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Eye Movement Desensitization and Reprocessing (EMDR) as an Effective Technique for Post Traumatic Disorders in Hearing Impaired Persons

Alison Freeman

Abstract

EMDR is an innovative and rapid technique for the reduction of trauma and anxiety disorders. Successfully used with victims of the Oklahoma City bombing, Hurricane Andrew, survivors of Bosnia as well as Vietnam War veterans and victims of rape/sexual abuse, EMDR uses a multimodal approach, which can be particularly effective with deaf clients who may not respond well to verbal psychotherapy due to minimal language skills. In the age of managed care and funding cutbacks, this is a welcome technique that can dramatically reduce the amount of time spent in therapy and returns the client more quickly to their pre-trauma state.

Introduction

Eye Movement Desensitization and Reprocessing (EMDR) was developed by a psychologist, Francine Shapiro, in 1987, who spontaneously discovered that disturbing thoughts would repeatedly disappear if she moved her eyes a certain way. To test her theories, she conducted a study with Vietnam War veterans and rape victims and found that the participants experienced a dramatic reduction in the intensity of their memories and trauma. Upon follow-up, the majority of these participants maintained their gains and did not experience a return or an increase in their pre-EMDR symptomatology.

EMDR has undergone tremendous growth and skepticism since its beginning, before the results from research and controlled studies proved its effectiveness. Fourteen years later, the efficacy of the method has been confirmed in numerous studies. However the mechanism as to how it works is still not entirely understood. The theory and protocol of the technique is that trauma produces an overload on sensory and information processing in the brain, which leaves the traumatic memory intact and unresolved. Traumatic memories may have visual, auditory, kinesthetic and/or emotional components that are not entirely addressed in verbally based psychotherapies. EMDR works on many levels and works to desensitize with emotional and physiological charges through flashback, fear, negative feeling or thoughts. EMDR can be a powerful...
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approach, which can bring significant relief to the symptomatic client in both degree and intensity.

Literature Review

There are more controlled studies on EMDR than on any other method used in the treatment of PTSD (Shapiro, 1995, 1996, 1999; Van Etten & Taylor 1998; Spector & Read, 1999). There have been numerous studies documenting not only the effectiveness of EMDR but also citing it's superiority to other clinical treatments. EMDR is an empirically valid treatment for civilian posttraumatic stress disorder (PTSD), meeting the criteria established by independent assessors (Chambless, et. al., 1998), who were members of a task force initiated by the American Psychological Association (APA: Division 12).

Van Etten & Taylor (1998) conducted a meta-analysis of 59 treatment outcome trials in 32 studies involving subjects with chronic PTSD. Interventions included pharmacotherapies, behavior therapy, EMDR, relaxation training, hypnotherapy and psychodynamic therapy with control conditions. EMDR and behavior therapy were more effective (about equally so) than other psychotherapies and drug therapies. Effect sizes for EMDR tended to increase at follow-up while effects for behavior therapy remained essentially the same. EMDR treatment time was shorter by a third than for behavior therapy (5 hours vs. 15 hours).

In a study by Marcus, Marquis and Sakai (1997), 67 adults with a PTSD diagnosis were assigned to either EMDR or Kaiser HMO standard clinical care treatment groups. After the first three sessions, 50% of the EMDR treatment subjects no longer met the criteria for PTSD as compared with 20% of the Kaiser standard care group subjects. EMDR was more effective for reducing symptoms of PTSD (more than twice the effect size), co-morbid depression and anxiety than Kaiser standard care. An independent analysis projected that the calculation of cost savings would be 2.8 million dollars annually for the Northern California Kaiser Region if all Kaiser patients with a PTSD diagnosis received EMDR treatment rather than Kaiser standard care.

Edmond and Rubin (1996) studied 59 adult female survivors of childhood sexual abuse, comparing EMDR with eclectic treatment (a variety of techniques organized to treat the focal issues) and to a delay-treatment control group. Several objective and subjective measures were used. After six sessions both treatment groups showed improvement, with the EMDR group gains being more than double the eclectic group's, whereas the delay group showed no change at all. At three-month follow-
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up, the EMDR group continued to improve, whereas the eclectic group gains deteriorated somewhat.

Chemtob and Nakashima (1996) reported very positive results in using EMDR with 32 children and adolescents traumatized by Hurricane Iniki in Kauai, and who did not respond to a generally effective previous treatment program. The design featured a delay control group, independent assessment with several standardized measures, and five therapists with varying degrees of experience. Participants averaged a 58% reduction in the primary trauma measure following three sessions, with results holding several months later.

