Using EMDR With Autistic Clients: How Do Therapists Adapt?

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Autistic people commonly experience co-morbid mental health conditions, including post-traumatic stress disorder (PTSD), anxiety, and low mood. General consensus is that autistic people can benefit from evidence-based psychological therapies, with the acceptability and effectiveness of eye movement desensitization and reprocessing (EMDR) therapy becoming a growing area of interest. One hundred and three EMDR therapists were asked if and how they adapt the standard EMDR protocol to make the process and content more tailored to the needs and preferences of autistic people. We analyzed the qualitative responses of participants to these questions, including barriers and adaptations to all eight phases of the EMDR standard protocol. Overall, therapists emphasized the need for flexibility and responsiveness to the individual client, and the importance of autism-specific knowledge and autism-informed clinical supervision. Implications and future directions are discussed.

Keywords: EMDR; trauma-focused therapy; autism; neurodiversity; adaptations

We have used "identity-first" language (i.e., autistic person) through this article. This is following the UK National Autistic Society guidance whose recommendations are based on the preferences of some autistic people National Autistic Society (2022). In line with these guidelines, we have avoided use of terms such as "high functioning" and "low functioning" as these can be stigmatizing.

Literature Review

Eye movement desensitization and reprocessing (EMDR) is an evidence-based psychological therapy, developed by Francine Shapiro. It was first described as an effective brief intervention for resolving symptoms of post-traumatic stress disorder (PTSD) in adults (Shapiro, 1989) and since then has developed into a well-established and effective full scale treatment for trauma (Shapiro, 2018). It is recommended by the World Health Organization (WHO, 2013), the International Society for Traumatic Stress Studies (ISTSS, 2020) and the UK's National Institute for Health and Care Excellence (NICE, 2018) as a treatment for PTSD. It is increasingly used for problems beyond PTSD, including depression, phobias, anxiety, psychosis, pain, eating disorders, and attachment-based conditions (Valiente-Gomez et al., 2017) and has been shown to be cost-effective when compared to other treatments for PTSD (Mavranezouli et al., 2020).

Shapiro developed the Adaptive Information Processing (AIP) model as a theory of trauma processing that underpins EMDR. This posits that all humans are naturally predisposed to psychologically heal themselves from adverse events (Shapiro, 2018).

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Briefly, we have a knowledge base (held generally in a narrative form), that informs us about life around us (who, where, and what to expect). Adverse events are part of normal life; when processed adaptively, we add to or update these memory stores to direct and prepare us further. When healing is interrupted or inhibited, this processing is not achieved, and the events or memories are stored in different form (with thoughts, feelings, and body sensations frozen in time or experienced as they were at the time of the event). These memories are locked within the nervous system and may become activated through daily life and influence current daily experiences in a distressing and unpleasant manner. This can be seen through an individual's fixed negative thinking patterns, emotional/arousal responses or symptoms of continuous unsuccessful attempts to process information, as indicated by flashbacks, intrusions, nightmares, and rumination, all of which are symptoms of PTSD (APA, 2013).

EMDR therapists conceptualize their client's difficulties using the AIP model. Sharing this with the individual can be helpful in reducing shame and enhancing a sense of hope, as they are able to see their emotional reactions as a understandable response to their traumatic experiences. Additionally, it helps to direct the therapy. Therapists support the client to facilitate the reprocessing of adverse/traumatic events through EMDR, which involves an emotional activation of the memory paired with bilateral stimulation (BLS). The goal of therapy is to enable the individual to be able to recall experiences as past events and respond to life now, without the influence of unprocessed memories. Negative beliefs about self and associated somatic experiences can also be targeted during EMDR.

