions are meant as a starting point for clinicians.

Academic sources and the author's experience as an AuDHD individual with a PDA profile inform this article. The following section takes a closer look at everyday experiences among clients with a PDA profile.

WHAT IS PATHOLOGICAL DEMAND AVOIDANCE?

Key features of a PDA profile, as outlined by the PDA Society UK, include:

- A tendency to resist and avoid ordinary demands of daily life
- Sociable appearance, yet with limited depth in social understanding
- Pronounced mood swings and impulsivity
- "Obsessive" behavior frequently centered on people rather than objects or routines
- Comfort with role play and pretending, sometimes to an extreme extent, though this characteristic is not universally present (PDA Society UK, 2024).

Understanding that clients with a PDA profile experience heightened nervous system responses and anxiety to demands is essential as these responses often trigger intense fight-or-flight reactions. Clients may respond with defiance, anger, or physical actions, such as fleeing or becoming combative. Importantly, any situation perceived as imposed, involving a power dynamic, or non-consensual—not just direct demands—can trigger these responses (Gould, 2024).

Clients with a PDA profile typically require more deliberate, clear boundaries from others due to a high intolerance of uncertainty, in addition to anxiety. A 2016 study on children in England found that intolerance of uncertainty held an even greater causal link to understanding PDA than anxiety. Since life constantly presents uncertainties, this may explain why threats to autonomy can trigger the nervous system (Stuart et al., 2020). This need for control of personal independence creates such intense anxiety and intolerance of uncertainty that it can lead to either nervous system shutdowns or meltdowns. It is a strong "I can't" response that is more physiological than psychological (Huffman, 2024).

Specific, non-directive language regulates a PDA profile's nervous system. Certain words, phrases, tone of voice, body language, and even facial expressions can result in a PDAer experiencing distress (Gould, 2024). Any language that creates a power dynamic and invalidates the PDA person will typically elicit a negative response. Faulty language boundaries that can activate individuals with a PDA profile include judging (blaming and commentary), making assumptions (projection, loaded questions), using punitive language (passive-aggressive or sniping remarks), emotional manipulation (guilt-tripping, expecting appreciation), abandonment threats ("if you don't, then I won't" statements), rewards and punishments (illogical consequences), playing the hero or victim (asserting that adults are always "right" or that "you always hurt me"), and dehumanizing language denying one's experience or personhood (McConnell, 2024). While not exhaustive, this list provides insight into the importance of language and clarity of intent in relationships with PDA clients.

Understanding that PDAers, whether children or adults, are not deliberately oppositional or defiant is crucial. They do not intend their responses to harm others; instead, they often feel profound shame and frustration about their reactions—a topic we will explore further in this article. These behaviors arise from an intensely sensitive threat-detection system that triggers heightened responses to perceived demands or threats (Gould, 2024). Recognizing these behaviors helps foster a more compassionate and accurate understanding of PDA, shifting the focus from perceived defiance to an appreciation of the underlying neurobiological response.

Most commonly, PDA occurs with autistic neurotypes, and generally, they do have non-stereotypical presentations of autism (Gould, 2024). While it is not formally recognized as an official diagnosis in the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5), research has been done since Professor Elizabeth Newsom recognized this phenomenon 15 years ago. It is acknowledged within diagnostic criteria in the U.K.

BUT IS IT PATHOLOGICAL?

While some professionals with lived experience find the term "pathological" to be less affirming, others believe it is essential to highlight that the response lies beyond an individual's control (Gould, 2024). Many prefer terms like "Pervasive Drive for Autonomy" as these terms capture the individual's experience with a more positive framing and emphasize autonomy as a critical driver of

behavior. Conversely, some argue that "pathological" accurately conveys the intensity and impact of these characteristics, describing them as "all-consuming" and pervasive in daily life (SharonAdmin, 2024). Ultimately, the terminology surrounding PDA represents a complex and evolving conversation. Each individual may have unique preferences, so clinicians should consult clients to determine the language that best aligns with their self-perception and comfort.

Researchers still need to fully understand the origins and prevalence of a PDA profile as studies continue to evolve. Although causation remains an open area of inquiry, experts often cite underlying anxiety about societal expectations and intense discomfort with the unexpected as core elements of the PDA experience (PDA Society, n.d.) From a neurodiversity-affirming standpoint, this profile is viewed as part of one's autistic experience, and as a neurotype, it cannot be cured or changed. From this perspective, individuals see PDA as a rational response to inauthentic demands or those that do not make sense to them (Moore, 2020). Like autism, PDA encompasses a spectrum of experiences and needs unique to everyone with each person presenting differently. The therapist's role is to understand how PDA manifests for each specific client while maintaining a comprehensive grasp of PDA and its potential impacts.

Currently, no formal diagnostic test exists for PDA. However, researchers have examined tools such as the Diagnostic Interview for Social and Communication Disorders (DISCO) as potential measures (O'Nionsn et al., 2015). The PDA Society UK has also developed assessment tools that are accessible through its resources. Dr. Jennifer Huffman, a neurodivergent neuropsychologist, has a checklist for identifying signs of PDA in children (Huffman, 2024). Within a neurodiversity-affirming framework, clinicians often accept self-identification with a PDA profile as a valid approach (Lewis, 2016) as we shift from a medical model to an identity model while continuing clinical evaluations to explore the possibility of other diagnoses or co-occurring conditions (Neff, 2024).

It is essential to recognize that autistic masking often prominently affects adults with a PDA profile.

CLINICAL IMPLICATIONS FOR THE EMDR THERAPIST

Attunement with a PDA Client

Authenticity is paramount in your relationship with a PDA client. To feel safe with you as a therapist, clients need to know that you understand and can relate to their experiences (Neff, 2024). Gaining knowledge about PDAers through neurodiversity-affirming training from recognized organizations, such as PDA North America or PDA Society UK, is critical. These trainings will equip you with tools to support the client and help you avoid triggering their sensitive nervous system. Trigging this sensitivity can lead to masking and nervous system meltdowns or shutdowns during your sessions, which can cause an impasse for reprocessing.

Autistic Masking and PDA during All Phases of EMDR

It is essential to recognize that autistic masking often prominently affects adults with a PDA profile. Many have learned that outward expressions, such as meltdowns, are not socially acceptable, leading them to work diligently to contain their reactions (Evans et al., 2024). As a result, these responses may become less visible during sessions and manifest internally. It is also essential to note clients' social strategies to mask (Neff, 2024). Masking

social strategies can include reassuring the clinician, where clients tell the clinician their SUD was reduced when it was not, avoiding engagement during all eight phases, from history-taking to processing, and distracting from the process by introducing new information at each session. Clients may report an inability to continue or indicate that "nothing is coming up," sometimes expressing a desire to end the session prematurely. They may need help to stay engaged, even when transitioning to grounding or resourcing techniques. It is important to note that these protect the client from extreme distress, not to manipulate or resist the therapeutic process. A solid therapeutic alliance allows clients to feel secure enough to unmask during sessions and communicate openly when their boundaries are crossed or they need to pause or redirect their focus (Evans et al., 2024).

Overlap of Trauma and PDA

Since PDA involves anxiety, a more sensitive nervous system, and a high degree of intolerance to uncertainty, it is not surprising that individuals who have experienced both trauma and a PDA profile are more likely to exhibit increased distress from their trauma. Those with trauma in core areas that trigger PDA boundaries (McConnell, 2024)—such as abandonment, dehumanization, or punitive experiences—essentially face two violations: first, from their nervous system's reaction to the boundary being crossed, and second, from the trauma itself (Clearly et al., 2023). Understanding the neurobiology surrounding PDA reveals that it can affect all areas of development, including sensory processing, attention, executive functioning, and learning and communication challenges. Due to these overlaps, we must approach PDA clients from a trauma-informed perspective (Huffman, 2024).

For an EMDR therapist, recognizing that unique developmental needs associated with a PDA profile necessitate accommodations in EMDR practice is essential (Fisher et al., 2022). Tailoring the therapeutic approach to respect these needs enhances the client's comfort and engagement, ensuring the process remains effective and affirming.

SKILLS NEEDED DURING THE EIGHT PHASES OF EMDR

Before initiating therapy, ensure you provide clear intake paperwork that communicates your awareness of PDA and neurodiversity-affirming EMDR. Given that this concept is relatively new in Canada and the United States, some clients may hesitate to disclose their PDA profile due to concerns about potential rejection or ableism from the therapist. They may also need to educate themselves about it, so opening the door through initial

paperwork can be helpful. Including questions related to PDA alongside other neurodivergent profiles in your intake forms reassures clients that you recognize their experiences and that you are safe for them to engage in their therapeutic work (Neff, 2024). Safety is even more critical for a PDA client, leading to better co-regulation of their sensitive nervous system (McConnell, 2024). This proactive approach fosters trust and creates a supportive environment for open dialogue.

HISTORY-TAKING AND TREATMENT PLANNING

The therapist should adopt a collaborative approach with no directive questioning. Allowing clients to weave their story without interruption proves extremely helpful. A narrative approach allows clients to become the experts in their experience (Fisher et al., 2022). Additionally, the therapist needs to understand the cumulative effects of trauma and shame (Morris, 2024). They must recognize the nuances of clients' expertise to help them identify when their profile leads to self-judgment. Shame often emerges as a common theme for PDA clients as others frequently judge their ways of expressing nervous system disruptions (Morris, 2024). This process of internalized shame and self-doubt accumulates and becomes more complex over time. Recognizing the overlap of additional trauma and how it increases the client's dysregulation is also helpful (Huffman, 2024).

PREPARATION

Teaching self-compassion during resourcing—since shame is a core emotion that PDA clients experience due to misunderstanding from society, peers, coworkers, and even family when they feel threatened (Morris, 2024), the therapist must first address the client's protective nature. Clients may internalize others' reactions and believe that they are at fault. Reassuring them that you do not see them as the problem can provide significant relief. Here, you need to note when the client is experiencing internalized ableism. Internalized ableism occurs when clients believe the negative cognitions made by society about them having a PDA profile. You can help support them by emphasizing that you recognize it as a nervous system response to misaligned expectations rather than a reflection of their identity, which is critical.

ASSESSMENT

When selecting targets for EMDR work with a client with a PDA profile, this author has found through anecdotal evidence that focusing on recent events often proves more effective than asking them to recall specific past instances. Requesting that clients identify cases for processing can feel like a demand, potentially triggering a stress response. Instead, using recent experiences that have affected the client and EMD (Eye Movement Desensitization) techniques provides a gentler entry point into the desensitization phase (EMDR International Association. (n.d.) This approach can naturally lead to earlier memories due to generalization effects with less risk of triggering shutdowns.

Moreover, exercise caution with SUD (Subjective Units of Distress) and VOC (Validity of Cognition) scales, as clients may perceive them as demands to evaluate the intensity of their responses (Gould, 2024). Observing the clients' emotional reactions while discussing the event, rather than asking them to rate distress, allows for a more attuned assessment of progress and minimizes the risk of masking behaviors addressed earlier. This strategy ensures a smoother, more supportive desensitization process for the client.

DESENSITIZATION

When determining the appropriate type of bilateral stimulation (BLS) for EMDR reprocessing, involving clients in decision-making is crucial to alleviate potential anxiety and increasing their sense of safety with the modality. For some clients with a PDA profile, eye movements alone may not provide sufficient stimulation due to specific neurobiological needs, making more intensive BLS methods beneficial. Strong buzzers combined with sound or loud knee tapping may prove more effective. Creativity, as highlighted in EMDR 2.0, plays an essential role here as the clinician and client collaboratively identify the most beneficial way to tax the working memory (Matthijssen et al., 2021).

However, traditional EMDR can sometimes overwhelm clients with a PDA profile who are experiencing complex trauma. In these cases, alternative approaches like the Flash Method (Mansfield) or the 4 Blinks method (Zimmerman) may offer gentler yet practical options (Browers et al., 2021).

Remain mindful of additional factors impacting the client's progress. Despite thorough preparation, blocking beliefs rooted in shame and internalized ableism can still arise during sessions. If emotional distress does not decrease, it may help to check in with the client to explore whether a blocking belief—such as "I don't deserve to be healed"—is impeding processing.

Another critical aspect to consider is the language used during Cognitive Interweaves. To avoid inadvertently disrupting the client's processing, use nondirective language and adopt a collaborative approach. Even simple prompts like "Go with that" may feel directive and trigger a shutdown.

Phrases such as "Please move forward if you are ready," or other types of phrasing mutually agreed upon by the client and clinician can provide a gentle alternative, ensuring that the client retains a sense of autonomy and safety throughout the session (PDA North America, 2023).

INSTALLATION

Even if clients report that their SUD has reduced to zero, you must verify that this response is not influenced by masking or reassuring the therapist. Gently revisiting the trauma and assessing whether any residual triggers remain can provide deeper insight. Confirming with the client whether the more adaptive belief feels authentic and valid is also helpful at this stage. While this step is crucial for all clients, it is critical for those with a PDA profile, as it respects their boundaries and emphasizes safety and authenticity.

For the VOC (Validity of Cognition), using a non-numerical approach may feel less demanding and more comfortable. Inviting the client to notice how the new belief feels is an effective and respectful way to gauge its strength without imposing the pressure of a specific rating.

BODY SCAN

According to Dr. Jennifer Huffman, a neurodivergent neuropsychologist who developed the checklist for identifying signs of PDA in children (2024), individuals with a PDA profile often experience sensory challenges that complicate attempts to conduct a traditional body scan. These sensory issues may include interoceptive concerns, where clients struggle to sense internal bodily cues, such as hunger. If clients report difficulties with interoception, you may find it beneficial to forgo the body scan to prevent discomfort or distress from their inability to identify specific bodily sensations.

Additionally, adapting the focus to observable physical sensations rather than internal ones may prove beneficial. This adaptation aligns with the neurodiversity-affirming approach, allowing clients to feel safe and understood without the added pressure of reporting sensations they may struggle to perceive (Fisher et al., 2022). For example, instead of asking clients to notice internal sensations such as tension, warmth, or discomfort, the therapist might guide them to observe aspects like their body's position in the chair, the weight of their hands resting on their lap, or the sensation of their feet on the ground. These adjustments offer clients a more accessible, non-intrusive way to connect with their physical presence without triggering anxiety or discomfort from their difficulties in interpreting internal bodily states.

This adapted approach supports a neurodiversity-affirming framework by prioritizing respect and understanding each client's unique experiences and challenges. By adjusting the body scan to accommodate the client's sensory sensitivities, therapists can foster an environment where clients feel understood and respected. Removing the expectation of traditional interoceptive responses alleviates the pressure on clients to "perform" in ways that might not align with their sensory experience (Huffman, 2024). In turn, this approach can reduce anxiety, allowing clients to participate in therapy without the fear of misunderstanding or judgment, which is especially important for those with a heightened sensitivity to perceived demands.

CLOSURE

Sensory needs are higher for PDA clients, so during the closure phase, you must ensure your client feels safe and is not still activated before leaving the office. Following a predictable routine with your client after processing, employing low-arousal strategies like deep breathing and slow tapping for nervous system regulation, and using indirect communication while depersonalizing requests can provide the sense of safety that PDA clients need. Remaining flexible and collaborative with your client's needs is essential (Neff, 2024).

REEVALUATION

In follow-up sessions, ensure that the target remains resolved and that the client is not masking by simply reporting a reduction in distress to move on. If you focus on a current event as a target in EMDR, this author has found it often reveals deeper targets that the client may not have been able to access previously. This approach, which emphasizes present-moment experiences, can gently unlock connections to early childhood or formative events inaccessible or overwhelming for the client before current-event reprocessing. As these foundational memories arise organically, clients may find it easier to process them, which reduces the likelihood of shutdowns or resistance. This is a good time to document these traumas during the reevaluation phase for additional processing.

EMDR AND PDA CAREGIVERS

Since PDA traits often emerge in early childhood, supporting PDA children challenges even the most patient caregivers. Young children still need to develop self-regulation tools, which is even more complicated for those with PDA nervous systems. To support parents and guardians of children with PDA, EMDR serves as a valuable tool in addressing the small but cumulative traumas these children experience due to ongoing nervous system dysregulation. Healthy co-regulation between a parent and a child with PDA is crucial for preventing dysregulation from occurring in the first place because emotional contagion is high in PDA children. When the caregiver remains calm, that feeling translates to the child (Kotha, 2023).

EMDR could assist caregivers by addressing negative beliefs, such as feeling inadequate in parenting a child with PDA or processing past traumas from their upbringing if they lacked supportive parental models. Additionally, EMDR helps caregivers navigate the demands of adapting to low-demand parenting approaches and refine their daily language for more effective communication. By supporting caregivers in these ways, EMDR fosters a calmer, more resilient nervous system, equipping them to manage the complexities of helping a child with PDA. While caregiver support could be a whole topic, the author believes it would be remiss not to include and address it when discussing PDA and EMDR.