EMDR has shown itself to be not only superior to many psychotherapeutic techniques but also to be long-lasting. Wilson, Becker and Tinker (1996) reported 15-month follow-up data to their original study in which they found 82 percent of the original participants. For those who had not been retraumatized since the initial 3-session treatment and 3-month follow-up, their gains maintained significantly.

The EMDR Procedure

After a thorough intake, history taking, description of symptomatology and a determination of the appropriateness of using EMDR, the standard protocol starts with the client's description of the traumatic event and the identification of disturbing pictures, thoughts, feelings and sensations associated with the event. If it is determined that the client can benefit by EMDR, the therapist helps to prepare further by helping the client define and clarify realistic goals in reducing the effects of the trauma and its associated symptomatology. Together, they determine which aspects to select (from most to least disturbing, etc.) depending on the client's ego strength and external resources.

All of this may take one to several sessions before engaging in the EMDR procedure. During the actual procedure, the clinician engages the client by having her focus on the clinician's fingers/hands as they are moving in front of the client's eye from side to side (other bilateral forms of attentional stimulation are used if the eyes are not appropriate). The clinician pauses at regular intervals to insure that the client is processing adequately. The clinician guides the process while the client processes at cognitive, affective, and/or somatic levels. An example of this would be a client who recalls the visual and kinesthetic picture of a rapist holding a gun to her head; she re-experiences the terror (affective) with clamminess of her hands and hyperventilation (somatic) with the thought of "I am going to die" (cognitive).

The goal is the client's rapid processing of information about the
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negative experience. This brings upon an "adaptive resolution". This means a reduction in the symptomatology and a shift in the negative belief system to a more positive one (Shapiro, 1989).

Neurobiology of EMDR

While it is still not exactly clear how EMDR works, one commonly held theory to explain how a reprocessing of human experience can facilitate a dramatic reduction in trauma related symptomatology is related to Rapid Eye Movement Sleep (REM). Traumatization is a disruption of sensory and brain information processing systems. Normally leads to integration and adaptive resolution following upsetting experiences (van der Kolk & Fisher, 1995). Under normal circumstances and daily activities, this information processing occurs during thinking, talking, expressive/artistic activities and/or dreaming. In trauma, however, malfunction of this natural information processing system occurs with the experience of the trauma remaining "frozen". This "arrested state" further manifests in persistent intrusive thoughts, negative emotions, body sensations and negative beliefs about oneself. EMDR may help in the treatment of PTSD by turning on memory processing systems normally activated during Rapid Eye Movement sleep (REM) but dysfunctional in the PTSD patient. In essence, EMDR is an accelerated information model in which traumatic material is specifically targeted and appears to restart this "stalled" information processing. It does so in a focused manner, facilitating the resolution of the traumatic memories through the activation of the neurophysiological networks in which appropriate and positive information is stored.

There is a general assumption in psychotherapy that if a trauma can be verbalized, it can be "worked through". On a neurobiological level, trauma occurs in the right brain. Without left-brain verbal processing, the ability to process trauma is restricted even more (Schore, 1994). Clearly, this is particularly relevant for deaf and hearing-impaired clients who have any degree of linguistic deprivation. Without the spoken word to provide a container and context for social and emotional experiences and resolution, feelings are often experienced as being out of control (Britton, 1998). Non-contained emotional experiences will remain as unprocessed data in a deaf person's psyche. As such, these experiences, or traumas, will be inadequately processed and associated symptomatology such as images/flashbacks will remain at a more primitive level of intensity. Accordingly, when trauma occurs in a deaf person's life, his ability to process what has happened to him may occur
on a concrete level. Instead of being able to talk about what happened, he may manifest psychosomatic symptomatology or acting out behaviors until some kind of resolution is reached through verbalization or desensitization. Even in the high functioning deaf adult who demonstrates more cognitive flexibility and creativity, it is possible that their emotional state associated with trauma is not as easily assessed or analyzed by conventional verbal psychotherapy.

EMDR with Deaf and Hearing Impaired Clients

There are several reasons why EMDR may be particularly effective with prelinguistically deaf and hearing-impaired clients. Firstly, EMDR utilizes a multimodal methodology of identifying sensory information, such as visual and kinesthetic data, to guide the course of treatment rather than being verbally guided. As such, the stress of "trying to put into words" what happened is reduced and more energy is available for dealing with the actual trauma. This stress becomes more apparent for some deaf client whose level of intellectual functioning may be at a concrete level. Here the focus of the treatment is on concrete symptomatology rather than abstract and theoretical constructs.

A deaf client's experience of psychotherapy may be qualitatively different as a result of the struggle to communicate in a language-based methodology (Freeman, 1984; Marschak, 1993). The typical hearing-impaired client that is seen in mental health clinics and private practice tends to be a congenitally deaf person whose hearing parents did not sign. This lack of communication between the hearing parent and the deaf child can lead to significant delays in language acquisition. Growing up in this linguistically impoverished environment, these deaf children grow up with emotional, social, educational and psychological delays.