Autism spectrum disorder (henceforth, referred to as autism) is a neurodevelopmental condition, diagnosed by assessing social interaction/communication impairments (e.g., difficulties knowing how to engage reciprocally in social interactions and form and maintain friendships and relationships; difficulties both expressing thoughts and feelings, and interpreting others' thoughts, feelings, and behaviors); hypo- and hyper-sensory sensitivities (e.g., to sound, light, taste, and touch); and restricted interests and patterns of behavior (e.g., having highly focused and narrow interests, repetitive motor movements, engaging in rituals and routines, and experiencing difficulty managing change and ambiguity; APA, 2013). Autism is a spectrum condition and varies in severity between individuals. It is of childhood onset and lifelong. However, characteristics may not always manifest until social demands exceed capacity; for some, this may only be in adulthood. To meet diagnostic criteria, characteristics need to be clinically significant and contribute to impairment in social, educational, and occupational contexts, as well as other areas of the person's life. Autism can be present with or without learning disabilities, and with or without language impairment (APA, 2013). Many autistic characteristics (such as the tendency to dive deeply into interests or an attention to detail) can be adaptive and useful in the right contexts.

Autistic people commonly experience co-occurring mental health conditions, including depression, anxiety disorders, obsessive compulsive disorder, psychosis, PTSD, and eating disorders (Lai et al., 2019). Emotion dysregulation is also a common experience (Keluskar et al., 2021). Recent research has found that autistic people may be more at risk of self-harm and suicide than non-autistic individuals (Blanchard et al., 2021). Others have written about the way in which many autistic people camouflage or "mask" their anxieties, hiding very significant levels of distress, confusion, and isolation (Cook et al., 2021). Lobregt-van Buuren et al. (2021) reported on adverse experiences and trauma being difficult to recognize in autistic clients, leading to diagnostic overshadowing. Signs of trauma can be misinterpreted as signs of autism, leading to autistic clients not being offered appropriate evidence-based interventions for trauma. They emphasize the need for increased recognition and for treatment models to be individually adapted.

There has been burgeoning interest in using EMDR with autistic clients. This could be due to several factors. There has been a huge increase in autism diagnoses over the last 30 years (Russell et al., 2021), meaning that many more therapists (and clients) are aware of autism. Online information and support groups have made it easier for people to find information about autism, and may also have contributed to the increase in demand for diagnosis, and there is increasing mainstream press coverage of adults being diagnosed with autism in later life.

The interest in EMDR for autistic clients may also be attributed to the fact that autistic people represent a client group who may experience more trauma than non-autistic people (Kerns et al., 2015) and experience their lives as more traumatic. This can be due to information and sensory processing differences as well as social-emotional difficulties, which can lead to shame, anxiety, and social isolation. There is some suggestion in the research (and much clinical anecdotal evidence) that adverse events that are seen to be mildly annoying by many people can be perceived as extremely distressing or traumatic by autistic people (Taylor & Gotham, 2016).

There is very little research to date on how EMDR is actually used with autistic people, leading many clinicians to develop their ideas "on the go," often in isolation and without much discussion with other EMDR therapists working with autistic clients. What literature is available to therapists is usually based on the clinical experience of one or two experts, rather than on research. However, it is clear that EMDR is being used and there are some studies that indicate it can be effective with certain modifications.

The earliest work in this area consisted of case studies demonstrating that EMDR can be effective with individuals with intellectual and developmental disabilities, four of whom were autistic (Barol & Seubert, 2010). They described several adaptations, including being more directive than is typical and taking more preparation time to work on self-soothing skills and resources. They checked on progress more during the processing and they were more interventionist in bringing in positive resources and titrating the painful event by breaking it down. They used a technique to check the outcome where they asked clients to imagine a "movie" of the event, so as to see if there was any remaining disturbance. In two cases, they focused on the here-and-now and emotional and somatic experiences only, as the clients were unable to make the link between their present-day distress and past traumas.

Kosatka and Ona (2014) reported using intensive EMDR with a 21-year-old female with a diagnosis of Asperger's Syndrome (a subtype of autism spectrum disorder in former diagnostic manuals which was given to people without an intellectual disability), who had been physically abused by her peers at school. She did not have an intellectual disability and they reported using only minor modifications, such as taking longer to help her to formulate her negative beliefs about herself. The therapist also allowed for a longer period than usual between eye movements in order to accommodate her difficulties in expressing her emotions.