SOME FINAL DO'S AND DON'TS OF SUPPORTING A PDA CLIENT WITH ND AFFIRMING EMDR

Do: Learn to assess your clients' PDA profile during history-taking. If they exhibit key PDA features, collaborate with them to establish a care plan that feels the safest and most effective.

Don't: Attempt to cure or fix PDA. Like ADHD and Autism, PDA is a neurotype, not a condition to treat. Focus on supporting clients through any internalized shame and trauma stemming from past misunderstandings about their autonomy needs.

Do: Seek training in neurodiversity-affirming practices and ensure you

are well-versed in working with PDA clients before integrating EMDR. Many clinicians unintentionally perpetuate harm when they lack adequate training. Embrace declarative language, adopt a collaborative stance, and incorporate humor where appropriate. Consider taking professional training through PDA North America.

Do: Embrace a collaborative, flexible approach with clients. Support them in finding solutions rather than prescribing them. Be open to adapting the session and working in the present rather than diving into the past initially.

Do: Foster an authentic relationship with your client. A solid therapeutic alliance built on attunement is essential. Appropriate self-disclosure can contribute positively. Compassion and genuine understanding of their lived experience are crucial for both the progress of therapy and the success of EMDR with PDA clients.

By incorporating these adaptations and a deeper understanding of working with PDA clients, Neurodiversity-Affirming EMDR can be a supportive and empowering approach for individuals with a PDA profile. This framework respects the client's need for autonomy and fosters resilience and self-acceptance through a commitment to safe, authentic, and client-centered care.

Christine MacInnis, MSed, MS, LMFT, owns Transcends Family Therapy in Torrance, Calif., specializing in neurodiversity and LGBTQIA+ affirming, trauma-informed care. She is an approved consultant with EMDRIA and provides EMDRIA and APA-approved advanced training on topics related to ND Affirming EMDR, ADHD, and Autism from a lived experience lens. To learn more about her or her training modules, please go to www.transcendstherapy.com.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

Brouwers, T. C., Matthijssen, S. J. M. A., & de Jongh, A. (2021). The effects of the flash technique compared to those of an abbreviated eye movement desensitization and reprocessing therapy protocol on the emotionality and vividness of aversive memories. *Frontiers in Psychology, 12*, Article 741163. https://doi.org/10.3389/fpsyg.2021.741163

Clarke, A. S., & Darker-Smith. (2023). Neurodiversity-affirming EMDR therapy with autism and ADHD. In D. Farrell, S. J. Schubert, & M. D. Kiernan (Eds.), *The Oxford Handbook of EMDR* (online ed.). Oxford Academic. https://doi.org/10.1093/oxfordhb/9780192898357.013.59

Cleary, M., West, S., Kornhaber, R., & Hungerford, C. (2023). Autism, Discrimination and Masking: Disrupting a Recipe for Trauma. *Issues in Mental Health Nursing, 44*(9), 799–808. https://doi.org/10.1080/01612840.2023.2239916

EMDR International Association. (n.d.). *Untangling EMDR: What are the EMDR, EMD, EMD(R), and R-TEP protocols?* Retrieved October 29, 2024, from www.emdria.org/resource/untangling-emdr-what-are-the-emdr-emd-emd-r-and-r-tep-protocols

Evans, J. A., Krumrei-Mancuso, E. J., & Rouse, S. V. (2024). What you are hiding could be hurting you: Autistic masking in relation to mental health, interpersonal trauma, authenticity, and self-esteem. *Autism in Adulthood, 6*(2), 229–240. https://doi.org/10.1089/aut.2022.0115

Fisher, N., Patel, H., van Diest, C., & Spain, D. (2022). Using eye movement desensitization and reprocessing (EMDR) with autistic individuals: A qualitative interview study with EMDR therapists. *Psychology and Psychotherapy: Theory, Research and Practice*, 95, 1071–1089. https://doi.org/10.1111/papt.12419

Gould, D., McConnell, S., & Morris, Z. (2024, October 15). *PDA North America Level 2 Training* [Powerpoint Slides, Lecture, Training]. PDA North America.

Hossain, M., Khan, N., Sultana, A., Ma, P., McKyer, E., Ahmed, H., & Purohit, N. (2020). Prevalence of comorbid psychiatric disorders among people with autism spectrum disorder: An umbrella review of systematic reviews and meta-analyses. *Psychiatry Research*, 287, 112922.

Hanville, C., MacInnis, C., & Lanza, T. (2024). Emergent neurodivergent: Neurodiversity-affirming therapeutic education. *The Therapist*, January-February. California Association of Marriage and Family Therapists (CAMFT). Retrieved from www.camft.org/Resources/Read-The-Therapist/The-Therapist-January-February-2024

Huffman, J. I. (2024, May 7). *A neuropsychological profile of pathological demand*. PDA North America. https://pdanorthamerica.org/a-neuropsychological-profile-of-pathological-demand-avoidance-by-jennifer-i-huffman-pdhd-abpdna

Huffman, J. (2024, September 22). *Identifying PDA in adults*. PDA North America. https://pdanorthamerica.org/wp-content/uploads/2024/10/Identifying-PDA-in-Adults-Dr-Huffman.pdf

Kotha, A. (2024, May 7). *Walking on eggshells?* PDA North America. https://pdanorthamerica.org/walking-on-eggshells

Lewis L. F. (2016). Exploring the experience of self-diagnosis of autism spectrum disorder in adults. *Arch. Psychiatr. Nurs.* 30, 575–580. doi: 10.1016/j.apnu.2016.03.009 [DOI(https://doi.org/10.1016/j.apnu.2016.03.009)]der%20in%20adults&author=L.%20F.%20Lewis&volume=30&publication

Lewis L. F. (2017). A mixed methods study of barriers to formal diagnosis of autism Spectrum disorder in adults. *J. Autism Dev. Disord.* 47, 2410–2424. doi: 10.1007/s10803-017-3168-3, PMID: [DOI (https://doi.org/10.1007/s10803-017-3168-3)

Matthijssen, S. J. M. A., Brouwers, T., van Roozendaal, C., Vuister, T., & de Jongh, A. (2021). The effect of EMDR versus EMDR 2.0 on emotionality and vividness of aversive memories in a non-clinical sample. *European Journal of Psychotraumatology, 12*(1), Article 1956793. https://doi.org/10.1080/20008198.2021.195679

Moore, A. (2020). Pathological demand avoidance: What and who are being pathologised and in whose interests? *Global Studies of Childhood, 10*(1), 39–52. https://doi.org/10.1177/2043610619890070

Newson, E., Le Maréchal, K., & David, C. (2003). Pathological demand avoidance syndrome: A necessary distinction within the pervasive developmental disorders. *Archives of Disease in Childhood, 88*(7), 595–600. https://doi.org/10.1136/adc.88.7.595

Neff, M. A. (2024b, June 13). *Autism PDA Explained: The Core Characteristics of Pathological Demand Avoidance*. Neurodivergent Insights. Retrieved October 28, 2024, from https://neurodivergentinsights.com/autism-infographics/autism-pda-explained?rq=PDA

Neff, M. A. (2024, February 7). "Neurodivergent Affirming Practice: Helping Your Clients Accept Their Authentic Selves." *Neurodivergent Insights*. Retrieved October 28, 2024, from https://neurodivergentinsights.com/blog/neurodivergent-affirming-practices

Neff, M. A. (2024, April 16). "Low-demand parenting." *Insights of a Neurodivergent Clinician*. https://neurodivergentinsights.com/blog/low-demand-parenting

Ozsivadjian, A. (2020). Editorial: Demand avoidance—Pathological, extreme or oppositional? *Child and Adolescent Mental Health*, *25*(2), 57–58. https://doi.org/10.1111/camh.12388

O'Nions, E., Gould, J., Christie, P., Gillberg, C., Viding, E., & Happé, F. (2016). Identifying features of 'pathological demand avoidance' using the Diagnostic Interview for Social and Communication Disorders (DISCO). *European Child & Adolescent Psychiatry*, *25*(4), 407–419. https://doi.org/10.1007/s00787-015-0740-2

Identifying PDA – PDA Society. (2024, September 24). PDA Society. Retrieved October 28, 2024, from www.pdasociety.org.uk/about-pda/identifying-pda

PDA North America. (2023, June 1). *Guidelines for Being a PDA Friendly Place*. Pdanorthamerican.org. https://pdanorthamerica.Org/wp-content/uploads/2023/06/Guidelines-for-being-a-PDA-Friendly-Place.Pdf.

PDA Society. (n.d.). Helpful approaches for children. PDA Society. Retrieved October 29, 2024, from www.pdasociety.org.uk/i-am-a-parent-carer/resources/helpful-approaches-for-children

Sharon_Admin. (2024, February 26). *Pathological Demand Avoidance (PDA) and Autism: a guide for allies* - Reframing Autism. Reframing Autism. https://reframingautism.org.au/pathological-demand-avoidance-pda-and-autism-guide-for-allies

Stuart, L., Grahame, V., Honey, E., & Freeston, M. (2020). Intolerance of uncertainty and anxiety as explanatory frameworks for extreme demand avoidance in children and adolescents. *Child and Adolescent Mental Health*, *25*(2), 59–67. https://doi.org/10.1111/camh.12336

Truman, C., Crane, L., Howlin, P., & Pellicano, E. (2024). The educational experiences of autistic children with and without extreme demand avoidance behaviours. *International Journal of Inclusive Education*, *28*(1), 57–77. https://doi.org/10.1080/13603116.2021.1916108

Van Diest, Caroline., Leoni, Marguerite., Fisher, Naomi., and Spain, Debbie, 'Using EMDR with Autistic Clients- How Do You Adapt? *Journal of EMDR Practice and Research*, Vol, 16 Issue 3, May 2022, DOI: 10.1891/EMDR-2022-0014

van Schie, K., Engelhard, I. M., & van den Hout, M. A. (2015). Taxing working memory during retrieval of emotional memories does not reduce memory accessibility when cued with reminders. *Frontiers in Psychiatry*, *6*, Article 16. https://doi.org/10.3389/fpsyt.2015.00016

Affirming EMDR of Gender Identity

at the **Intersection** and **Neurodiversity**

By Cathy Hanville

Neurodivergent (ND) individuals face many challenges with traditional therapeutic approaches, and that translates into challenges with EMDR therapy. Research shows that neurodivergent clients respond best to ND-affirming therapy (Kroll et al., 2024; Camm-Crosbie et al., 2024; Chapman & Botha, 2024; Jones & Kargas., 2023). This research shows that therapeutic interventions using a neurotypical framework are, at best, ineffective for clients and, at worst, create additional trauma. SaraRose Hogan, LCSW, defined ND-affirming care as provided through a "client-centered, neurodiverse-affirming lens that does not impose subjective ideas on individuals. It does not approach neurodivergent diagnosis or traits as problems to be solved, but instead, it embraces the diversity of minds and thrives on collaboration" (Hogan, 2023). All clinical work, including EMDR, needs adaptations to work effectively with our ND clients.

This article explores how therapists can adapt EMDR for clients who are both neurodivergent—such as individuals with autism, ADHD, or other neurological differences—and identify as transgender-gender diverse (TGD), along with highlighting the importance of providing affirming therapy that addresses clients' experiences at the intersection of neurodiversity and gender-diversity.

The author focuses on using the standard EMDR protocol with specific adaptations for ND and transgender gender-diverse clients rather than developing a new protocol. The standard protocol is effective, and since our ND and TGD clients present in many ways, we cannot develop a protocol that will fit all of their needs.

Many therapists received no training in assessing for neurodivergence in their therapy programs. Additionally, they absorbed media and other cultural messages that may have shown them ND people in a way that oversimplifies or demeans neurodivergence. For example, many learned that Autistic people do not make eye contact or that they often have physical tics such as arm flapping. Those behaviors are not something all Autistic people exhibit. However, if that is what therapists expect to see an Autistic person do, then when they come into contact with an Autistic person who does not have these behaviors; they might not believe they are Autistic. Therapists denying clients identities traumatize them by creating an experience that invalidates their being and understanding of the world (McVey et al., 2023).

One result of this lack of training and understanding is an underdiagnosis of neurodivergence. Women, in particular, are undiagnosed or misdiagnosed. Research estimates that as many as 80 percent of Autistic females are not diagnosed by age 18 (McCrossin, 2022). ADHD is also underdiagnosed in females. Doctors diagnose boys three times more often in childhood than girls, but by adulthood, they distribute diagnoses evenly between genders (da Silva et al., 2020). This change in prevalence indicates that many girls are not getting diagnosed as children but instead receive their diagnoses as adults. One reason is that young girls tend to have more inattentive symptoms than hyperactivity (Quinn & Madhoo, 2014). This results in girls receiving diagnoses of depression and anxiety rather than ADHD. Society also socializes girls to behave in specific ways, encouraging them to hide their symptoms (Quinn & Madhoo, 2014).

Without a diagnosis, people struggle into adulthood, navigating a neurotypical society and not understanding why they are not able to meet neurotypical expectations. Research shows that the effects of a misdiagnosis or lack of diagnosis are substantial (Attoe & Climie, 2023). Self-esteem, the ability to form relationships, emotional regulation, and depression rates were all adversely

affected (Attoe & Climie, 2023). While this author does not support diagnoses that pathologize ND people, it is imperative to understand how clients' brains interpret information to work effectively with them.

While the author found no research on how each type of neurodivergence intersects with gender identity, there is research showing that transgender and gender-diverse people are between 3.03-6.36 times more likely to be autistic than cisgender (non-transgender) people (Warrier et al., 2020). For therapists to provide neurodivergent-affirming EMDR care, therapists also need to provide gender-affirming care.

To provide affirming care, we need first to understand its language. For this article, the author uses the term transgender-gender-diverse (TGD). Recent research states that it is the most preferred term for people with lived experience (Zwicki et al., 2024). Those who identify within that definition use many other terms, such as gender non-conforming, genderqueer, gender fluid, gender spicy, and non-binary. Therapists should always honor the client's language, but this article will use TGD (Chang, 2017).

Dr. Nick Walker, a queer Autistic scholar, defines neurodivergent as people whose cognitive functioning deviates significantly from the dominant societal standards of "normal" (Walker, 2021, p. 38). Walker defines neurotypical (NT) as having neurocognitive functioning that aligns with societal norms and defines neurodiversity as "the diversity of human minds." Walker emphasizes that it encompasses the brain and the nervous system (Walker, 2021, p. 34). It is essential to distinguish between neurodiversity as a concept relating to an entire community and neurodivergence, which refers to individuals.

Dr. Walker also believes the existing dominant paradigm defining neurodiversity is one of pathology (Walker, 2021, p. 16). A pathology paradigm asserts there is only one correct or usual way of being. If someone does not function that way, they are not considered 'normal.' Walker proposes shifting to a neurodiversity paradigm, which asserts that diversity in minds is healthy and valuable and does not need treatment. She also discusses the neurodiversity movement, which seeks 'civil rights, equality, respect, and full societal inclusion for the neurodivergent' (Walker, 2021, p.33).

An essential aspect of a neurodiversity paradigm is using identity-first language. First-person language sends a message that there is a problem with the person and is part of the pathology paradigm we are trying to move away from (Botha & Williams, 2023). Identity-first language uses Autistic people instead of people with autism. Person-first language sends a message that there is a problem and is part of the pathology paradigm we are trying to move away from (Botha & Williams, 2023).

The research on outcomes for EMDR with ND clients shows it can be highly effective (Barol & Seubert, 2010; Guidetti et al., 2023; Kosatka & Ona, 2014; Leuning et al., 2023). There are some issues that EMDR for ND clients may successfully address. Many ND clients have had experiences of chronic invalidation and internalized ableism. Dr. Megan Neff, an Autistic-ADHD psychologist, defines internalized ableism as "our beliefs and prejudices that come from living in an ableist society. These beliefs often form our expectations about ourselves. For example, 'I should be able to work a 40-hour work week' or 'I shouldn't need accommodations.'" (Neff, 2024). Using EMDR to address this can increase self-acceptance and acceptance of ND challenges so that they can feel empowered to ask for the things that they need rather than telling themselves there is something wrong with them and making them inclined to hide their neurodivergence.

If an ND client experiences anxiety or sensory overload, EMDR may be able to help reduce that. If clients have any self-directed goals for emotional regulation, therapists can use EMDR to minimize stress in triggering situations as opposed to having to mask their neurodivergence.

The author did not find any research specific to EMDR and TGD clients. However, Dr. Sand Chang wrote a chapter titled "EMDR therapy as affirmative care for transgender and gender non-conforming clients" (Chang, 2017). Dr. Chang discussed three categories in which EMDR can support gender-diverse clients.

- Gender-related concerns include coming out, gender dysphoria, or using therapy to access gender-affirming care.
- Addressing societal reactions such as anti-trans biases or abuse.
- Trauma for something unrelated to gender identity.