For the deaf or hearing-impaired client whose trauma may have occurred prior to full linguistic acquisition, the trauma remains unconscious and non-verbal. If we understand that in linguistically deprived environments, learning occurs on an emotional level, then it becomes imperative to find a therapeutic technique that is affectively focused. In the child who is hearing impaired, the lack of verbal communication forces an obvious reliance on non-verbal cues and non-verbal language from the start. Additionally, the relationship between language and affect becomes ambiguous. "The child's experience of affects will remain global and indistinct, and because the connections that he uses to refer to affects and internal state will be weak, such persons will not develop a rich inner experience through which to understand themselves..." (Saari, 1980). Accordingly, all experiences
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including trauma is processed and mediated on a non-verbal level. The longer the acquisition of language is delayed, the more experiences are processed within an emotion-based and iconic context.

Particularly for some deaf client who may have trouble understanding their symptoms on a conceptual level, EMDR often bypasses this step as the client focuses on concrete and physical symptoms related with the disturbing event (stomach clenching or clammy hands) when talking about the event i.e. abuse. The standard EMDR protocol calls for a "body scan" which is a frequent monitoring of the client's physical state associated with what they are processing i.e. where do you feel your anger in your body when you think of what your father did to you? The need for verbal processing decreases as the intensity of the trauma is decreased, again placing less of a demand for verbal explanations of their experience in conceptual terms.

With deaf and hearing-impaired clients, the standard protocol may not be appropriate for clients with low language skills and may need to be abbreviated or modified. During the initial stages where the client is asked to describe the traumatic event or to identify feelings, negative beliefs or sensations, the clinician may only get one or two aspects to work from rather than the complete protocol. The clinician needs to assess how much information is really necessary for the EMDR to proceed. The clinician does not need to know all the details of a trauma before engaging in EMDR. In the author's experience, it appears that deaf and hearing-impaired clients generally report more somatic content and fewer cognitive associations. In fact, cognitive input from the client tends to occur later, towards the end of the EMDR processing, if at all.

The Role of the Therapist

EMDR is not only different for the client but also for the therapist who may ordinarily be active and directive with clients The therapist assumes a less active role as the client generates material in response to the EMDR. The client's experience of EMDR tends to be less interactive during the actual processing of the trauma. As such, the role of the clinician in an EMDR session becomes more like a guide and less like a clinician making psychological interpretations. In fact, during a typical EMDR session, interpretations are saved for subsequent sessions as the client may continue to process beyond the therapeutic hour. Accordingly, analytic interpretations can be premature if the trauma or experiences are not fully processed, understood or verbalized.

EMDR can be used within a standard psychotherapy format, as an adjunctive treatment with a separate therapist, as a treatment all by
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itself, or on an as needed basis. Even if a client is specifically referred for EMDR referrals, it is often used every other session in order to process and integrate material from the previous EMDR session in alternate weeks.

Clinical Cases

An eight year old boy was referred by his therapist because of his inability to sleep in his room six months after the Loma Prieta (California) earthquake. When the earthquake occurred, Jonathan was in his bedroom and could not reach his mother who was downstairs. EMDR targeted his feelings of what happened and after 30 minutes of using child-modified techniques, he reported that the "bad feelings" were all gone. Since the session was adjunctive and he returned to his therapist, the follow up found out that he returned to sleeping in his room immediately. This seemed to be too remarkable and was followed up a month later to find that he had continued to sleep in his room with a dramatic reduction in his fears.

More typically, EMDR is not a "one-session cure" and it is frequently integrated into an existing therapy. Jessica was a 35 year old, deaf woman who was referred by the state Victims of Crime program after her husband beat her and she filed a police report for the third time. Separated for three months, she was afraid that she would break down her resolve and to return to her abusive husband. Prior to meeting her husband at age 22, she had a moderate hearing loss. She met her husband, also hard-of hearing, in a sign language class and they married six months later. Shortly after they married, Jessica suffered her first beating to her head, which resulted in her losing the remainder of her hearing. Even after numerous beatings, several police reports and her husband's descent into alcohol abuse, she couldn't leave as she was terrified of being alone without anyone to communicate or a partner to interpret for her in social situations. She believed that, on some level, she was responsible for the abuse and that if she didn't have such a terrible temper, her husband would not have hit her.