The first larger scale study of EMDR with autistic people was published in 2019 (Lobregt-van Buuren et al., 2019). This study used the Dutch EMDR protocol for children and did not include any additional stabilization techniques. Study authors found a significant reduction in PTSD symptoms, psychological distress, and also in difficulties with social motivation and communication. Participants were reported to be less impaired in their daily lives after EMDR therapy. These results were maintained over 6–8 weeks of follow-up.

EMDR is clearly being used with autistic clients, potentially with adaptations, but as yet there is no consensus about which adaptations may be important, or why and how they are incorporated into therapy. The present paper describes the modifications made to the standard EMDR protocol by a group of 103 EMDR therapists who have worked with autistic people. The therapists were asked to describe the adaptations they had made. This survey was then used as part of a three-round Delphi survey, which has been reported elsewhere (Fisher et al., 2022). The survey, was written by the authors, following the structure of the EMDR protocol. This present study used a qualitative analysis to draw out themes in participants' responses, which could help EMDR therapists to improve the quality of their work with this client group. It is therefore a practical clinical paper based on research.

Methodology

Study Design

Data described here were obtained in the EPAS (EMDR for People on the Autistic Spectrum) 1 study. The EPAS 1 study used a Delphi survey design to (1) examine barriers to EMDR for autistic people and (2) generate consensus about important adaptations to EMDR for this client group. Delphi surveys are commonly used in healthcare research and aim to generate consensus amongst a group of health professionals about topics that are under-explored (Langlands et al., 2008). Usually, participants are asked to comment on more open-ended questions in the first survey, so as to elicit their initial opinions and experiences about a topic.

The present paper focuses on participants' qualitative responses to Round 1 of the Delphi survey. The full results of the Delphi survey will be published separately. This was because we felt that, while the full Delphi survey focused on generating consensus between participants, this inevitably narrowed down the data. In this article, we aimed to reflect the breadth and depth of the responses to Round 1 of the survey. We hope that seeing the themes which emerged across the eight-phased protocol will be useful to clinicians wondering how to adapt their work with autistic clients.

The survey questions were written by three of the authors, based on their knowledge of EMDR and the AIP model. It followed the structure of other surveys, which have been used to assess barriers and adaptations to therapy for autistic individuals (Spain & Happé, 2020).

Recruitment Strategy

We used opportunistic sampling methods and recruited nationally and internationally-based participants via EMDR associations, special interest groups, clinical networks, social media, and word of mouth. Therapists were invited to participate by three of the research team who were themselves EMDR therapists. Therapists were eligible to participate if they had completed at least some formal training in EMDR and worked with autistic people at least occasionally. They self-selected and we did not independently measure their experience or expertise in EMDR or working with autistic individuals. They could be based in any setting and work with any clinical population.

Procedure

Participants were invited to read the Participant Information Sheet and to contact the study team if they had any questions. If they agreed to take part, they were required to give informed consent. They then completed the survey, which comprised some questions relating to demographic information (e.g., their professional background, work setting, years of EMDR practice), as well as questions relating to potential barriers to each of the eight EMDR phases and any adaptations they had incorporated into their practice to enhance accessibility or effectiveness of EMDR for autistic people. Participants were able to offer free text responses throughout the survey. The survey questions are given in Table 1. Information about the Round 2 and 3 surveys is outlined in detail in Fisher et al. (2022). All three surveys were completed online, in Qualtrics (an online survey platform).

Participants

One hundred and three participants took part in the survey. Participants represented a range of professional disciplines, including psychiatry, psychology, psychotherapy, nursing, social work, and occupational therapy. They worked across inpatient, community, forensic, and education settings. Sixty-one participants worked with young people and adults, six only worked with young people, and 31 only with adults. Approximately 50% of the sample had completed basic adult training, approximately 25% had attained accreditation, approximately 20% were EMDR consultants, and four participants were either facilitators or EMDR trainers. Their experience of using EMDR ranged from 1 to 32 years. Table 2 outlines the demographic characteristics of the participants.