With the understanding of what our TGD and ND clients might seek treatment for, we will examine areas of overlap between the two groups, which can guide our affirming EMDR care.

The first overlap is masking. Dr. Neff defines Autistic masking as an adaptive phenomenon in which people develop intricate strategies to navigate an allistic (non-autistic) society, seamlessly blending in like chameleons in their surroundings (Neff, 2024b). Masking can involve forcing oneself to make eye contact, repressing stimming behaviors, or memorizing specific responses and using them in situations (MacInnis, 2024).

TGD people often wear similar protective masks to hide their gender identity and stay safe. Although people

INTERESTED IN BECOMING A MASTER?

The Center for Excellence in EMDR Therapy now offers a comprehensive training program for EMDR therapists who truly understand that our clients can only go as far as we can accompany them in their journey towards healing.

The Master Certificate in Relational EMDR Therapy℠ offers an integrated approach to treating complex developmental trauma.

It opens a whole new pathway from a symptom-focused approach to one that is more centered on the therapeutic relationship, co-creating conditions that make it possible for our clients to “go there”.

No one else offers this personal and professional growth opportunity.

We are currently taking a limited number of applications. Find out more on our website.

The Center for Excellence in EMDR Therapy
Training. Certification. Community.

emdrtherapy.com

@thecenterforexcellence

have not applied the term 'masking' to the LGBTQ+ community, they have used the term 'coming out of the closet.' 'Coming out' refers to someone becoming open about their gender or sexual identity (Human Rights Campaign Foundation, 2022), while people describe someone who is not open as 'in the closet'" (Ariane Resnick, 2021).

The effects of masking can be profound. Imagine moving through a world where one must always be hypervigilant to those around them, constantly adapting to others' expectations and needs rather than acting comfortably or as their true self. It is exhausting. The trauma of masking can cause substance use to cope, perfectionism, dissociation, and burnout (MacInnis, 2024).

Our ND and gender-diverse clients also experience a high level of identity trauma. Early reporting from the *2022 U.S. Transgender Survey* indicates that three percent of the respondents experienced physical harm in the last 12 months, 30 percent reported verbal harassment, and 10 percent reported denial of equal treatment (James et al., 2024). Statistics are less available with ND people, but we know neurodivergent people have often experienced cumulative trauma, beginning in childhood from societal correction and invalidation. For instance, a child with ADHD may receive thousands of corrective comments by age ten (Jellinek, 2018).

Sadly, both the medical and therapy fields have had a history of traumatizing these groups (James et al., 2024; Doherty et al., 2022). As a result, clients often come to us with a strong sense of mistrust. When a provider in a position of power misgenders a person or tells them that they are not who they know they are, it is demeaning to the person and can trigger a shame spiral or other negative consequences.

Our ND and gender-diverse clients also experience a high level of identity trauma.

One way clients may have been traumatized by the medical field is having an experience of being entered into therapies that coerced them into behaving in ways inauthentic to who they are. Neurodivergent individuals may have received Applied Behavioral Analysis (ABA), a treatment that aims to train children to exhibit neurotypical behaviors, such as making eye contact when speaking with someone. The Autistic community increasingly views ABA as abusive, and currently, there is discussion within the medical community about the need for more compassionate, evidence-based care (Gibson & Douglas, 2018; Enright, 2023; Hanville et al., 2023). ABA currently remains a widely endorsed treatment for Autistic minors.

TGD clients may have engaged in conversion therapy, also known as reparative therapy or gender identity change efforts (GICE). GICE has an explicit goal of changing someone's gender identity to match the gender assigned at birth. Interestingly, Ole Ivar Lovaas both created ABA and practiced conversion therapy on gay people (Gibson & Douglas, 2018; Hanville et al., 2023).

Mental health organizations have discredited conversion therapy. In early 2024, The American Psychological Association made a strong statement on using Affirming Evidence-Based Inclusive Care. The APA advocates for noncoercive, evidence-based clinical care that is adaptive to and centered on the needs of the individual receiving care and rooted in psychological and clinical science, including recognition of gender diversity as a part of normal human diversity (APA, 2024, p 2). The American Association for Marriage and Family Therapy (AAMFT) recently issued a statement that GICE was "harmful, unethical, and in direct violation of the AAMFT Code of Ethics" (American Association For Marriage Family Therapy, 2024). EMDR International Association (EMDRIA) has a position on conversion therapy for sexual orientation change efforts (SOCE). EMDRIA prohibits using SOCE by its members, EMDR Certified Therapists,™ EMDR Consultants,™ Credit Providers, and EMDR Trainers™ (EMDRIA, 2024). Despite the opposition of these professional organizations, many therapists have treated clients with therapies that attempted to change their gender identity, causing significant trauma.

The research on the intersection of neurodivergence and gender dysphoria has a focus on Autistic individuals. Autistic TGD clients may experience gender dysphoria differently (Cooper et al., 2022). They may have heightened sensitivity to discomfort or distress in how they experience their bodies or are accepted in the world (Cooper et al., 2022). These sensitivities can intensify the experience of

dysphoria, making it more challenging for them to navigate (Cooper et al., 2022). Cooper used an example of a participant who wanted to wear a binder to address their gender dysphoria but was not able to because of their sensory sensitivities (Cooper et al., 2022).

The research on younger Autistic people showed that rigid thinking patterns were challenged by the lack of clear and timely transition plans and the obstacles they faced (Cooper et al., 2023). Puberty was tough for these youths as their bodies changed without an explanation or in the manner in which they understood or desired (Cooper et al., 2023).

Once an Autistic person comes to accept that they are TGD, they must navigate a healthcare system that may tell them things such as:

- it is a phase that they will grow out of, and that will cause them to regret any transition.
- it is a response to trauma
- they are attention-seeking
- they are confusing a special interest with their identity.

The recent anti-transgender backlash has influenced the healthcare system in the United States; some states, such as Missouri, explicitly cite autism as a reason for restricting gender-related care (Huckins, 2023). These laws remove autonomy from Autistic people to make decisions about their health and well-being and cause them more trauma. With an understanding of the issues that ND and TGD clients face, the author will move to recommendations for gender-diverse neurodiversity-affirming EMDR work.

To start we will begin with suggestions for developing an affirming framework.

1. **Acknowledge the harm experienced by neurodivergent and gender-diverse clients:** Therapists must confront their internal biases and strive for cultural competency. Clients cannot engage safely in trauma work if they feel the need to correct or educate their therapists about neurodivergence or gender identity. If there is a lack of understanding, it may undermine the therapeutic relationship and impede healing (Hanville, 2024).
2. **Adopt an affirming framework for gender diversity and neurodiversity:** Clinicians can integrate Dr. Walker's diversity paradigm and view neurodiversity through a strengths-based lens, recognizing the value of cognitive differences instead of pathologizing (Walker, 2021). Similarly, therapists need to approach gender identity with this affirming perspective.
3. **Move beyond the absence of prejudice:** Affirming care requires more than a lack of prejudice. It requires addressing internal bias and reaching cultural competency (Hanville, 2024). Reaching this competency requires training that is, at minimum, informed by people of lived experience and better if provided by those with lived experience (Hanville, 2024). This competency requires therapists to challenge any biases about either group.

Let's look at specific recommendations for affirming EMDR therapy through each phase.

Phase 1

HISTORY TAKING

Begin phase one by incorporating questions about neurodivergence and gender identity into the intake process. Many clients have self-identified as neurodivergent, and it is essential to respect and affirm self-diagnoses, given the systemic barriers to formal diagnosis, including financial and emotional costs (Lewis, 2017). Misdiagnosis and experiences of ableism can further complicate clients' therapeutic experiences, and clinicians must remain vigilant not to create those dynamics. Therapists can also incorporate questions that might reveal symptoms that could indicate ND, such as high anxiety, rigid thinking, impulsive behavior, executive functioning struggles, and a pervasive feeling of not belonging (Strang et al., 2023).

For TGD clients, respect self-identification and use the name and pronouns the client requests (Chang, 2017). If a legal name needs to be on billing paperwork, indicate the reason, so clients understand why the therapist requests it. It is crucial that intake forms normalize diverse experiences rather than introduce additional obstacles or microaggressions. The intake process is the time to provide a safe and secure sensory environment (Jones, 2024). Neurodivergent individuals may experience heightened sensory sensitivities and have different communication preferences (Jones, 2024). Ask all clients about their sensory needs to ensure none get overlooked. Specifically, inquire about temperature, lighting, olfactory needs, executive functioning issues, and auditory needs. Research has shown that clients value therapists asking them about any accommodations they need at the beginning of treatment rather than the client having to bring it up (Jones, 2024). Ask these questions within a framework of clients' needs rather than as a need for accommodations. Doing this normalizes the process and can make clients feel seen. As therapists learn about clients' sensory needs, they will understand which bilateral stimulation method (BLS) might work best for them.

During intake, it is essential to establish clear and explicit communication

and ensure that clients understand the expectations. Many ND clients reported that open-ended questions were hard to understand (Jones, 2024). They also wanted ease in initial contact as many have challenges with phone calls (Jones, 2024).

While taking the history, take the time to learn about the client's strengths and interests. The therapist can use this information for future adaptations or resourcing. It can also help determine what method of BLS will work best for the client. Therapists should affirm clients' lived experiences as many will have past encounters of invalidation and disbelief. A way to do this is with appropriate self-disclosure, which is another way to affirm clients' experiences. Research on non-binary clients' experience of therapy showed that they felt it essential to know their therapist's gender identity and sexual orientation (Rosati et al., 2022). This disclosure can build attunement, confidence, and safety with clients, especially if the clinician has lived experiences or identities like the client.

Phase 2

PREPARATION-RESOURCING

Understanding the sensory profiles of neurodivergent (ND) clients is helpful to therapists' ability to tailor the EMDR process to meet the client's needs. Research indicates that many neurodivergent individuals experience *aphantasia*—the inability to visualize (Dutta, 2022). Many are unaware they have aphantasia until something makes them aware that others can visualize. Many people with aphantasia have developed strategies to compensate. Assessing whether a client can visualize is essential in the preparation stage of EMDR. If visualization proves challenging, exploring how clients have previously navigated this experience is invaluable for creating adaptations to support the client. Adaptations might include using tangible objects, such as holding a calming fidget or another sensory item, to establish a resource connection.

Using concrete visuals, such as a photo or drawing, can also be a way to connect with memories or resources. These adaptations honor the client's sensory preferences and foster a more inclusive and effective therapeutic process.

When resourcing with TGD clients, be mindful of language when creating visualization resources, ensuring they are free from hetero- or cis-normative terms. TGD clients may want to avoid visualizing or resourcing their younger selves, who looked differently. Dr. Chang recommends never using this technique without thoroughly conversing about these issues with the client. Dr. Chang articulates the confusion that may arise when transgender people visualize themselves as children. Do they visualize what they appear like or themselves as they wish they were (Chang, 2017)?

Autistic clients may also have a higher rate of alexithymia (Kinnaird et al., 2017). In broad terms, this term refers to people having difficulty identifying and describing emotions (Neff, 2022). One of the questions asked in the standard EMDR script is: What emotion goes with that (Shapiro, 2001)? ND clients may not have an answer to that question. Assessing that ability beforehand allows the therapist to avoid frustration during the processing. Adaptations can include asking clients if they associate a color with

If therapists ask them to do things that do not work for their brains, it can trigger shame. Shame is also often prevalent in the TGD client group due to hearing that their identity is wrong. This shame is a potential target for processing for both groups.

their experience or finding another way to get at how the client relates to the memory, such as through art or music. Go with whatever they bring to the session. The therapist and client can use the strengths established during the history-taking phase at this point.

In the author's clinical experience, both ND and gender-diverse clients may have parts that learned to dissociate to protect them. Forced presence through grounding or other meditation may cause distress. In addition, both groups may have experienced traumas related to a lack of bodily autonomy. Younger TGD clients may have had a traumatic experience going through puberty. If providers used ABA with ND clients, they may have repeatedly told them to use their bodies in ways that felt uncomfortable to them. Therapists must seek consent for each intervention and regularly check in to ensure the client is comfortable with the interactions.

Phase 3

ASSESSMENT

When completing the assessment phase, therapists should focus on the issue for which the clients sought therapy, which may not relate to their gender identity or neurodivergence (Hanville, 2024). At the same time, therapists need to be mindful of the level of trauma that these clients will have faced just within and because of their identities.

As the target plan develops, it should be sensitive to not shaming clients who may already be worried about doing something wrong (van Diest et al., 2022). Many of our clients will have the belief that they are not good enough as a result of a lifetime of microaggressions and directly abusive behaviors that they have experienced. If therapists ask them to do things that do not work for their brains, it can trigger shame. Shame is also often prevalent in the TGD client group due to hearing that their identity is wrong. This shame is a potential target for processing for both groups.

Assess whether the client has experienced adverse or stigmatizing reactions from neurotypical individuals related to their behavioral expressions, such as stimming or verbal processing, along with any adverse feedback they may have received about their gender identity, presentation, or choice of pronouns. Additional targets may relate to executive functioning. Clients who struggle to complete tasks and have received negative feedback or been labeled lazy have targets related to those experiences.

Autistic burnout, which Dr. Neff defines as "a state of physical, emotional, and mental exhaustion, can also be a target. Burnout gets triggered by various things, like stress, sensory overload, social isolation, or difficulty navigating social or educational systems" (Neff para 4, 2024). It often happens in multiple incidents, so utilizing a float-back can identify different traumas around masking (MacInnis, 2022).

Phase 4

DESENSITIZATION

Many ND people have sensory sensitivities, and the eye movement aspect of EMDR may be overwhelming for some. Therapists need to adapt BLS to be sensory-friendly. During the History Taking and Treatment Planning stage, the therapist and client should have already discussed the client's preferred method of BLS. Therapists might try a few different types of BLS with the client to determine what feels right. Some things that the author has used for BLS include music, movement, and fidgets. Therapists can use other adaptations during BLS, such as allowing clients to talk through the entire process if that helps their processing.

Phase 5

INSTALLATION AND PHASE 6 BODY SCAN

Our ND and TGD clients may have past experiences that are also ongoing, such as microaggressions. Installing a positive belief that they are safe will not resonate, may not be factually accurate, and will challenge our concrete-thinking ND clients. If the therapist reframes the language of positive cognition to that of an adaptive belief, it may feel more accessible to a client. For example, the therapist might say, "Let us approach this from a different angle. Instead of focusing on what you 'want' to believe about yourself, how about we explore what might be a helpful way for you to cope with similar situations in the future?" Dr. Chang recommends emphasizing choice and empowerment in the face of their day-to-day challenges (Chang, 2017). Focusing on choice allows clients to shift their minds to developing coping strategies and strengths and creates a space that may feel more accessible and empowering for the client. This approach supports the clients to find a belief that resonates with them and fosters their sense of agency and growth. An example of an adaptive belief is "I can use my strength to navigate challenging times."

This article does not address intersectionality beyond the intersection of ND and gender diversity. People in these communities can have additional intersecting identities, such as race, disability, and socioeconomic challenges. Recognizing these intersections is crucial for providing comprehensive support to ND clients (Hanville et al., 2023).

Continue exploring this topic by getting additional training on

the intersection of gender identity and neurodiversity and each topic separately. The best training includes a lived experience component. These communities' voices need to be a part of any discussion on working with them in the therapeutic context.

EMBRACING AN INCLUSIVE AND ADAPTIVE APPROACH

The intersection of gender identity and neurodivergence is essential to therapeutic practice. Therapists should embrace an inclusive and adaptive approach to foster an environment where all clients feel seen and understood. Therapists' ethical codes require that we provide culturally competent care. To ensure that level of care, therapists must challenge their biases and adapt their practices to meet the unique needs of neurodivergent, gender-diverse clients.

Cathy Hanville, LCSW (They/She), is a gender-queer late-diagnosed ADHDer. They are a licensed clinical social worker practicing in both PA and CA. They provide consultation and training on working with complex trauma with a focus on integrating parts work and working with Queer and TGD clients.

References

American Psychological Association. (2024, February). APA Policy statement on evidence-based inclusive care for transgender, gender diverse, and nonbinary individuals. American Psychological Association. www.apa.org/about/policy/transgender-nonbinary-inclusive-care

American Association For Marriage Family Therapy. (2024, October). Gender-Affirming Care Position Statement. www.aamft.org/AAMFT/About_AAMFT/Pos_on_couples.aspx#anchor1

Ariane Resnick, C. (2021, July 21). What does it mean to be in the closet? *Verywell Mind*. www.verywellmind.com/what-does-it-mean-to-be-in-the-closet-5192426

Attoe DE, Climie EA. Miss. Diagnosis: A Systematic Review of ADHD in Adult Women. *J Atten Disord.* 2023 May;27(7):645-657. doi: 10.1177/10870547231161533. Epub 2023 Mar 30. PMID: 36995125; PMCID: PMC10173330.