In her first EMDR session, she realized that her belief that she had caused the abuse was an erroneous one as she remembered what actually happened during one beating episode prior to their marriage. She reported that she had just moved to live with him and he had been very

* All names in clinical cases have been changed and details have been altered for purposes of confidentiality.
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stressed because he had recently lost his job. When asked what happened, she could not remember the actual incident but just assumed that it was her fault. After an EMDR session, she remembered that the incident actually occurred when she wanted to take her own car somewhere and he insisted on driving. When she refused to let him drive because he had had his drivers' license suspended for drunk driving, she remembered cowering to protect herself as he hit her repeatedly.

This session was remarkable because she was able to correct a long-standing negative belief system that she provoked (and therefore deserved the abuse) and began to assign blame to her husband. This newly changed belief system was particularly timely in her therapy because her husband, who was currently in an alcohol detoxification and treatment program (30 miles away from where she lived), was angry that she would not "give" him her car so that he could get to work even though his license had been suspended again. Subsequent EMDR sessions would reinforce her corrected belief system whenever she wavered in her decision to return to him. Six months later, she filed for divorce and she is working on other issues.

Teresa was a 46 year old, moderately hearing impaired woman who was self referred to deal with depression and PTSD. Six months prior, she witnessed the murder of her boss at a computer company in which an unidentified man had come in threatening to kill everyone with a gun. A co-worker grabbed her and they both went under a desk where they could see the gunman firing shots before turning the gun on himself. Teresa was so traumatized that she could not go back to work and was now on psychological disability. She had recurring nightmares and flashbacks, had difficulty taking care of her 14-year-old son and being intimate with her husband of 25 years. She would frequently be tormented by intrusive thoughts, feelings and memories as she relived the sounds of the gunshots, the black face of the gunman and the feelings of helplessness as she watched her boss gunned down.

The therapy lasted four months of weekly sessions, with six of them using EMDR. By the end of the treatment, she was able to sleep through the night, take care of her son, be more affectionate with her husband and to regain a strong sense of her pre-trauma self. She could talk about the crime and describe it as a bad memory in sharp contrast to reliving the tape of violence in her mind on a recurring basis without relief. She realized that she had options and that she didn't have to go back to work at her previous job. She took time to reassess what she wanted to do and three months later, found a job in another computer company. She was ecstatic when she realized that she could work again.
in a different environment, get off of disability and function without the constant reminder of the tragedy that dominated her life for the previous year.

Unlike Jessica and Teresa, Michael was a 23 year old, deaf, gay male with limited language skills who had been referred by his boss because of aggressive behavior on the job. Michael was sexually abused by his father for years until he was 16 years old when he hit his father and told him to never lay a hand on him again. Shortly thereafter, he left home and engaged in sex with other men as a way to make a living. He would jump from relationship to relationship every few months and leave whenever communication demands exceeded his abilities.

In therapy, he had tremendous difficulty verbalizing his needs, wants or frustrations and did not benefit from any insight-oriented intervention. Therapy focused on impulse control, anger management and education about sexual responsibility as he would not use safe sex safeguards.

Michael reported flashbacks to his father's beatings which would "come out of nowhere" as well as a longing for a long term relationship. He did not understand how his flashbacks and his difficulties in sustaining relationships could be related to his childhood abuse. As such, EMDR was utilized along with flashbacks as a way to "desensitize" the pain and to provide "cognitive interweaving" of correcting erroneous beliefs i.e. "it was my fault that I was beaten because I was deaf". In one session, he complained that when he was having sex with a man with whom he had had the longest relationship (six months), he was bothered by intrusive images of his father sexually abusing him. EMDR was used to alternate between his current pain of unfulfilling sexual promiscuity, with the emerging of his past pain of abuse to build a bridge of insight. When this occurred, Michael began to understand and make the connection between his forced passivity in an environment with no communication with his current promiscuity. He was receptive to cognitive and behavioral intervention through role-playing that he could be assertive about what he liked and didn't like in his relationship instead of running away at the first sign of conflict.

After several sessions of desensitizing the pain of past episodes of abuse, and of educational interventions, he was able to recognize that when he felt angry. He had options in dealing with his explosive anger. Additionally, he was able to bring in his boyfriend for a number of sessions and was able to engage in couple's therapy.
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Summary
In conclusion, EMDR has proven to be a particularly effective technique in working with deaf and hard of hearing persons for the following reasons:

1. EMDR is an empirically valid treatment for posttraumatic stress disorder in reducing symptoms as well as significantly reducing treatment time.
2. EMDR utilizes a multimodal and non-verbal approach (visual, kinesthetic and somatic components) which places fewer demands on clients for linguistic comprehension and verbalization of symptomatology.
3. EMDR focuses on concrete symptomatology rather than symbolic or conceptual representation of trauma.
4. EMDR shares features of other non-verbal therapies in more easily accessing unconscious material associated with trauma due to its emotion-based and iconic nature.

References


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