Data analysis

Survey responses were downloaded from Qualtrics for the analysis. We used descriptive tests to analyse the data about demographic information (e.g., establishing the number of participants who worked in young people's vs. adults vs. young people and adults services). This current article outlines the qualitative analysis of participants' open-text responses.

Responses to the open-text questions were analysed using inductive thematic analysis based on Braun and Clarke's (2013) six-step methodology. The six stages are: becoming familiar with the data; generating codes; searching for themes; reviewing themes; labelling themes; and writing up a data summary. A "bottom-up" approach (Braun & Clarke, 2006, 2020) was used to reduce the risk of being influenced by preconceived assumptions regarding the use of EMDR with autistic clients. Responses were analysed by ML using NVivo (version 12; QSR International, 2018).

Ethical Approvals

Ethical approvals were obtained (REC reference MRA-20/21-21063, King's College London). Participants gave informed consent (via the online survey) and were informed the study would be written up for dissemination purposes. The article contains no person-identifiable information.

Findings

In this section, we will summarize the main themes and will then go through the eight phases of the EMDR protocol, discussing themes which arose from each section. We will end by discussing our findings about clinical supervision.

All of the EMDR therapists in our sample were positive about using EMDR with autistic clients. No one reported avoiding work with this client group, although this may reflect the way in which we recruited our sample: we sought therapists who had worked with autistic clients and so those who avoid the work were unlikely to participate.

Summary of Main Themes

Several overriding themes were identified from the research. Therapists emphasized the need for clarity in expectations of both therapists and clients, and the importance of having good knowledge of autism, trauma, and EMDR. They thought that information about EMDR and the progression of therapy should be clearly provided, individualized to the client and

TABLE 1. Survey Questions

The next part of the survey asks about the stages of the EMDR Standard Protocol. Please note down any particular barriers you have found at each stage when working with autistic people, and the adaptations that you have made for these or other reasons We are interested in all the adaptations you are making, even if you think they are 'off-piste'.
[free space after each option]

1. History Taking
   a. Barriers
   b. Adaptations
2. Case conceptualisation using the AIP model
   a. Barriers
   b. Adaptations
3. Preparation Phase (including Safe Place and stabilisation)
   a. Barriers
   b. Adaptations
4. Resource Development and Installation
   a. Barriers
   b. Adaptations
5. Assessment Phase (Target, NC, PC, VOC, Emotion, Body sensations and SUDS, 'tuning in')
   a. Barriers
   b. Adaptations
6. Re-evaluation (after an incomplete session)
   a. Barriers
   b. Adaptations
7. Desensitisation Phase (type of BLS, length of sets, cognitive interweaves, unblocking processing)
   a. Barriers
   b. Adaptations
8. Installation Phase (installing the PC)
   a. Barriers
   b. Adaptations
9. Body Scan
   a. Barriers
   b. Adaptations
10. Closure (ending the session, including debrief, safe space if an Incomplete session)
    a. Barriers
    b. Adaptations
11. Do you use any of these EMDR approaches with autistic people? Please briefly explain if you adapt them in any way. [free space after each option]
    a. Attachment-based EMDR (Parnell)
    b. EMDR 2.0 (De Jongh)
    c. Ego-state therapy/parts work (e.g. Paulsen)
    d. Flash Technique (Manfield)
    e. Flashforwards (Logie and De Jongh)
    f. Future Templates
    g. Loving Eyes/CIPOS (Knipe)
    h. Progressive Approach (Gonzalez & Mosquera)
    i. Storytelling/Narrative (Lovett, Logie et al.)
    j. Other (please specify)
12. Are there other adjustments you have made when using EMDR with autistic people? [free text]
13. Do you think there are any additional considerations for clinical supervision (either as a supervisee or supervisor), when using EMDR with autistic people?
    [free text]
14. Are you using EMDR remotely? (e.g. via Zoom or Teams)?
    a. No
    b. No, but planning to
    c. Yes
    If so, are there any additional considerations with this, compared to in person EMDR?
    [free text]
15. Is there anything else you think it is important for us to know about your experience of using EMDR with autistic people? Please do include specific (but fully anonymized and not person identifiable) examples of work with clients if you wish.

unambiguous. They mentioned the need to understand and respond to a person's sensory profile and to take account of individual characteristics, such as attentional differences and the potential need for extra structure and routine.