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. https://doi.org/10.1891/1933-3196.4.4.156

Bo, L., van der Mieser, A.I.R., Klomp, S.E., Williams, Z.J., Szatmari, P., Lai, M.C.. The missing clinical guidance: a scoping review of care for autistic transgender and gender-diverse people. *EClinical Medicine,* September 27, 2024; 76:102849. DOI: 10.1016/j.eclinm.2024.102849. PMID: 39398492; PMCID: PMC11470179.

Botha, M., Hanlon, J., Williams, G.L. Does Language Matter? Identity-First Versus Person-First Language Use in Autism Research: A Response to Vivanti. J *Autism Dev Disord.* 2023 Feb;53(2):870-878. doi: 10.1007/s10803-020-04858-w. Epub 2021 Jan 20. PMID: 33474662; PMCID: PMC7817071.

Bruce, H., Munday, K., Kapp, S.K. Exploring the Experiences of Autistic Transgender and Non-Binary Adults in Seeking Gender Identity Health Care. *Autism Adulthood.* 2023 Jun 1;5(2):191-203. doi: 10.1089/aut.2023.0003. Epub 2023 Jun 13. Erratum in: *Autism Adulthood.* 2023 Sep 1;5(3):343. doi: 10.1089/aut.2023.0003.correx. PMID: 37346990; PMCID: PMC10280216.

Camm-Crosbie, L., Bradley, L., Shaw, R., Baron-Cohen, S., Cassidy, S. "People like me don't get support:" Autistic adults' experiences of support and treatment for mental health difficulties, self-injury and suicidality. *Autism.* 2019 Aug;23(6):1431-1441. doi: 10.1177/1362361318816053. Epub 2018 Nov 29. PMID: 30497279; PMCID: PMC6625034.

Chang, S. C. (2017). EMDR therapy as affirmative care for transgender and gender nonconforming clients. In M. Nickerson (Ed.), *Cultural competence and healing culturally based trauma with EMDR therapy* (pp. 177–194). Springer Publishing Company.

Chapman, R., Botha, M. Neurodivergence-informed therapy. *Dev Med Child Neurol.* 2023 Mar;65(3):310–317. doi: 10.1111/dmcn.15384. Epub 2022 Sep 9. PMID: 36082483.

For example, the therapist might say, "Let us approach this from a different angle. Instead of focusing on what you 'want' to believe about yourself, how about we explore what might be a helpful way for you to cope with similar situations in the future?"

Cleary, M., West, S., Kornhaber, R., & Hungerford, C. (2023). Autism, Discrimination, and Masking: Disrupting a Recipe for Trauma. *Issues in Mental Health Nursing*, *44*(9), 799–808. https://doi.org/10.1080/01612840.2023.2239916

Cooper, K., Butler, C., Russell, A., & Mandy, W. (2022). The lived experience of gender dysphoria in autistic young people: A phenomenological study with young people and their parents. *European Child & Adolescent Psychiatry*. https://doi.org/10.1007/s00787-022-01979-8

Cooper, K., Mandy, W., Butler, C., & Russell, A. (2021). The lived experience of gender dysphoria in autistic adults: An interpretative phenomenological analysis. *Autism*, pp. 26, 963– 974. https://doi.org/10.1177/13623613211039113

Coming out: Living authentically as transgender or non-binary. Human Rights Campaign Foundation. (2022, October). https://reports.hrc.org/coming-out-living-authentically-as-transgender-non-binary#coming-out-and-inviting-in

da Silva, A.G., Malloy-Diniz, L.F., Garcia, M.S., Rocha, R. (2020). Attention-Deficit/Hyperactivity Disorder and Women. In: Rennó Jr., J., Valadares, G., Cantilino, A., Mendes-Ribeiro, J., Rocha, R., Geraldo da Silva, A. (eds) *Women's Mental Health*. Springer, Cham. https://doi.org/10.1007/978-3-030-29081-8_15

Doherty, M., Neilson, S., O'Sullivan, J., Carravallah, L., Johnson, M., Cullen, W., Shaw, S.C.K. Barriers to healthcare and self-reported adverse outcomes for autistic adults: a cross-sectional study. *BMJ Open*. 2022 Feb 22;12(2):e056904. doi: 10.1136/bmjopen-2021-056904. PMID: 35193921; PMCID: PMC8883251.

Dutta, N. (2022, March 8). What it's like to be "mind blind." *Time*. https://time.com/6155443/aphantasia-mind-blind/ accessed 11/1/23

EMDRIA. (2024, January 24). EMDR International Association policies. EMDR International Association. www.emdria.org/about-emdria/emdr-international-association-policies

Enright, J. (July 12, 2023). The AMA on ABA: The American Medical Association's stance on applied behavioural analysis. Retrieved from https://medium.com/neurodiversified/the-ama-on-aba-6b39237942ea.

Expósito-Campos, P., Pérez-Fernández, J. I., & Salaberria, K. (2023). Empirically supported affirmative psychological interventions for transgender and non-binary youth and adults: A systematic review. *Clinical Psychology Review*, *100*, 102229. https://doi.org/10.1016/j.cpr.2022.102229

Fletcher-Watson Autism and neurodiversity: a new paradigm *Journal of Neurology, Neurosurgery & Psychiatry* 2023;94:e2.

Gender-Affirming Care Position Statement. (2024, October). Retrieved from www.aamft.org/AAMFT/About_AAMFT/Pos_on_couples.aspx.

Gibson, M. F., & Douglas, P. (2018). Disturbing behaviors: Ole Ivar Lovaas and the queer history of autism science. *Catalyst: Feminism, Theory, Technoscience*, *4*(2), 1–28.

References

Glackin, A., Pearson, A., Davis, R. "You Are the Expert of Your Own Experience:" A Thematic Analysis of Experiences of Autism and Gender Diversity in Adulthood. *Autism Adulthood.* 2024 Sep 16;6(3):300-311. doi: 10.1089/aut.2022.0111. PMID: 39371358; PMCID: PMC11447393.

Guidetti, C., Brogna, P., Chieffo, D. P., Turrini, I., Arcangeli, V., Rausa, A., Bianchetti, M., Rolleri, E., Santomassimo, C., Di Cesare, G., Ducci, G., Romeo, D. M., & Brogna, C. (2023). Eye movement desensitization and reprocessing (EMDR) as a possible evidence-based rehabilitation treatment option for a patient with ADHD and history of adverse childhood experiences: A case report study. *Journal of Personalized Medicine*, 13(2), 200. https://doi.org/10.3390/jpm13020200

Hanville, C. (2024, August 12). Gender-affirming EMDR therapy. EMDR International Association. *Focal Point Blog*. www.emdria.org/blog/gender-affirming-emdr-therapy

Hanville, C., MacInnis, C., Lanza, T. (2024). Emergent Neurodivergent: Neurodiversity-Affirming therapeutic education. *The Therapist: Magazine of the California Association of Marriage and Family Therapists,* 37(1), 6-9

Hallett, S. & Kerr, C. (2020). You need support, validation, good coping skills. You need and deserve acceptance: Autistic Adult Experiences of Counselling. Autistic Mental Health & Autistic Mutual Aid Society Edinburgh (AMASE). www.autistic-mentalhealth.uk/counsellingreport

Hogan, S. J. (2023, Winter). Affirm Your Practice. *Go With That Magazine.*® www.emdria.org/magazine/affirm-your-practice

Huckins, G. (2023, July 7). Trans people's mental health is being weaponized against them. *Wired*. www.wired.com/story/trans-gender-affirming-care-mental-health-autism

James, S.E., Herman, J.L., Durso, L.E., & Heng-Lehtinen, R. (2024). *Early Insights: A Report of the 2022 U.S. Transgender Survey.* National Center for Transgender Equality, Washington, D.C. https://ustranssurvey.org/download-reports

Jones, F., Hamilton, J., & Kargas, N. (2024). Accessibility and affirmation in counseling: An exploration into neurodivergent clients' experiences. *Counseling and Psychotherapy Research*, 00, 1–16. https://doi.org/10.1002/capr.12742

Kallitsounaki, A., & Williams, D. M. (2023). Brief report: An exploration of alexithymia in autistic and nonautistic transgender adults. *Autism in Adulthood*, *5*(2), 210–216. https://doi.org/10.1089/aut.2022.0113

Kinnaird, E., Stewart, C., Tchanturia, K. Investigating alexithymia in autism: A systematic review and meta-analysis. *Eur Psychiatry.* 2019 Jan;55:80-89. doi: 10.1016/j.eurpsy.2018.09.004. Epub 2018 Nov 3. PMID: 30399531; PMCID: PMC6331035.

Kosatka, D., & Ona, C. (2014). Eye movement desensitization and reprocessing in a patient with asperger's disorder: Case report. *Journal of EMDR Practice and Research*, 8(1), 13–18. https://doi.org/10.1891/1933-3196.8.1.13

Kroll, E., Lederman, M., Kohlmeier, J., Kumar, K., Ballard, J., Zant, I., Fenkel, C. The positive impact of identity-affirming mental health treatment for neurodivergent individuals. *Front Psychol*. 2024 Jul 15;15:1403129. Doi: 10.3389/fpsyg.2024.1403129. PMID: 39077203; PMCID: PMC11285098.

Leuning, E. M., van den Berk-Smeekens, I., van Dongen-Boomsma, M., & Staal, W. G. (2023). Eye movement desensitization and reprocessing in adolescents with autism; efficacy on ASD symptoms and stress. *Frontiers in Psychiatry*, 14. https://doi.org/10.3389/fpsyt.2023.981975

Lewis, L. F. (2017). A mixed methods study of barriers to formal diagnosis of autism Spectrum disorder in adults. *J. Autism Dev. Disord.* 47, 2410–2424. doi: 10.1007/s10803-017-3168-3, PMID: [DOI] [PubMed] [Google Scholar]

MacInnis, C. *Special Considerations for EMDR with Autistic and ADHD Clients- Part 2- Advanced* July 13, 2024-On Demand www.transcendstherapy.com/about-4-1

McAuliffe, C., Walsh, R. J., & Cage, E. (2023). "My whole life has been a process of finding labels that fit:" A thematic analysis of autistic LGBTQIA+ identity and inclusion in the LGBTQIA+ community. *Autism in Adulthood*, *5*(2), 127–138. https://doi.org/10.1089/aut.2021.0074

McCrossin, R. *Finding the True Number of Females with Autistic Spectrum Disorder by Estimating the Biases in Initial Recognition and Clinical Diagnosis. Children* (Basel). 2022 Feb 17;9(2):272. doi: 10.3390/children9020272. PMID: 35204992; PMCID: PMC8870038.

McVey, AJ., Glaves, KJ., Seaver, S., Casagrande, KA. The ethical imperative to honor autistic clients' autonomy in mental health treatment. *Front Psychiatry.* 2023 Sep 25;14:1259025. doi: 10.3389/fpsyt.2023.1259025. PMID: 37817832; PMCID: PMC10561286.

Neff, M. A. (2022, September 3). What is Alexithymia? Alexithymia Defined and Explained. *Insights of a Neurodivergent Clinician*. https://neurodivergentinsights.com/blog/what-is-alexithymia-alexithymia-defined-and-explained

Neff, M. A. (2024, May 2). Autistic burnout recovery. *Insights of a Neurodivergent Clinician*. https://neurodivergentinsights.com/blog/autistic-burnout-recovery

Neff, M. A. (2024b, May 25). What is autistic masking? *Insights of a Neurodivergent Clinician*. https://neurodivergentinsights.com/blog/what-is-masking-in-autism

Quinn, P.O., Madhoo, M. A review of attention-deficit/hyperactivity disorder in women and girls: uncovering this hidden diagnosis. *Prim Care Companion CNS Disord.* 2014;16(3):PCC.13r01596. doi: 10.4088/PCC.13r01596. Epub 2014 Oct 13. PMID: 25317366; PMCID: PMC4195638.

Quinn, P. O. (2005). Treating adolescent girls and women with ADHD: Gender-specific issues. *Journal of Clinical Psychology*, *61*(5), 579–587. https://doi.org/10.1002/jclp.20121

Reed, E. (2024, September 30). *Anti-Trans Legislative Risk Assessment Map: September 2024 edition*. www.erininthemorning.com/p/anti-trans-legislative-risk-assessment-212

Rosati, F., Lorusso, M.M., Pistella, J., Giovanardi, G., Di Giannantonio, B., Mirabella, M., Williams, R., Lingiardi, V., Baiocco, R. Non-Binary Clients' Experiences of Psychotherapy: Uncomfortable and Affirmative Approaches. *Int J Environ Res Public Health*. 2022 Nov 20;19(22):15339. Doi: 10.3390/ijerph192215339. PMID: 36430057; PMCID: PMC9690436.

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing (EMDR), second edition: Basic Principles, Protocols, and Procedures.* Guilford Press.

Steinberg, H., Garfield, T., Becker, A., & Shea, L. (2023). What category best fits: Understanding transgender identity in a survey of autistic individuals. *Autism in Adulthood*, 5(2), 204–209. https://doi.org/10.1089/aut.2021.0079

Strang, J.F., McClellan, L.S., Raaijmakers, D., Caplan, R., Klomp, S.E., Reutter, M., Lai, M.C., Song, M., Gratton, F.V., Dale, L.K., Schutte, A., de Vries, A.L.C., Gardiner, F., Edwards-Leeper, L., Minnaard, A.L., Eleveld, N.L., Corbin, E., Purkis, Y., Lawson, W., Kim, D.Y., van Wieringen, I.M., Rodríguez-Roldán, V.M., Harris, M.C., Wilks, M.F., Abraham, G., Balleur-van Rijn, A., Brown, L.X.Z., Forshaw, A., Wilks, G.B., Griffin, A.D., Graham, E.K., Krause, S., Pervez, N., Bok, I.A., Song, A., Fischbach, A.L., van der Miesen, A.I.R. The Gender-Diversity and Autism Questionnaire: A Community-Developed Clinical, Research, and Self-Advocacy Tool for Autistic Transgender and Gender-Diverse Young Adults. *Autism Adulthood.* 2023 Jun 1;5(2):175-190. doi: 10.1089/aut.2023.0002. Epub 2023 Jun 13. PMID: 37346994; PMCID: PMC10280183.

Thorne, N., Yip, A.K., Bouman, W.P., Marshall, E., Arcelus, J. The terminology of identities between, outside and beyond the gender binary-A systematic review. *Int J Transgend.* 2019 Jul 18;20(2-3):138–154. doi: 10.1080/15532739.2019.1640654. PMID: 32999602; PMCID: PMC6830980

van Diest, C., Leoni, M., Fisher, N., & Spain, D. (2022). Using EMDR with autistic clients: How do therapists adapt? *Journal of EMDR Practice and Research*, *16*(3), 123–134. https://doi.org/10.1891/emdr-2022-0014

Walker, N. (2021). *Neuroqueer heresies: Notes on the neurodiversity paradigm, autistic empowerment, and postnormal possibilities.* Autonomous Press.

Warrier, V., Greenberg, D. M., Weir, E., Buckingham, C., Smith, P., Lai, M.-C., Allison, C., & Baron-Cohen, S. (2020). Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals. *Nature Communications*, *11*(1). https://doi.org/10.1038/s41467-020-17794-1

Zwickl, S., Skewis, F., Ruggles, T., Murray, J., Cook, T., & Cheung, A. S. (2024). Language and terminology to describe transgender communities; Perspectives from people with lived experience. *International Journal of Transgender Health, pp. 1–11.* https://doi.org/10.1080/26895269.2024.2415684

Finding the Magic in the Neurotype: Using EMDR with Neurodivergent Clients

By Dr. Tiff Lanza

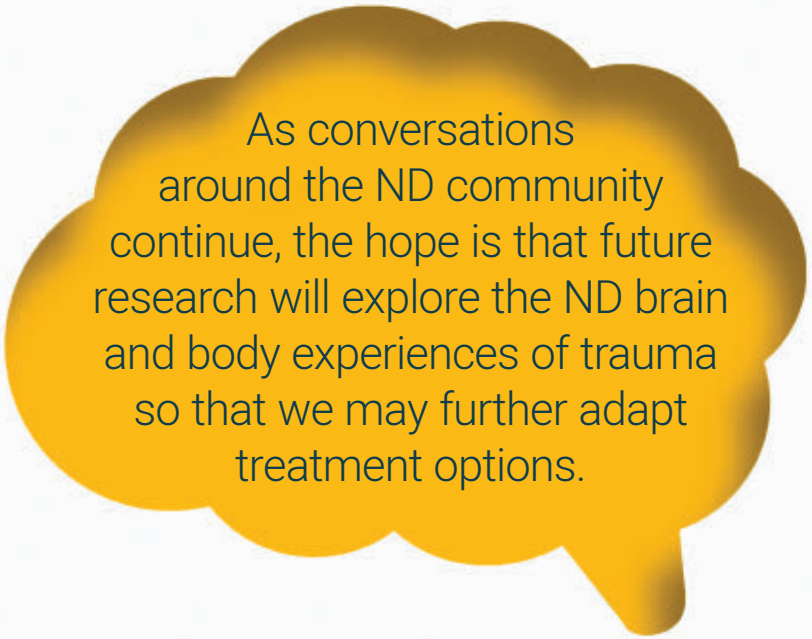
Take a moment to appreciate the magic that can happen through Eye Movement Desensitization Reprocessing (EMDR). This modality brings an entirely different experience to processing trauma, understanding feelings, and recognizing self-awareness. EMDR provides a foundation open to scaffolding various accommodations and creativity, meeting clients' individual needs. This article explores the exciting and impactful adaptations to EMDR when working with neurodivergent (ND) clients. It is important to begin by acknowledging one's connection to one's work. This author is a transgender, nonbinary, queer, neurodivergent (late-diagnosed), chronically ill therapist. The article includes aspects of lived and professional experience.

The neurodivergent community experiences higher levels of trauma; however, the research statistics are flawed. The ND umbrella was limited in scope to define and diagnose autism and ADHD rigidly. Now that society recognizes that the definition and understanding of neurodivergence has expanded, one can recognize the limited purview of prior study findings. The research that does exist focuses on specific pockets within the ND community perpetuating biased assumptions within a limited scope (Hogan, 2023). This is especially salient since ND individuals experience trauma in connection to their neurodivergence and as an ancillary component of their life experiences. For example, many ND people report that growing up not knowing about their neurotype or not having that neurotype supported was traumatic. The shame, embarrassment, isolation, bullying, and corrective actions forced upon them for being different acts in tandem as a form of abuse enacted by a society that operates under the assumption of neuro-typicality. In addition, NDs are also susceptible to the impact of other traumas that are not directly related to being neurodivergent. As conversations around the ND community continue, the hope is that future research will explore the ND brain and body experiences of trauma so that we may further adapt treatment options.

NEURODIVERGENT DIAGNOSIS

This section provides a brief context to the diagnosis experience, specific to the ND community. The reality is that receiving a diagnosis is a privilege. Many individuals do not have the means to access a mental health provider and support. Health insurance, finances, and accessibility to a neuro-affirming assessor can all be barriers. Individuals who had a late-in-life diagnosis or are late-diagnosed reported having years of misdiagnosis before meeting an informed professional.

In understanding that access to therapeutic support and assessments is a privilege, we recognize that self-realization or self-diagnosis is valid. Some skeptics claim that



TikTok is diagnosing everyone with autism. Social media gives access and a platform to those with lived experience. It is the most accessible way for communities forced into marginalization to share their stories with others. These content creators and everyday sharers are bringing relief to many ND people by mirroring their experiences and offering language that helps others describe their experience as an ND person living in an ableist world. Once the connection to a commonality is found, the next step is to do research. Self-realized individuals often log more hours to research ND qualities and symptoms than are required by mental health educational programs. By the time an individual reaches a therapist and says they wonder if they are neurodivergent, they have most likely dedicated years in the pursuit of understanding themselves. Until the barriers and oppression limiting access to mental health are removed, the self-realization movement must be awarded the respect it deserves.

LANGUAGE

The foundational step in supporting any community is working to understand its language. The next step is to continue engaging with the community to know when the language evolves and changes. This can become a barrier for some people as it can be overwhelming to keep up with changes. Therapists may wonder if a client does not like the word neurodivergent; what word should be used.

NEURODIVERGENT-AFFIRMING WORK WITHIN EMDR

Statements such as "meet the client where they are" or "individualize the care" are aspects of affirming care, but those phrases can miss crucial elements of affirming work. Affirming work, in general, proactively supports and validates a person's full self-identity, experiences, and beliefs through positive reinforcement. Affirming work creates a space where a person feels seen, heard, and understood. Neurodivergent affirming work should be met through the framework that ND brains are just a different neurotype—not broken and not needing to be healed or fixed. There are three pillars that can be used in working with ND humans that are a culmination of long-term communications in the disability field. The three pillars that can be used in ND-Affirming work are:

- Value the whole person
- Presume competence
- Lead with curiosity and exploration.

These pillars are what the author identifies as a framework for approaching ND individuals. Our baseline of interacting with other humans in this world should be led by the premise of valuing the whole person. This concept is about appreciating and considering all aspects of a human being versus a one-dimensional focus (i.e., one specific traumatic event). Recognizing the intersectionality (Crenshaw, 1991) of human experience can go a long way in healing and treatment. An example of intersectionality is how their ND experience was affected or part of the traumatic event. In 1984, researcher Anna Donnellan coined the phrase presume competence as a way to approach individuals with disabilities in academia (1984). The mental health field was initiated with the assumption that therapists hold power over the client because they are all-knowing. Part of decolonizing and dismantling oppressive systems—shifting from all-knowing to leading with curiosity and exploration—allows for clients to regain control of their narratives. This concept has been used in leadership and behavioral research since the mid-1990s.

Society was built around assumptions of neurotypical brains, which should inform any strategy employed with clients. Therapeutic modalities were created assuming neurotypical processing experiences. EMDR is a therapeutic tool; it is only with the creativity and consideration of an affirming therapist that it becomes an accommodating tool. EMDR therapy is effective in supporting ND clients as long as the three pillars of affirming care are implemented. It

Tips to Start Using the Language

1. In general, the language used to describe a community at large should be based on what the community asks others to use.
   a. The community is asking not to use words like "spectrum" or "person with autism." The respectful request is to use statements like "autistic community" or "autistic person."
2. Individual work should start with asking people what language fits best to describe their neurotype.
   a. This is when a client says, "I like to use Asperger's," when the majority of the community no longer uses that term.

It is pivotal that therapists continue to learn from and adapt to the changes the community is making. This includes moving away from person-first language (a person with autism) and using identity-first language (an autistic person). This shift originated from the disabled community members who expressed discomfort with person-first language. Although well-intentioned, person-first language ended up diminishing the experience of being disabled by society as though it was an accessory a person carried with them. In contrast, identity-first language shows how society disables those humans. Until the next iteration of societal learning occurs, settings such as professional websites, trainings, and general communications should use identity-first language to honor the macro-level community preference.

While many professionals attend training on neurodiversity, there still seems to be confusion in the field with repetitive questions on language. It can become exhausting for folks in the community to be in spaces where they must teach supporters about affirming language. If people are still questioning terminology or how to use it, they may benefit from self-reflection on the barriers that have deterred them from fluency. It is important to note that the language discussed here is current, and some of these words may shift in the future. For now, the following language can be used when referencing the ND community.

Lived experience: Knowledge gained by first-hand experience. This is a professional who is ND and works with the ND population. They have lived experience in the ND world versus an ally who does not have lived experience as an ND human.

Neurotype: Describing the concept that all brains work differently (Stimpunks, 2024). Each brain has its own neurotype; from neuro-typical to ND and everything in between.

Neurodiversity: To describe "the diversity of human minds" (Walker, 2021). Our brains are as diverse as our fingerprints. By using the word neurodiversity, one is simply referring to the fluctuations of human brains we encounter in our world.

Neurodiverse: This word is used to describe groups of people. There are two ways that this word can be used:
1. To describe a group of people that have various neurotypes, including neurotypical.
2. To describe a mixed group of people that are all neurodivergent.

Neuro-typical or Neuro-conforming: When describing a brain "that falls within the dominant social standards of 'normal'" (Walker, 2021). This brain works in a way that society expects or understands. Neuro-typical is more widely used and known. Neuro-conforming can be used when unsure what a person's neurotype could be.

Neurodivergence: An experience of an innate or acquired brain that operates differently than the dominant societal standards. Neurodivergence is used mostly when describing experiences within the community at large or a group (Wise, 2019).

Neurodivergent: This describes a singular person's neurotype. It specifically describes a brain that is different from dominant society standards. Neurodivergent people can be diagnosed, self-realized, innate, or acquired. These include but are not limited to: obsessive-compulsive disorder (OCD), dyslexia, plurality, intellectual disabilities, or dyspraxia.

Innate neurodivergence: When an individual is born with a neurodivergent brain (Edgar, 2024). Examples of innate neurodivergence include but are not limited to ADHD and Autism.

Acquired neurodivergence: An experience where an individual develops neurodivergence through a medical condition or an event (Edgar, 2024). Examples include—and are not limited to—stroke or traumatic brain injury (TBI).

Multi or Multiple Divergent: When a person has multiple neurodivergent experiences. For example, a bipolar person who is also dyslexic would be considered a multi-divergent or multiple-divergent neurotype.

Masking: Suppressing needs, movements, and emotions in attempt to camouflage with neurotypical expectations of socializing (Storey & Holmes, 2023). Masking is associated with trauma and negative mental health effects. An individual may hold back stimming behaviors due to societal shame and judgment as a form of masking. When professionals hold back asking clarifying questions about an instructed task to understand what they are being asked to do, they are masking because neurotypical society treats questions as challenges or attacks to the requester. This can leave the ND individual at risk of confrontation due to asking questions.

is important to note that there is no foolproof instruction manual or one-size-fits-all program for working with ND individuals. Learning and adapting to each client is neuro-affirming care.

PERFORMATIVE NEURO-AFFIRMING WORK

Some pieces of training and resources have the label "neuro-affirming," which perpetuates ableist stereotypes. When learning about a specific community, the education should come from a professional who has lived experience. This is not to say that neuro-typicals cannot speak to this topic, but the underlying research and approved methodologies need to originate from within the community rather than outside. Learning from those with lived experience may illuminate underrecognized practices and assumptions that are harmful, biased, and engaging in antiquated rhetoric. This separates those going through the motions to appear neuro-affirming from those willing to make progressive change. Imagine an agency that puts up a kiosk of rainbow flag-covered paraphernalia in June but makes no other systemic supportive changes for the LGBTQIA2S+ community. Performative work is not affirming.

PRACTICAL TOOLS FOR ND AFFIRMING EMDR

One of the foundational skills to learning something new or leaning into something uncomfortable is to keep it simple. EMDR provides an abundant number of scripts to guide the healing process; however, one script or strategy may not give you all the answers. When adhering to strict approaches that express only one way to do something, it inherently falls into oppressive, ableist, and non-affirming practices. Fuel work through curiosity driven by questions and collaboration. None of us have all the answers. Let's not assume clients' targets or their feelings. Simply ask the client.

ND ACCOMMODATIONS

Accommodations within EMDR include adjusting to the clients' needs in a way that propels the work. Clients rarely have experiences that allow them to know and understand their accommodation needs. In most cases, the therapist asking if they have any accommodation needs is the first time that someone has considered this a possibility for them. Here are some general ND-affirming skills to start the process.

- Direct communication can be a powerful tool when working with ND clients. Do not use euphemisms or statements with "fluff" when talking with clients. An example of using "fluff" in your language in asking someone about their sensory needs. A fluff example would be: "I know that sometimes people can feel uncomfortable when they touch things and it does not make them feel good. There are times this can be with other senses as well. Are there things that make you feel uncomfortable?" A direct ask without fluff would be: "Tell me about your sensory likes and dislikes." Ask clear and direct questions and provide clear and direct information.

Over 50 top-notch Upcoming and OnDemand Advanced EMDR Trainings, Conferences and Book CE Programs

www.EMDRadvancedtrainings.com

EMDR

- Having multiple forms of important communications; written, spoken with clients, on your website, and in video could all be helpful for clients to remember information.
- Prioritizing clients' strengths by asking when they feel the clearest or most aware can help schedule the client sessions at their prime time of day. For example, ADHD clients who use stimulants to manage their ADHD may struggle with evening or later sessions. This can be when their medication is wearing off, they are feeling less clear, and their exhaustion could be stronger at that time of day. Sleep can be a struggle for many ND clients, so scheduling early in the morning may not be conducive to the client's success within EMDR.
- ND experiences can be synonymous with justice sensitivity and rule-following. Be explicit about your policies. Give notice of any changes. Provide specific steps that a client must take for things like cancellations or reschedules.

THERAPIST

It takes much more than putting neuro-affirming as a skill on a professional website to be neuro-affirming. Speak your truth in a way that feels right to you. If this is new to you, it may take practice and trial and error. Lean into it.

- If you are an ND therapist and feel comfortable sharing that information, put it on your website or share it with clients when you meet as a part of your introduction.
- If you are a neurotypical therapist, do the same as the ND therapist; put on your website or marketing information that you are neurotypical and/or share that information with your clients when you meet as part of your introduction.
- Although it is not required per our licenses, it would be invaluable if you prioritized a specific ND training when considering your continuing education units (CEUs) for the license renewal process.
- Consultation with those with lived experience—ongoing or as needed—is a resource that should be used by all therapists. Many times, therapists will ask questions in large groups, like an organizational question board or in an online group. This is not inherently wrong; however, it does not truly serve you or your client as you will get conflicting and numerous responses without the responders knowing much about your client and typically puts those in a community in a position of having to offer their expertise numerous times without proper consideration and compensation.

Sharing identities with clients is not new for therapists who have lived experience with marginalization. To ascribe to the model that therapists are mysterious to their clients upholds oppressive models in which mental health supports were built. This does not mean you share all personal details with your clients. This is where purposeful disclosure comes into the work.

It is important to include the therapist, especially if you are an ND therapist, in the accommodations. As we dismantle the oppressive systems, here is another area where our needs and survival may not align. For example, an ideal schedule for ND therapists may be three to four clients a day. However, their financial situation may require them to negate their needs. Finding balance and figuring out what compromises to make for self-care can be incredibly difficult. Some things to consider, similar to how we support clients:

- What time of day do you find you work best?
- What sensory needs do you have that could help you stay grounded and present in sessions?
- How do you structure EMDR client sessions? All in one day? Mixed in with other clients who do not use EMDR?
- Where do you find EMDR exhausts you? How can you adjust?

INITIAL CONNECTION AND PAPERWORK

The paperwork clients fill out before starting their therapeutic work can easily set a precedent for the work, organization, and/or therapist.

- Do you have a question about your intake forms regarding neurotype? If not, think about adding a question or a section about neurotype with the option for someone to pass or write "N/A" if it is not something they have had any experience with.
- How do you initially inquire about a person's neurotype? Asking questions such as "Is there a way you process information best?" or "Are there any considerations for our communication together?" These can be asked on a consultation call, intake documents, or an intake session.
- Whether in person or virtual, how do you set up the space to be as conducive to the process as possible? Again, get curious. "Tell me what makes you feel the most comfortable when talking with another person?" "What are things that make you feel

A way to create an ND-affirming environment in the therapy session is by having a menu of BLS options for the client to practice and choose from that stimulate the right to left motion. Having the client practice these then allows for an ND-affirming approach versus an abstract ask to the client of which BLS modality they would prefer. Many ND individuals need to see or try something rather than an abstract ask when it comes to decision-making.

comfortable?" "How do you find comfort?"

- Traumatic experiences live within the senses. It is one of the reasons that EMDR can be incredibly effective in lessening traumatic symptoms because there is attunement to one's sensory system. Asking client's when meeting, "What can you tell me about your sensory system?" or "What can you tell me about your experiences with sensory needs?" This is a start to creating a sensory profile for your client. If you notice your clients in a room with low light, ask them about it. "I noticed the calm lighting in your space; tell me about that."

The beginning of your work with clients is about getting to know them. The more you understand a client's interests, work, family, friends, connections, and sensory needs, the more you will have numerous tools to provide to your client throughout your time together. There may be thoughts like, "What if the client cannot answer or does not get the question?" That will happen. One way to approach this concern is to let clients know that you are gathering as much information as possible to individualize their journey, and we can revisit these topics more than once. This can be a space for psychoeducation. When using the sensory questions, if a client does not understand, take a moment to explain the sensory system and its impact on how one experiences the world. Of course, if any of these topics are unfamiliar, move toward consultation and resources first before jumping into it with clients.

BILATERAL STIMULATION (BLS) TOOLS

Bilateral stimulation (BLS) is a tool used within EMDR that can be incredibly limiting. Many EMDR therapists rely on eye movements as the primary or only form of BLS. A way to create an ND-affirming environment in the therapy session is by having a menu of BLS options for the client to practice and choose from that stimulate the right to left motion. Having the client practice these then allows for an ND-affirming approach versus an abstract ask to the client of which BLS modality they would prefer. Many ND individuals need to see or try something rather than respond to an abstract ask when it comes to decision-making. Then, clients should be provided the opportunity to practice these options before going into a target to find what may work best.

Here are some ways to practice BLS:

- When creating the peaceful place
- When creating the container
- With a positive feeling
- With a positive experience
- As a way to think of answers to questions:
  - Example: When asking about sensory experiences, ask a direct question and then have clients go into BLS for a short time to contemplate their response.