Therapists also mentioned some barriers to accessing EMDR therapy, which included comorbidities such as anxiety and very high levels of psychological distress, as well as service-based limitations such as only being able to offer a capped number of sessions.

TABLE 2. Participant Demographics

	N = 103
Population worked with	
Children and adolescents	6
Adults	31
Lifespan	61
Level of EMDR training	
Not yet finished basic training	1
Completed basic adult training	57
Completed basic child training	27
EMDR Practitioner	26
EMDR Consultant	20
EMDR Training Facilitator/Trainer	4
Years of experience in EMDR	
1–4 years	47
5–9 years	22
10–14 years	17
15–20 years	9
20+ years	2
Experience of working with autistic individuals	
Occasionally	28
Sometimes	17
Regularly	47
All the time	6
Experience of working with individuals with an intellectual disability	42

Many therapists described the need to adapt to their individual client's characteristics and how they felt there was sometimes a discrepancy between the requirements of the EMDR protocol and the client's understanding and capacities. Difficulties that therapists experienced when using the protocol included helping clients to judge the amount of detail necessary, facilitating linking emotional arousal to past events, problems with finding negative and positive cognitions, and other factors that made it difficult to conduct sessions as usual, such as sensory issues. This required creativity and flexibility on the part of the therapist in order to reduce barriers to accessing EMDR therapy.

Across all the prompted open-text responses, participants mentioned the importance of developing their knowledge around autism. This included having greater experience, but also having a supervisor or consultant with autism-specific knowledge to better support them in their practice.

The majority of the practitioners who took part also highlighted the need to have and take more time to plan before and during sessions, and to be able to slow down the pace and possibly offer more sessions than they would offer to non-autistic clients. As a whole, the group of therapists emphasized the importance of an individualized and client-centered approach, with no assumptions based on diagnosis. They emphasized the wide differences between different autistic people, as exemplified by one participant:

> For me, it's more about how the client presents, as people with ASD are as individual as "neurotypical" individuals, e.g., some people with ASD have incredible imaginations, whereas others have none, or some cognitively able clients may have good insight into their own emotions, whereas others may have challenges with emotional literacy and so it's important to individualize what works best and what supports are required to accommodate these different presentations.

Main Themes in Relation to the Eight Phases

We will next discuss some of the themes which arose for each of the eight phases of the EMDR protocol. Direct quotes from therapists are used to illustrate the themes and are selected to be representative of the wider group.

Phase 1: History-taking. Taking a systemic approach to history-taking was emphasized by many therapists, with several saying that they asked for additional information about a client's history from family members when appropriate, including when working with adults.

Others emphasized the importance of flexibility right from the start and this was in response to the client's individual needs rather than diagnosis. One therapist said, "A few of my clients lie down for part of the session if they are feeling overwhelmed, I don't tend to suggest this to my non-autistic clients." Another said they, "Encourage the client to tell their story in their own way, rather than having a set way of doing it."

Others talked about the need for flexibility within sessions, both by making sessions shorter in some cases and by being ready to shift between different activities during the session in order to manage attention and arousal. As one therapist said, they offer the "Standard session length but pay attention to person's attention levels, so may change activities often (as needed) and make [the] session more experiential and practical." Another said that they "Break it down into smaller chunks and intersperse with resourcing skills to help manage arousal levels."

Specific autism knowledge was cited by several therapists. This included knowing that autistic people are both more likely to experience trauma and also potentially more likely to be traumatized by some experiences, leading to an accumulation of trauma. As one therapist said, an important factor for them was, "Remembering that autistic people will be traumatized much easier and have issues with letting go of things than neurotypical individuals." This difficulty in letting go could reflect the neurocognitive tendency, common to many autistic people, to perseverate on thoughts or ideas.

Therapists emphasized the importance of seeing people's strengths and asking about how they have coped with life. One remarked, "I have learned a lot through working with autistic people about neurodiversity but also about the way they have developed many skills to live in a neurotypical world."