Here are some examples of BLS:

- Eye movements: following a hand, light, ball on a screen, wand.
- Touch or tactile: Tapping (tappers), body tapping (with hands or fingers), buzzing (vibrations).
- Auditory: Music—either with or without headphones. Spotify or YouTube are places that have bilateral stimulation music that is accessible and free.
  - Note: Many would say that headphones are required here. Please remember that processing is different for everyone. Listening to music in headphones can be a sensory overload, whereas it can be more accessible if it is played from a speaker.
- Physical movement: Walking, pacing, running/jogging, swaying, rocking, jumping, swinging, tapping feet.
- Other: Scribbling, drawing, coloring, folding paper.

A great way to help ND clients with BLS is by exploring multiple options at a time.

Here are some examples of dual-BLS:

- Listening to music while swaying
- Tossing a ball from hand to hand while listening to music
- Eye movements while tapping
- Using tappers while listening to music.

The main goal of the BLS exploration is to eliminate as many distractions, struggles, or frustrations as possible before a client goes into a target. We want clients to feel empowered and in control of their process before embarking on this tough work.

EMDR CONSULTATION

Start by setting a boundary with consultation; there is no expectation of "free labor." Whether you know a therapist or not, if you ask for intellectual energy and support, it is important to expect to pay the individual as a consultant. Our colleagues, just like our clients, are part of a community forced into marginalization and deserve to be compensated for their time and energy.

Consultation is an incredible resource to support growth in understanding and comfort with EMDR and ND clients. Remember, there is no one way to do this work. To get the most out of a consultation, consider that framework when working through strategies during consultation. Ask yourself:

- Is this strategy adaptable?
- Can I use this with (fill in client)?
- Can I get creative with this strategy?

Consultation should not be directive. It should provide a framework for example that is then adapted further. The goal is not to get the answer to what the client needs; it is to formulate plans when feeling stuck, unsure, or not confident. Many therapists struggle to conceptualize the 8-phases of EMDR with ND clients because they are faced with challenges that are not easily remedied through a protocol or script.

There can be some panic that can lead EMDR therapists to assume EMDR does not work for that client. If you find yourself experiencing a sense of panic or anxiety using any part of the 8-phases of EMDR with a client, get curious.

- What am I feeling?
- What am I curious about?
- What can I ask my client about?

In some cases, the therapist's struggle may be a sign that EMDR needs to pause or is not working in the way it is currently being approached. However, it is important to note that the struggle does not automatically mean that EMDR as a tool has failed to support this ND individual.

CUSTOMIZING THE EMDR EXPERIENCE FOR ND CLIENTS

If there are still questions about how to use EMDR with ND clients, it is important to ask, "What answers am I looking for?" Our hesitation, confusion, or anxiety around working with specific populations can result from looking for a guide, step-by-step instructions, or one answer that makes our lives easier. Unfortunately, one size rarely fits all. By moving away from that mindset, therapists can open themselves up to a new level of creativity and comfort they may not have previously accessed. Removing the therapist from telling a client what we will be doing to more of a collaborative approach not only offers relief and space within the therapeutic relationship but also empowers and affirms the client's autonomy. The more confident therapist are in their modality, the more trust clients can have in what they are about to embark upon through their healing journey.

A true social worker at heart, Dr. Lanza earned a dual Master's in Social Work & Human Sexuality. Dr. Lanza continued

to earn a Ph.D. in Human Sexuality. Like many professionals, Dr. Lanza has worked in several settings throughout their career. Experiences include inpatient, CAC's, rape crisis centers, community mental health, and in-home support. Dr. Lanza has worked with people ages four to older adults throughout these settings. Dr. Lanza has also taught at the university level as an adjunct professor. Currently, Dr. Lanza is the Executive Director at Maverique Therapeutic Services, providing services such as therapy, supervision, consultation, and trainings. Communities prioritized in this practice are the LGBTQIA+, Neurodivergent, Disabled, and People of the Global Majority. Dr. Lanza is an EMDRIA-approved EMDR Consultant, prioritizing trauma healing and recovery with clients. Dr. Lanza has lived experience as a transgender, non-binary, queer, neurodivergent, and chronically ill human. Dr. Lanza is a proud activist, spouse, and Broadway lover.

References

Crenshaw, K. (1991). *Mapping the margins: Intersectionality, identity politics, and violence against women of color.* Standford Law Review, 43(6), 1241-1299. doi: 10.2307/1229039

Donnellan, A. M. (1984). The Criterion of the Least Dangerous Assumption. *Behavioral Disorders* 9(2), 141-150. doi: 10.1177/019874298400900201

Edgar, H. (2024). Neurodiversity - Language matters. *Autistic Realms: Neurodiversity Affirming* www.autisticrealms.com/post/neurodiversity-language-matters

EMDRIA (2021). The eight phases of EMDR therapy. EMDR International Association. www.emdria.org/library-copy/publications-resources/practice-resources/8-phases-of-emdr-therapy-resources

Fisher, N., van Diest, C., Leoni, M., & Spain, D. (2022). Using EMDR with Autistic individuals: A Delphi survey with EMDR therapists. *Autism,* 00(0). 1 - 11.

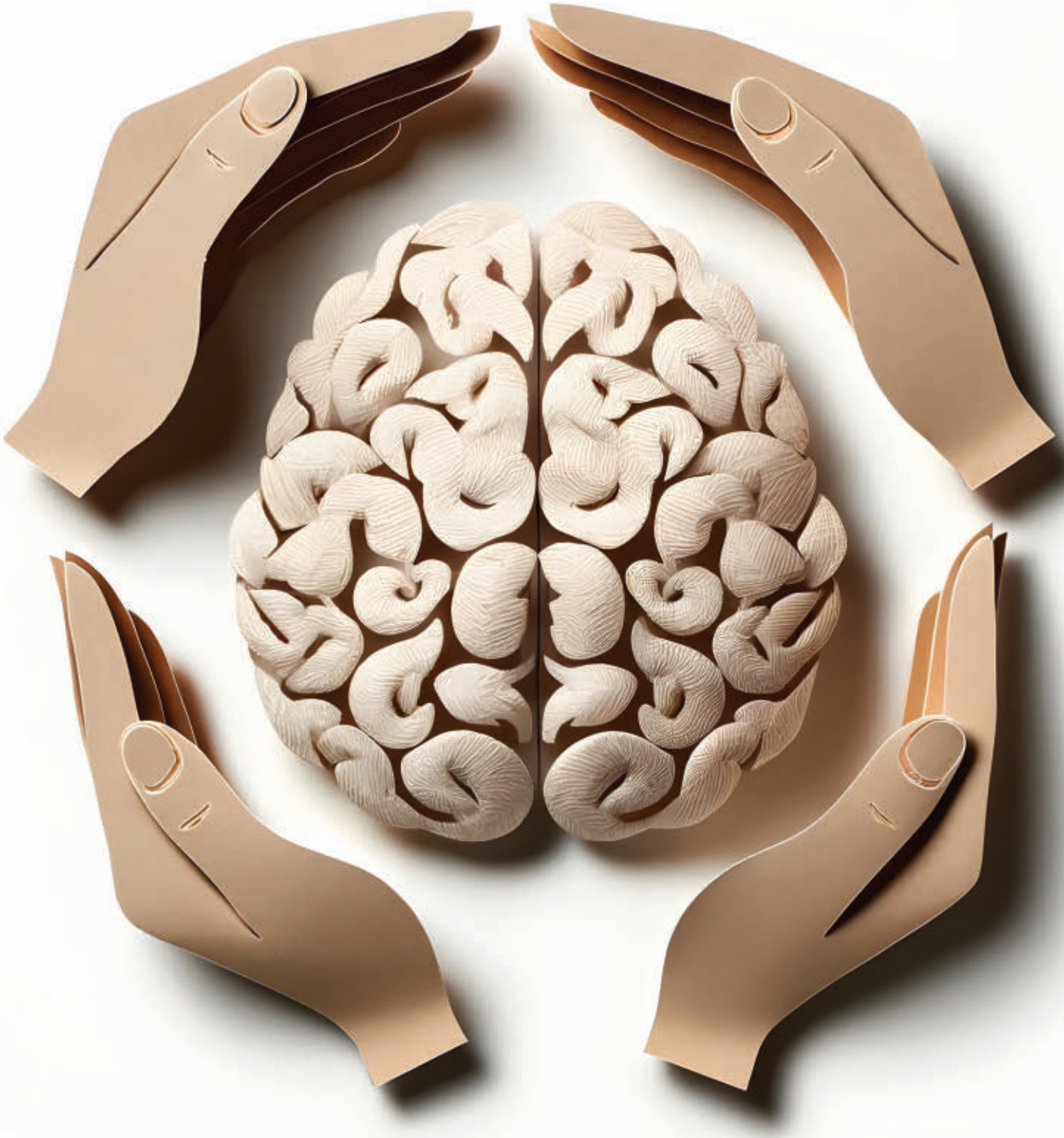
Hogan, S. R. (2023). Affirm your practice. *EMDRIA Go With That Magazine®.* Winter edition. www.emdria.org/magazine/affirm-your-practice

Stimpunks Foundation. (2024, February 17). *Neurotype.* Stimpunks. https://stimpunks.org/glossary/neurotype/

Storey, W. & Holmes, K. D. (2023). Neurodivergent Therapy: A Practitioner's Guide. First Edition. KDH Collective

Walker, N. (2021). *Neuroqueer Heresies: Notes on the Neurodiversity Paradigm, Autistic empowerment, and postnormal possibilities.* Autonomous Press, LLC

Wise, S. J. (2019). Resources. *Lived Experience Educator.* www.livedexperience-educator.com/resources



Using EMDR to Treat PTSD Associated with Traumatic Brain Injury

Navigating a Changed Brain and Sense of Self

By J. Laurel Thornton, MA, LPC/ALPS, NCC

Neurodiversity and neurodivergence are now common terms in psychotherapy spaces and beyond. However, settling on what criteria make someone neurodivergent remains unclear. The literature embraces the idea that, like fingerprints, everyone's brain is different based on their genetics, biology, nutrition, attachment, and lived experiences (Jäncke et al., 2018). But with an ever-growing list of diagnoses under the neurodiverse umbrella, how do clinicians keep up, and what does this mean for how we continue to practice Eye Movement Desensitization and Reprocessing (EMDR) with our neurodivergent clients successfully? We trust the process and lean into the person-centered nature of the Adaptive Information Processing (AIP) Model.

Though research is limited and mainly relies on case studies and small retrospective studies, the use of EMDR to help with post-traumatic stress disorder (PTSD) and its symptoms in all types of neurodivergent clients, including applied, clinical, and acquired neurodiversity shows promising results with decreased subject units of distress scale (SUDs) and symptoms following EMDR. The focus of this article is on acquired neurodiversity and using EMDR with individuals who have been diagnosed with traumatic brain injuries (TBIs) and PTSD.

The acquired subgroup of neurodivergence is one that EMDR clinicians work with regularly since it includes PTSD. When working with PTSD symptoms in individuals who also have TBIs this familiarity can be helpful, but our comfort with common presentations can also create

Neurodiversity Definition Types

Applied: refers to a condition that one is born with and typically applies to learning differences such as dyslexia, dyscalculia, dysgraphia. These forms of neurodivergence are not considered health conditions.

Clinical: Developmental or present since birth and related to behavioral and social skills. These diagnoses include Autism Spectrum Disorder (ASD), ADHD, and Tourette's Syndrome.

Acquired: Acquired neurodiversity includes diagnoses that develop in response to an event or health condition, such as post-traumatic stress disorder, as well as schizophrenia, bipolar, stroke survivors, and people with traumatic brain injuries.

blind spots when working with other diagnoses combined with PTSD. The following themes are regularly discussed in EMDR training, including some specific considerations for TBI clients. When providing psychotherapy to neurodivergent clients, a strong case conceptualization and curiosity to find how their symptoms make sense for their unique brains in their environment is the best place to start.

BUILDING A CASE CONCEPTUALIZATION WHEN WORKING WITH TBIS: Establishing and Defining Common Language and Terms

The words we use in clinical work matter, but more than what words we use, it's important that both client and clinician have a common and shared understanding of what the important words for treatment mean. This can be especially important when working with clients with TBIs as access to language or understanding newer and complex topics has often changed and is coupled with frustration. Being prepared to rephrase or simplify concepts is an important permission that clinicians grant themselves when working with acquired neurodivergence.

Remember that when any brain is stressed to a high degree or assesses there is an extreme threat, the Salience Network (SN) takes over and accesses the problem-solving capacity of the Default Mode Network (DMN), and Broca's and Wernicke's areas are greatly diminished (Zhang et al., 2019). The SN, with its connections to subcortical nuclei of the brain such as the amygdala, hypothalamus, and ventral striatum (Panksepp & Biven, 2012), gives it much control over how a brain navigates environmental stressors. Since language processing and finding words are common symptoms in TBIs, helping clients feel grounded, safe, and familiar with the process is even more critical to help clients be successful in the process of EMDR. When we can help clients access words and scaffold familiarity with the process of EMDR by explaining things first or showing them examples in writing before going

An Overview of Neurodivergent Categories

Category	Applied, Developmental Neurominority	
Examples of Diagnoses	**Dyslexia, Dyspracia, Dyscalculia, Dysgraphia, Sensory Processing Disorder, Visual Processing Disorder**	
Other Information	**Innate Difference:** Present from birth as a natural variation in brain development. **Affects Practical and Educational Skills:** Impacts abilities like reading, writing, or motor coordination. **Not a Medical Condition:** Viewed as a neurodevelopmental variation rather than a health issue.	
Potential Strengths	**Dynamic Skill Set for Innovation:** A blend of entrepreneurial spirit, creativity, cognitive control, visual reasoning, practical and visual-spatial skills, storytelling ability, and exceptional verbal comprehension.	

through a part of a protocol for their answers, clients are more likely to feel confident in what they are sharing. An example of this would be in Phase 3. After explaining and reminding clients of what you will be asking, they immediately give you a body sensation when you ask them to bring up the experience. We can plug in the information we need in an order that is more accessible and natural for them.

Other examples of the possible editing in the process and language during EMDR for TBIs:

a. If you're having difficulty finding a word, feel free to use hand motions, sounds, or anything else that is coming to mind. We can figure it out together.
b. I've noticed you have a hard time accessing emotion words. Would a feeling chart be helpful, or when you think about emotions, does other information show up for you like colors, vibrations, and body sensations? Any description is helpful to me.
c. Let's define what safety means in our work together. You are safe if there is no imminent threat of death or extreme physical harm. It's okay to say I don't feel safe but that doesn't mean you are not safe. We want to be able to explore the difference between what is true externally and what you are feeling internally.
d. When I ask, "What are you noticing?" I ask for anything that is getting your attention. I'm especially interested if you notice a headache coming on, you're dizzy, or your eyes feel weird. I trust that what is getting your attention is important. We can take as many breaks as you need.

BEFORE AND AFTER—IDENTITY AND GRIEF

It's estimated that between three and five million people in the United States are living with long-term disabilities associated with TBIs. For many, this means that many activities that helped define them are no longer accessible to them in the same ways they were before their injury, such as their jobs, ability to play sports, tolerate crowds, and

Clinical, Developmental Neurominority	Acquired Neurominority (Potentially Transient)	Acquired Neurominority
Tourette Syndrome, Autism, ADHD, Executive Function Disorder, Down Syndrome	**Adjustment Disorders, Generalized Anxiety Disorder, Major Depressive Disorder, Separation Anxiety**	**TBI, Stroke, Parkinson's**
Innate Neurodevelopmental Trait: Present from birth, shaping brain function and development. **Impacts Behavioral Skills:** Influences abilities like communication, emotional regulation, and self-control. **Classified as a Health Condition:** Currently recognized within medical and diagnostic frameworks.	Arises as a result of underlying health conditions, like anxiety or depression. May revert to a neurotypical state if the underlying condition is addressed.	**Emerges as a result of an underlying health condition.** May improve with recovery or worsen if the condition progresses: Often classifed mid, moderate or severe.
Specialized Talents and Innovative Thinking: Encompasses strong memory, expertise in skills like reading, drawing, music, and computation, paired with innovative thinking and keen attention to detail. **Innovative Problem-Solving:** Combines creative thinking, visual-spatial reasoning, and the ability to hyper-focus with passion and courage.	**Profound Insight and Advocacy**: Characterized by deep thinking, depth of emotional expression, heightened awareness, and the ability to advocate for oneself and others through shifted perspectives.	**Adaptiblility, Adaptability and Empathetic Communication:** Ability to connect, advocate, and communicate, shaped by an awareness of both neurotypical and neurodivergent experiences. Empathy, Wisdom.