Phase 2: Preparation Phase. Again, flexibility was a key feature of the preparation phase with autistic clients. A wide range of EMDR adjunct techniques were used by therapists, including Constant Installation of Present Orientation and Safety (CIPOS; Knipe, 2018), the Flash technique (Manfield et al., 2017), the Loving Eyes technique (Knipe, 2018) and stabilization techniques from other therapies, including cognitive behavior therapy (CBT), dialectical behavior therapy (DBT), acceptance and commitment therapy (ACT) and compassion focused therapy (CFT). We did not ask exactly how these adjunct techniques were used and how therapists made the decision to use these modification.

The need for a longer preparation phase was mentioned by some. Reasons for this include the need to establish the therapeutic relationship over an extended time period and recognising that autistic people may need more time to process new information, particularly if it is emotional in nature. Autistic individuals may well have had previous experiences of not being understood by health professionals and therefore building trust is an essential part of the preparation phase. As one therapist said, "For some, therapy takes longer because many autistic people need a longer Preparation phase, sometimes a lot of patience is needed as generalization doesn't often happen."

Some therapists said that they were more directive about using resources outside the sessions, with one saying that they see part of their role as "ensuring clients can use resources outside of sessions by monitoring practice outside sessions." Some clients can have difficulty in visualization or using imaginal resources, and here therapists adapted exercises by making things more concrete. One therapist said that they used, "Physical depictions of resources, e.g., postcard, picture, action figures." Using a person's particular interests during this phase was also mentioned, with resources being planned around these. This also helped with engagement and the therapeutic alliance.

These comments perhaps reflect that many autistic people benefit from having expectations communicated explicitly, as they may find it more difficult to infer the intentions of others indirectly. Therapists should not assume that autistic clients know why something is being done; explaining their intentions clearly can help to reduce anxiety and improve the therapeutic alliance.

Phase 3: Assessment Phase. Again, therapists emphasized the need to respond to the client in front of them during the assessment phase, with some clients needing no adaptations at all, whilst others needed the therapist to use adaptations such as visual outcome scales. As one therapist said "I use visual material and scales I learned in child EMDR training to assess some of these elements of assessment and target." Others said that they may skip elements of Phase 3 of the standard protocol, but only when it becomes obvious that the client requires this. This was summarised by one therapist who said, "I'll generally try to get the information required by standard protocol but with flexibility and skipping something if client unable to do or think about." Responsiveness to the client was a theme that ran through all the comments; for example, as reported by one therapist, "My approach in this section is very much dependent on the client's needs and processing style" Autistic people are often highly sensitive to shame and feel that they are "getting things wrong" when they are not able to meet expectations, due to their earlier experiences. Flexibility here is essential in order for clients to feel safe and comfortable in therapy.

Phase 4: Desensitization phase. In the desensitization phase, therapists reported using a range of different bilateral stimulation (BLS) including eye movements, tapping, and self-tapping. They described being responsive to the client's emotional arousal and body sensations, perhaps to a higher degree than when working with non-autistic clients. One therapist highlighted, "I do review the sensations and spend extra time reviewing so that we can stop any sensation."

Therapists mentioned their awareness of the possibility that this client group may be more likely to become over-aroused. It is common for autistic clients

to be hypersensitive to some emotionally charged stimuli and this perhaps reflects this.

Other therapists commented on the sensory profiles of many autistic clients, whereby they may be more or less sensitive to sensory stimuli, making some forms of BLS aversive or less useful. As one person said, "just awareness around modality used in regard to sensitivity to touch and environmental factors (light/sound)." Related to this, others said that they would slow down the process "with some autistic clients – a radically slowing of pace due to their difficulties in processing somatic sensation." Others also referred to different speeds of information processing and the need to allow people time and space, sometimes meaning that the therapist had to hold back to allow the person enough time to process. Differences in information processing are a common part of an autistic presentation, often (but not always) meaning a person processes emotional material more slowly.

Some therapists said that they used shorter sets at first to build up tolerance whilst others said that they allowed their clients to choose the length of sets, instructing them to end a set when they noticed a change (an adaptation sometimes used with children). Given how life can feel out of control for many autistic individuals, it is important to consider how they can feel more in control of the therapeutic process across the whole of EMDR therapy.

Conversely, others said that they would speed up or add other forms of BLS in order to facilitate processing with some autistic clients, some of whom seemed to need greater working memory taxation for processing to work. A lack of generalization was mentioned by several, meaning that more targets needed to be processed. Therapists also mentioned being more directive than usual with some clients when using cognitive interweaves, again perhaps reflecting the need to make more of the implicit explicit so that autistic clients did not have to intuit their therapist's intentions.

Phase 5: Installation Phase. Again, flexibility was key in this stage. Some therapists reported not identifying a positive cognition (PC) during the assessment phase but instead allowing for this to emerge during processing. Others reported doing some extra cognitive work during the installation phase in order to identify a PC.

Some clients found the numerical Validity of Cognition (VOC) scale difficult to use. Therapists reported using a visual VOC when necessary or asking clients to rate using their hands to show change. As one therapist said, "I use visual material and scales I learned in child EMDR training."

Therapists said they used a range of extra cues to install a PC, including using movement and pictures. Some said they used visual means such as charts to track progress.

Phase 6: Body Scan. The body scan was usually able to progress without adaptations, but some therapists said that they directed their client's attention to each part of their body in turn, rather than simply asking them to scan through their whole body. Others said that they used movement to increase their client's awareness of their body sensations. One person said that they are used to, "Keeping an extra close eye on signs of overwhelm."

These modifications reflect the difficulties which some autistic people have in answering open-ended questions, and how a task (such as the Body Scan) can be broken down into constituent parts to make it more accessible. General instructions such as those which are usually used for the Body Scan may be less accessible than specific directions.

Phase 7: Closure. In the closure phase, some therapists would offer their thoughts, but emphasized the importance of doing this in a sensible manner. As one person said, "Sometimes they find my thoughts on what has happened to be affirming, other times they can become overly focused on what I have said and can become dysregulated." Again, the importance of responding to the individual client was reiterated. As another therapist said, "It depends on the client."

Some therapists said they leave more time for the closure part of the session, and make sure to finish with a positive activity, perhaps related to the client's special interest if they have one.

Phase 8: Re-Evaluation. Therapists interpreted this question as asking about how the week had gone.

Some therapists said that they relied on reports of quality of life and general functioning in order to assess progress, and other said that they would ask family members how the week had gone. Some said they do not emphasize keeping logs of any symptoms or changes between sessions because this can become a source of anxiety for some autistic clients. As one therapist said, they take a collaborative and individualized approach, focusing on "Working with the client and discussing targets, pace, etc. with them" across sessions.

Therapists consistently said that having a supervisor or consultant with experience of the autism spectrum was useful and they felt many supervisors lacked this knowledge. One therapist remarked, "I consider myself to be someone with strong autism expertise and I would benefit from peer supervision. I would strongly urge anyone without autism expertise who is offering EMDR to autistic clients to seek autism expert consultation."

Specific things that therapists felt would be useful included supervisors helping them to think about using the EMDR protocol and how to be flexible whilst retaining fidelity to the model. As one person said, "Thinking more about how we can use the protocol as fully as possible to help, whilst also being creative, adapting to their needs and gaining practice-based evidence on what helps."

Several therapists felt that a role of the clinical supervisor might be to point out neurodiversity when the therapist themselves might have missed it, perhaps because the client was responding in an unconventional way, as highlighted by one therapist: "I feel that clinical supervisors have a role in helping educate therapists to also be neurodiverse aware when we see and assess clients for trauma work. There is a real risk of missing this and pathologizing people's difference, perpetuating problems and shame in particular. I think it can be very difficult to tease out what is perhaps attachment trauma related and what might be neurodiversity—it seems to me there is a lot to learn still here."