Source: Adapted from Nancy Doyle, Neurodiversity at work*: a biopsychosocial model and the impact on working adults, British Medical Bulletin, Volume 135, Issue 1, September 2020, Pages 108–25, https://doi.org/10.1093/bmb/ldaa021*

A Taxonomy of Neurominorities

Dyslexia, DCE, Dyscalculia, Dysgraphia
Applied, developmental neurominority
- Born with condition
- Relates to applied, educational skills such as reading or motor control
- Not considered a health condition

Tourette Syndrome, Autism, and ADHD
Clinical, developmental neurominority
- Born with condition
- Relates to behavioral skills such as communication and self-control
- Considered a health condition (currently)

Mental Ill Health
Acquired neurominority (potentially transient)
- Develops in response to a health condition such as anxiety or depression
- Could return to a "neuro-typical" if health condition resolves

Neurological Illness or Brain Injury
Acquired neurominority
- Develops in response to a health condition
- Potentially resolves as injury heals or worsens as health deteriorates

Source: Neurodiversity at work: a biopsychosocial model and the impact on working adults. Nancy Doyle British Medical Bulletin, Volume 135, Issue 1, September 2020, Pages 108–125, https://doi.org/10.1093/bmb/ldaa021

participate in vigorous exercise. Most of the improvements in functioning and symptoms occur within the first two years post-injury, and it is not uncommon for the majority of support to shift from doctors to primarily occupational and psychotherapists (Fleminger and Ponsford, 2005).

Nelson and her colleagues (2023) also reported that mild TBI patients showed similarly lower odds for better quality of life than severe TBI patients when assessed across cognitive, emotional, and physical functioning compared to the orthopedic traumatic control group. These findings support clinical reports that even a mild TBI impacts a person's perceived quality of life regardless of severity. Therefore, psychotherapy, and particularly EMDR, can offer a way to reprocess and install more adaptive perceptions of what is possible as people adjust to their new circumstances.

The same study found that only 72 percent of people with moderate to severe symptoms were able to function independently for at least 8 hours at one year, with the rate increasing to 80 percent by year 5 (Nelson et al., 2023). These findings provide a snapshot of all various ways that someone's life can be changed, even by a mild TBI. Themes of grief are present throughout working with TBIs as they notice and evaluate what is different for them after their injury. There is often also grief about what they imagine their future and what would be possible for them in retirement or promotion.

The grief of losing how you used to be, your vision of the future, and missing taste, smell, or sounds can all be parts of the post-TBI experience. In this way, increased frustration and anger make sense as a normal part of the healing and grieving experience. It is helpful to explore grief and its responses with the client as a possible explanation for their symptoms. This shift in conceptualization can offer movement and the potential to move through some of these symptoms as they have before with other losses and transitions.

STRESS TOLERANCE

It is reported that 70 to 90 percent of TBIs are classified as mild, but that does not mean these individuals do not experience prolonged symptoms, particularly after multiple TBIs. Certain groups, like veterans who have served in combat, athletes, and survivors of domestic violence, are at higher risk of experiencing multiple TBIs (Matney, 2022). Common adverse effects of even mild TBIs are headaches, trouble sleeping, memory impairment, emotional regulation struggles, sensory integration issues, and concentration difficulties. These issues can make more traditional talk therapy techniques more challenging due to demands on verbal processing and memory recall.

EMDR can be particularly beneficial in this context because it bypasses the need for extensive verbal processing, allowing clients to experience therapeutic change without overtaxing their cognitive resources. Many people with TBI experience what is known as "memory fragmentation," meaning they may struggle to connect specific memories to coherent narratives. This is something that is also commonly seen when working with clients with PTSD, and EMDR has many ways to account for and help clients who are experiencing fragmentation.

An important area to provide psychoeducation to TBI clients and their loved ones is that the brain does not differentiate between good and bad stress very well, particularly after a TBI. To a TBI brain, stress or demands on processing are all considered stress, and in most cases, the capacity to handle stress has decreased. If being around people and playing music was a "stress reliever"

4,9 Excellent Trustpilot

EMDR KIT

NEW

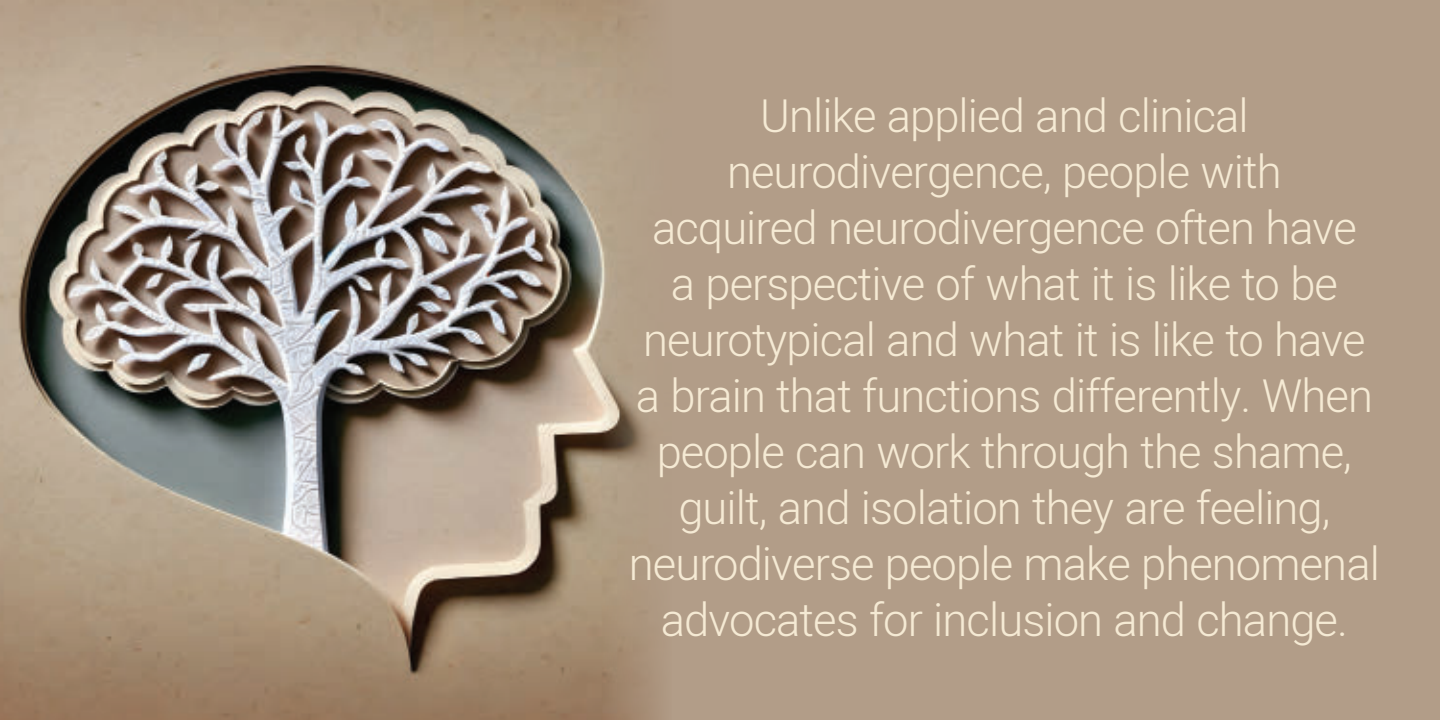
WIRELESS PULSATORS

- Improved connectivity
- New design
- Light strip for visual stimulation
- Effortless induction charging

Visit our webshop for more information!

■ Fast shipping ■ CE certified ■ 2-year warranty ■ Excellent service

www.EMDRkit.com



Unlike applied and clinical neurodivergence, people with acquired neurodivergence often have a perspective of what it is like to be neurotypical and what it is like to have a brain that functions differently. When people can work through the shame, guilt, and isolation they are feeling, neurodiverse people make phenomenal advocates for inclusion and change.

before being diagnosed with a TBI, that activity may not even be possible due to the increased demand of having to drive to a location and then filter out background noise to be able to start playing music. Helping clients see how many jobs a brain is doing other than the desired task can create space for new ideas and creativity on how to eliminate unnecessary stressors to be able to focus on one task; like bringing musician friends to your front porch eliminates driving and background crowd noise.

A NEW PERSPECTIVE

With acquired neurodiversity, clients often see and experience life differently after their injuries, accidents, or traumas. This shift in perspective can be one of the most challenging aspects for clients. In 2017, the leading cause of death for individuals with TBIs was suicide, at 34.7 percent (Matney, 2020). With high rates of decreased life satisfaction, depression, and an increased risk of suicide, therapists must be open to and able to work with these clients. TBIs and their impacts on patients and their loved ones present an opportunity for them to find or access greater empathy, compassion, and ingenuity. Unlike applied and clinical neurodivergence, people with acquired neurodivergence often have a perspective of what it is like to be neurotypical and what it is like to have a brain that functions differently. When people can work through the shame, guilt, and isolation they are feeling, neurodiverse people make phenomenal advocates for inclusion and change.

Creating and installing new perspectives can be an integral part of healing that can honor their grief while also creating future templates of what is possible for the client. It can be an important reminder that all our brains change with time. Very few of us get to control exactly how and when we retire or drive a car for the last time. All brains experience glitches from time to time, and we all have a limit to how much stress, good or bad, we can handle before it negatively impacts our system.

CONSIDERATIONS FOR ADAPTING THE 8 PHASES WHEN WORKING WITH TBI CLIENTS

Phase 1

History Taking and Treatment Planning

It is common for survivors of TBIs to have changes in cognitive functioning. Examples of this include trouble finding words, difficulty with timelines, problems concentrating, decreased processing speeds, impaired attention, and amnesia, particularly about the accident. All these symptoms can get in the way of traditional techniques to gather biopsychosocial information. There are also specific challenges that are present when working on experiences and events that caused a TBI and, subsequently, PTSD when there are no or very few episodic and declarative memories of that event accessible to the client. Following are areas of potential interest during history taking specific to TBI clients. This is also an invitation to start with resourcing and symptom reduction if gathering pieces of traditional biopsychosocial information is inaccessible or highly taxing. There

is great value in learning about how their brain responds to resourcing, bilateral stimulation, and the general flow and process of EMDR as you are building your case conceptualization.

Specific Considerations and Optional Questions for Phase 1

- When needed, get help gathering relevant history and information from loved ones or friends.
- History of head injuries before the accident and the recovery process
- Sleep issues before and after TBI
- Information about headaches and triggers for headaches: What do they feel like? Where and what do they feel like? How often do you experience them? Is there a pattern to when and how they show up? Does anything help them go away?
- Signs that they have "overdone it"
- What brings them joy?
- What do they miss the most from before the accident?
- Did they lose consciousness?
- What do they know about the accident?
- What are your biggest worries or fears if this doesn't change?
- How would people have described your personality before the accident? How would you have described you before the accident?
- Options to write or speak information when sharing it

Phase 2

Resource Development and Installation

The goal during this phase is to increase the client's capacity for positive affect and stress. It is also about exploring what the person can tolerate in session. With TBIs, the brain typically can no longer handle as much stress as it could before. When working together, it's important to bring awareness to how the client and clinician assess tolerance and warning signs for adverse reactions. Like EMDR with any other client, it is ideal when the client processes the adequate and appropriate adaptive resources before moving into the active reprocessing phases of EMDR.

Trust your existing clinical experience and intuition when it comes to what resources to offer a client. However, it can be helpful to be ready to offer more guidance and help in creating imagery or coming up with PCs. Physicalizing an activity using sand, art, music, or photos can also be helpful. Chamberlain (2019) speaks about "safety blindness" when he writes about how PTSD shifts our brains to constantly search for stimuli connected to maladaptively stored networks or unsafe past experiences. One of the major roles of phase 2 is

Neurodiversity as a Social Movement

The term neurodiversity was coined by Judith Singer, an Australian sociologist, to challenge the status quo in how we look at and treat people with differing mental abilities. What started as a social movement to highlight how autism was not a disability but more of a difference has grown into a vast field of study and clinical focus. Being neurodivergent or "neuro-spicy" are terms commonly heard in clinical spaces and educational settings, but this giant umbrella term incorporates many different diagnoses, each with differing sets of challenges. Challenges and differences make neurodivergent populations more prone to experiencing threat, isolation, and trauma. While EMDR has been widely accepted as a form of treatment to help with stress and trauma-based issues, it is important also to consider how an individual's abilities and capacities may impact their ability to use the standard protocol of EMDR.

to make sure that the client has the ability and capacity to accurately orient and "see the now" (Chamberlin, 2019). Safety blindness is a symptom of trauma and an important area to resource in all clients, especially ones who have experienced TBIs, since it is even more common after a brain injury for clients to feel as though they cannot trust the information from their brains. Grounding exercises and other resources that orient clients to present safety can be helpful and essential before moving to later phases of EMDR.

Before beginning Phase 3, it's important to explore options and allow the client to experience different forms of BLS. We are taught in EMDR Basic Training that during Phase 4, BLS needs to be long sets at a fast speed (Shapiro, 2017). However, we gain a better understanding of what dysregulation in clients is communicating about their stress level, more creative suggestions are made about how to alter BLS to shorter sets, standing, or physicalized forms of BLS like a sand tray and art (Fisher, 2000). It feels important to note that all the mechanisms of the neurobiology of trauma are not fully understood yet, and understanding exactly how EMDR works cannot be understood yet, either. As research continues to emerge describing the function and purpose of BLS and how it assists the adaptive information processing system in our brains, we will hopefully be able to more purposely tailor our BLS choice to the individual needs of each client's brain.

Notably, some approaches are de-emphasizing the importance of BLS in processing (Brainspotting, EMDR 2.0, Flash Technique) and instead focusing on the importance of tax working memory and creating prediction errors, which leads to memory reconsolidation (Wong and Foreman, 2022). So with so many reported variations for BLS and ways to adapt BLS so that the client tolerates it, this is an opportunity to be creative with your client to find a form of dual attention stimulus (DAS) or BLS that works for your sessions. We will focus on the traditional execution of EMDR and forms of BLS, such as the DAS. However, suppose you are trained in other approaches. In that case, this is an invitation to incorporate those techniques into your work with clients with TBIs if they are more helpful to your client than the traditional or adapted forms of BLS presented here.

The most important aspect to test and examine is whether they can tolerate the form of BLS and how it feels to them and in their bodies. BLS should not be painful or be a source of disturbance when utilizing standard protocol around a traditional PTSD treatment plan. An exception would be if you are targeting a headache, then the presence of the headache would be purposeful (Marcus, 2008).

Often, eye movements can cause dizziness or headaches in people with TBIs. There have been a few retrospective and case studies published looking at the efficacy of EMDR with people with TBIs, they either used eye moments or tactile stimulation for BLS but offered alternatives for individuals who did not tolerate eye movements (Jansen et al. 2023; Hutchins & Simblett, 2024). In clinical practice, just as we welcome creativity in using BLS

with children, we would do the same with TBIs. The purpose of BLS is to create a Dual Attention Stimulus that helps clients stay connected to the present environment and that they are safe enough in the moment so that they can also reprocess the past (Chamberlin, 2019). Often, the best forms of BLS for people are a form that connects them to an adaptive network, such as a drum pad for a client who loved marching band, a favorite fidget their child gave them, or painting for someone who has always loved being creative.

Types of BLS and DAS should be considered if traditional eye movements are not working well or cannot be tolerated.

1. Tapping on legs or the butterfly tap
2. Drum pad or playing an instrument
   These have worked well for multiple clients who enjoyed playing music before their TBIs. They are a way to bring an adaptive network into reprocessing.
3. Rolling a tennis ball back and forth between hands on a table.
   This can be a gentle way to bring eye movements to phase 4 when doing telehealth, alleviating some of the stress of staring at a screen during reprocessing.
4. Lightly tapping cheekbones
5. Slow auditory BLS, especially drum tones
   This has worked well with clients who come in reporting significant pain. BLS should ideally be slow, about 1 second between tones. This has been shown to increase GABA levels (Grant, 2020).

Phase 3
Assessment

When approaching phase 3 with a client who has experienced a TBI, it is important to remember the purpose of this phase over the script. It is common with head injuries that access words, particularly when the system is stressed, can be challenging. The purpose of phase 3 is to activate and access a maladaptively stored network in a tolerable and tolerable way to the brain on that day. If finding the right word is a stressor for your client and something that activates feelings of grief, loss, frustration, or anger, this can be counterproductive. It is essential to be prepared to help them find words or have other means to express themselves, such as feeling charts, sensations vocabulary, and colors. It is also okay to give more details of a target that you've collected from History Taking. We want to preserve the client's tolerance for cognitive demand for phase 4.

Phase 4
Reprocessing

Our job is to help the client maintain dual attention and connection to the present. When working with someone who has TBI, you may need to take more breaks in phase 4, phase 4 may be shorter, and you might need to use an EMD or EMDr protocol. The most important piece is that the clinician stays attuned to both verbal and nonverbal signs about how the brain is doing throughout the process and does not attempt to push someone with a TBI past their limit. Oftentimes, helping clients realize how to tell when they are approaching tired versus being tired can be an extremely helpful skill to develop, and this is easiest to guide and help with while they are in session.

Phase 5
Installation

For many clients with TBIs, the session is flowing more typically by this point in the process. The targeted memory or experience is no longer disturbing, and adaptive networks are present. However, just as installation can look different with our neurotypical clients, we don't want to assume that the Validity of Cognition (VoC) Scale will resonate or coming up with a concise PC will be easy for them. Be prepared with a list of PCs or remind them of the adaptive statements they used during Phase 4. You may also want to give alternate phrasing to the VoC 1-7 scale, like if "I am not broken" was going to be delicious pie, would it be a full pie, half a pie, no pie? Alternatively, just simply using percentages were 100 percent true versus 0 percent true instead of the Likert scale. Remember, Phase 5 is a celebration of what has been accomplished and a way to anchor a positive into the space where "ick" has been. Take your time here, and do not be afraid to add another set of BLS to the PC and where they connected to that truth in their body.

Phase 6
Body Scan

When the body is often a source of pain, such as extreme headaches or residual physical impacts of an accident, the body can feel unsafe or be a source of remembering the pain or experience of an accident. Post EMDR reprocessing, when the "ick" associated with a target has been cleared, there can be great value to slowing down and creating more time for them to notice that their body is capable of feeling differently.

Phase 7
Closure

In this phase, recognizing accomplishments is valuable. It can be helpful to frame the work completed through a therapeutic and AIP lens. The move connection points to adaptive networks and reminders clinicians can provide clients with TBIs to help them familiarize themselves with

positives that are possible with their current brain and its abilities.

It can also be helpful to close sessions with mini future rehearsals where a client takes a PC or a positive image, felt sense, or goal into the following week. Prompts like "Notice you are capable of laughter, joy, and connection. Notice where you feel connected to this truth in your body. Now see yourself moving through your week from a place of knowing you are capable of laughter, joy, and connection." When a client does well with this future rehearsal, we can challenge the AIP system by adding "bumps in the road," such as you get a headache, you have trouble finding words with a less familiar person, or you have to leave somewhere early because you are feeling tired.

Phase 8

Re-evaluation and a Bridge

This phase is extremely important when working with clients with TBIs. The variance of symptoms that people experience week to week can be vast. It is often helpful to remind the client about what was worked on in the past session and have routine check-in questions for continuity. By starting with general questions like, how was your week; what was sleep like for you this week; are there any updates from your doctors or the lawyers? The clinician can often gain as much information from their eye movements, the cadence of speech, flow of ideas, and ability to find words than the specific answers. Based on how they can use and share information, the plan for a session will emerge. It is not unusual to successfully use standard EMDR protocol for one week with few variations, only to find the following week that factors like headaches, stress, or lack of sleep make it difficult for them to communicate about their week. In such cases, the focus often shifts to pain management, grounding, or resourcing. As with any client, we want to check in about the symptoms of interest, not only about how they have been since the last session, but how they are currently at the time of the session.

Phase 8 also offers an opportunity to shift into Phase 2 work to strengthen the natural occurrence of adaptive networks and examples of their brain healing. There is value in assessing and asking about adaptive networks and behaviors that were present in the previous session or that exist generally. Questions like, "At the end of our last session, you reported how nice it was to laugh with your wife. Were there any other moments of laughter this week or even when you noticed yourself smiling? Or, I know you love this time of year; what got your attention this week about the change of seasons?" Another amazing and often overlooked part of working with clients who have experienced TBIs, is celebrating the arrival of "good days and bad days." There is a healing opportunity when a pause is created around the transition from just taking it day by day/being in survival mode to being able to notice that some of our days are good. Phase 8 is an invitation for hope, for celebration, for strengthening what's already in the client.

DIFFERENT BRAINS ARE NOT DISEASED OR BAD

With growing acceptance around the idea that different brains are not diseased or bad, there is a growing opportunity to expand how EMDR clinicians can approach working with neurodivergent clients. EMDR standard protocol applies to neurodivergent clients precisely for its capacity to adapt to the needs of each client. All protocols are accommodations of the standard protocol, and each brain will process in a different way, which is consistent with the AIP model. EMDR therapy, at its best, is a modality that meets clients where they are on the day and in the moment. It provides a structure that allows clinicians to work with the amazingly resilient, unique adaptive information processing system in each client in a way best suited to the client and somatic experience of the clinician and client. New protocols come from practice and the belief that we are capable of healing from maladaptively stored stress, regardless of your diagnosis or type of neurodivergence. Seek consultation, attend the growing list of continuing educational opportunities on neurodiversity, and have the courage to start working with what the client brings you: sleep, connection, autonomy, and self-acceptance. You may have to edit or adapt things and offer choices, but increased access to a positive felt sense and fewer maladaptive reactions to environmental stressors is helpful and healthy for all brains.

Laurel Thornton owns Whole Brain Solutions, a private practice specializing in using EMDR to work with stress and trauma-based issues. She co-founded the Whole Brain Institute, which empowers helpers and healers by encouraging them to embrace their unique brains through training, consultation, and community. Thornton focused on neuropsychology in her undergraduate studies and has a master's in counseling. She is a Licensed Professional Counselor and Supervisor. She is proud to have been trained in EMDR by HAP in 2011 and is currently an EMDRIA Approved Consultant and provider of advanced training. The AIP model is foundational to all her professional work. Thornton believes in our innate capacity to survive and heal, particularly through safe and meaningful connections.

References

Chamberlain, E. (2019) The Network Balance Model of Trauma and Resolution—Level I: Large-Scale Neural Networks. *Journal of EMDR Practice and Research* 13(2) DOI:10.1891/1933-3196.13.2.124

Fisher, J. (2000) Adapting EMDR Techniques in the Treatment of Dysregulated or Dissociative Patients. Paper presented at the International Society for the Study of Dissociation Annual Meeting, San Antonio, Texas, November 12, 2000 http://mindsite.co.uk/wp-content/uploads/2015/02/emdr-and-dissociation.pdf

Fleminger S., Ponsford J.: Long-term outcomes after traumatic brain injury. *BMJ*. 2005, Dec 17;331(7530):1419-20. doi: 10.1136/bmj.331.7530.1419. PMID: 16356951; PMCID: PMC1315633.

Grant, M.D. (2020) *Change Your Brain, Change Your Pain: A Trauma-Informed Approach.* ISBN 9781925457247

Hutchins, J. & Simblett, S. (2024) A Cognitive Strategy Approach to EMDR for Trauma Post Severe Traumatic Brain Injury: A Single-Case Feasibility and Acceptability Study. *Journal of EMDR Practice and Research* 18:3, pages 118-128.

Janssen, EPJ., Spauwen, PJJ., Rijnen, SJM., Ponds, RWHM. Exploration of eye movement desensitization and reprocessing in treating posttraumatic stress-disorder in patients with acquired brain injury: a retrospective case series. *Eur J Psychotraumatol*. 2023;14(2):2264117. doi: 10.1080/20008066.2023.2264117. Epub 2023 Oct 20. PMID: 37860867; PMCID: PMC10591538.

Marcus, Steven V.: Phase 1 of integrated EMDR: An Abortive Treatment for Migraine Headaches. *Journal of EMDR Practice & Research*, Vol. 2, Number 1, 2008, pg. 15ff

Matney, C., Bowman, K., Berwick, D., editors. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Board on Health Sciences Policy; Committee on Accelerating Progress in Traumatic Brain Injury Research and Care. *Traumatic Brain Injury: A Roadmap for Accelerating Progress*. Washington (DC): National Academies Press (US); 2022 Feb 1. 2, The Scope and Burden of Traumatic Brain Injury. Available from: www.ncbi.nlm.nih.gov/books/NBK580076

Nelson LD., Temkin NR., Barber J., et al. Functional Recovery, Symptoms, and Quality of Life 1 to 5 Years After Traumatic Brain Injury: Findings From the TRACK-TBI Study. *JAMA Network Open. 2023;6(3): e233660. doi:10.1001/jamanetworkopen.2023.3660*

Shapiro, F., & Solomon, R. (2017). "Eye movement desensitization and reprocessing therapy." In S. N. Gold, J. M. Cook, & C. J. Dalenberg (Eds.), *Handbook of trauma psychology: Vol 2. Trauma practice*. Washington, D.C.: The American Psychological Association

Valizadeh, S.A., Liem, F., Mérillat, S., Hänggi, J., & Lutz Jäncke. Identification of individual subjects on the basis of their brain anatomical features. *Scientific Reports, 2018; 8 (1) DOI:* 10.1038/s41598-018-23696-6

Wong, S.L. & Forman-Patel, H. Doing the Flash Technique Without Bilateral Stimulation and Without Prompted Blinking: Two Vignettes. *Journal of EMDR Practice and Research*, 2022, 16(2) DOI:10.1891/EMDR-2022-0001

Zhang, W., Hashemi, M.M., Kaldewaij, R., Koch, S.B.J., Beckmann, C., Klumpers, F., & Roelofs, K. (2019). Acute stress alters the 'default' brain processing, *NeuroImage, Volume 189, p870-877,*https://doi.org/10.1016/j.neuroimage.2019.01.063.

Q Could you offer a specific example of how some aspect of a client's culture/race was deeply meaningful as a resource and/or as a challenge in using EMDR with neurodiverse clients?

I had a teenage biracial female client born to a Caucasian mom and African American dad (both parents were extremely supportive and aware that the client's experiences were not their own), who attended a predominantly white school was diagnosed with anxiety and was experiencing a lot of microaggressions regarding her ethnicity and appearance, and was also experiencing some suggestive acculturation from peers, all of which were exacerbating her anxiety and diminishing her confidence. At intake, her mom said, "I can't teach her how to be a strong and confident Black woman." Over time, the client ended up taking an interest in plays due to her love of singing. Through plays, the client could escape her insecurities and embrace the uniqueness of having both ethnicities while boosting her confidence. When setting up resource development, when the client got ready to do EMDR, she picked a safe place as a resource. The client's safe place was the stage inside a theater because it not only made her feel safe to demand attention and embrace her stature and her kinky hair, but there, she was just her and didn't have to explain to anyone "What are you?"

–Nakendra Kinard, LISW-CP/S, LPC/S, LAC/S, MAC, CS

I was honored to work with a Black client with a neurodivergent diagnosis. One of my clients' intersecting identities was also from one of the Caribbean islands. They were struggling with deeply rooted negative beliefs about their body. These beliefs stemmed from repeated negative comments made by family members throughout their lives, reflecting certain cultural beauty standards that excluded their bodies. These views stemmed from white supremacist and colonial ideas about body type and contributed to the anxiety, shame, and disconnection from their island to visit, fearing judgment and rejection.

During phase two, we used the client's connection to visiting other islands and their love of the ocean as a grounding resource. This connection to the natural beauty and cultural richness of their Caribbean heritage contributed to the client expressing peace and identifying this as their calm place, noting the ocean, lush landscape, rhythms, and traditional music.

During phase three, while reprocessing, we focused on the negative thought "I am not enough" related to body shaming as a child. Using bilateral stimulation permitted us to work through healing from the memories and hurtful comments, allowing the client to see their body as a symbol of strength and beauty connected to her Black identity and heritage. Bringing forth the client's Black Caribbean heritage in EMDR as a resource and challenge allowed the client to reclaim their self-worth and connection to their island and community.

–Dr. Janelle Cox, Ed.D (she, her, hers) MD Board Approved Supervisor MACES President; Coordinator, Mental Health Counseling M.A. program; Assistant Professor, Department of Counseling and Psychological Studies

The EMDRIA Foundation promotes, fosters, and preserves eduction, science, and knowledge regarding EMDR therapy and trauma-informed care.

One of our first initiatives, the Racial Equity Support Initiative (RESI) program is to increase the number of certified therapists, consultants in training, and approved consultants from BIPOC communities.

emdria foundation
Advancing EMDR Therapy & Trauma-Informed Care

To learn more about our RESI program or donate, visit emdriafoundation.org

Q Does anyone have any insight on clients taking stimulant medications for ADHD and wanting to do EMDR?

I don't see any contraindications... many of our clients are on stimulants and other medications and are doing well with EMDR.

–Monica D. Klisz, E-Mersion Therapy

I do not know that we can generalize to every client because ADHD and stimulant medications affect everyone differently. I would ask the client how the medication affects them.

For many, I would say the medication will help them better focus on the process. Perhaps they can do the standard protocol with fewer medications, or perhaps they will still need ND adaptations.

Christine MacInnis has training in working with ND clients with a lived experience focus. Many ND EMDR therapists and consultants, such as Christine and I, are willing to help.

Christine also runs a Facebook group for ND and EMDR with a ton of information and resources. It is essential to establish an ND-affirming practice as these clients have often experienced harm from the medical profession and therapists.

–Cathy Hanville, LCSW
They/She, Certified EMDR Therapist
EMDRIA-Approved Consultant

I'm ambivalent about clients taking amphetamines or other stimulants when it comes to EMDR therapy. In my professional experience, stimulants make the resourcing phase infinitely more difficult. We can work on coping skills, but often clients struggle to calm their nervous system because they are artificially stimulating it via stimulant Rx.

Additionally, I've also observed that many ADHD-diagnosed clients have severe phobic responses to emotions and sensations, which are more contained in the dorsal vagal nerve of the parasympathetic nervous system... using stimulants can often be a secondary gains issue to avoid these emotions and sensations.

Generally, I tend not to take clients who are using Rx amphetamines or other akin stimulants. We discuss the issues regarding EMDR therapy and certain types of medications. I encourage them to talk to their prescriber about lowering the dose and/or changing to non-narcotic medications. I do inform clients on these types of medications that EMDR may not be a right fit for them, particularly as it relates to barriers around self-regulation and distress tolerance and using drugs (illicit or licit) to avoid distressing thoughts and feelings.

–Weston Zink

In my experience working with clients who have ADHD and complex trauma, there is a lot of fear of being misdiagnosed by psychiatric providers who do not recognize ADHD. This, unfortunately, is especially common for fem presenting individuals. For clients who have already been diagnosed with ADHD but may not take meds consistently after having struggled to be with their emotions

then before starting Phase 4 (sometimes even earlier), they will go back on medication or start taking it more regularly, and it actually helps all phases go more smoothly.

I was diagnosed with ADHD only a few years ago, and medication has been life changing in so many ways and also made EMDR more accessible and effective for me when I am working through something personally.

Because ADHD medication doesn't have the same effect in people with ADHD as it would on someone who is NT, I find it difficult and frustrating when there is an assumption of abuse. I have also seen and been on the receiving end of some providers who have medication biases, and I have never in my life misused or abused any substances, so there isn't even history for someone to refer to. Please be careful and considerate of your approach.

–Dana Strickland

I'm from the U.K. but presently living in Melbourne. I'm a clinical lead and EMDR consultant in a large AOD & mental health service covering six sites. I do EMDR with people in active addiction using illicit drugs, alcohol, and medication. I see people using amphetamines-based meds for ADHD, too. I've been practicing in this field for many years.

I'm just finishing some research for my professor doc psychotherapy, where I've researched participants' experience of receiving EMDR in active addiction. All participants in the study finished all 8 phases of EMDR. I've also searched the literature on this, and things are changing with the perspectives of this group and not requiring abstinence before proceeding with EMDR. However, we do require management.

There is bias amongst therapists, but I think it's habituated from misunderstanding. I remove barriers to being able to access EMDR for clients with C-PTSD/PTSD without focusing on the AOD use at the start. I manage medication, alcohol, and illicit drugs; I have boundaries where clients don't use directly before or after the EMDR session. I also work with addiction medicine specialist doctors.

The key is in the clinical assessment and stage of change model for illicit drugs; there is a massive difference between someone taking ADHD medication and someone intoxicated from methamphetamine where their motor system can't allow them to sit still. Everyone is unique and needs their own treatment plan.

If you look at the history of psychotherapy, you can see where the abstinence ethos developed early in the 19th century. However, my perspective is that if we don't treat people where they are, some will never reach abstinence, and we miss the opportunity to support them on their well-being journey.

I would suggest that if anyone is not comfortable treating clients like the ones above, they refer them to an EMDR therapist who is qualified and skilled in this area. It is a specialist area, and I see many clients who, after EMDR treatment, either cease or reduce AOD use in a safer way.

Lastly, you will be surprised at what the brain can process, and you won't know until you try. Yes, it takes skill, creativity, and experience, but it can work. I also sometimes suggest if clients want abstinence, that we process the trauma before detox or reduction, as then the person can go into recovery without PTSD symptoms. Yes, they can return after detox for anything that stuck, but in my experience, it's only a few sessions. I love this work as it's so creative, and I see many successes; the client can attend mutual aid meetings, start fixing relationships, education, employment, and get on with their lives.

–Jo Pioro, Clinical Registrant pafca Australia, EMDR Consultant Allied Health Professional Australia Addiction Specialist, Prof/Doc Psychotherapy candidate Melbourne, Australia

emdria™
EMDR International Association

CREATING GLOBAL HEALING, HEALTH & HOPE™

7000 N. Mopac Expressway | Suite 200 | Austin, TX 78731

Visit us today at EMDRIA.org