This was echoed by several therapists who said that they felt that they worked with several undiagnosed autistic clients and were becoming more aware of neurodiversity as they worked with more clients on the spectrum. Other therapists mentioned their own autism diagnoses and how this affected their work. One person said, "I can see reading these questions how profoundly my own practice of EMDR even with neurotypical clients is informed by my own experience of self and world." Whilst another commented, "I have been working intuitively with EMDR in this way almost since I trained in 2004, and realize now how powerfully if subtly/implicitly my therapy practice reflects my identity as autistic."

Several therapists mentioned things they would like supervisors to be aware of, in particular the need to slow down and allow time to process without jumping in. As one said, "Notice what you are feeling a pull to do and check in whether it is for the patient or for you (i.e., settling ourselves, reassuring ourselves, or our own curiosity not for the benefit of our patient). Working with people on ASD spectrum can throw our therapeutic instincts, leave us feeling somewhat unsure… slowing down and noticing this and not jumping to fix it."

Discussion

This is the first research study to examine the adaptations made to EMDR by therapists working with autistic clients. Previous studies have made modifications based on the clinical experience and judgement of a few expert therapists. Here, we have drawn on the experience of a sample of 103 therapists. This gives our findings a depth and breadth that so far has been missing in the literature on EMDR and autism. These therapists spanned a wide range of experience, both in EMDR and working with autistic clients. They ranged from EMDR trainers to those who had completed their basic training, and their level of experience with autism ranged from occasional to daily. Our findings therefore reflect EMDR as it is being carried out "on the ground" by therapists, both expert and less expert. There is little written about EMDR and autism, and so therapists are often in the position of trying to work things out as they go along. This study was an attempt to look at what they do as a result of this process.

The implications for clinical practice are many. This is a highly heterogenous client group which has become more so since the autism diagnostic criteria changed in 2013. This means that earlier research may not in fact be reflective of the characteristics of the group who are currently being diagnosed. This is at the point where well-respected autism researchers are arguing that the diagnosis itself now tells us very little about a person's difficulties and needs (Gallagher, 2021). The autism spectrum now ranges from severely disabled to exceptionally high achieving individuals. An "autism EMDR protocol" or even a list of "autism-specific adaptations" may therefore not be as useful as it initially seems, as it may narrow the perspective of the therapists. However, a need for a better understanding of the autistic spectrum and how autistic characteristics can interact with the EMDR protocol, particularly among EMDR supervisors, was a strong theme. There is clearly a need for greater awareness in the EMDR community of the ways in which autism can affect a person's ability to engage in EMDR and therapy in general.

Flexibility and responding to the individual were the key themes mentioned by therapists, across all stages of the protocol. This flexibility included using

aspects of adaptations usually made for young people, varying how sessions were run, using a variety of ways to establish a safe space and resources and even suggesting that clients lie on the floor if they felt overwhelmed. These adaptations were made in response to common autistic characteristics, such as perseveration, a need for expectations to be made explicit, sensitivity to emotional and somatic stimuli, and a need to feel in control where possible. These changes were made to reduce anxiety and thus to facilitate the ease of EMDR processing. Therapists need to be creative and ready to make changes during the course of the session.

Within the question of flexibility, some themes emerged that therapists should consider. A lack of generalization was mentioned by many, as was the need to consider sensory and attentional issues. Some said they were more directive and structured to the point of telling clients in advance what to expect in each session, whilst others said they gave more control to their autistic clients, allowing them to decide the length of sets and when to stop.

Any discussion of adaptations poses the question of what changes are possible whilst preserving the integrity of the EMDR protocol, and what adaptations should not be made as they will compromise the effectiveness of the adaptive information processing. This may be particularly difficult for novice therapists to discern. For example, as Morris-Smith and Silvestre say in their book on using EMDR with children (Morris-Smith & Silvestre, 2014), sometimes therapists make "adaptations" which are in fact errors, such as not returning to target to take a SUDs but instead asking at the end of the channel. Perhaps reflecting their uncertainty about what changes they can make, therapists often said that they used EMDR adaptations which they had learnt in relationship to working with children. Some of them said that they changed how they presented particular parts of the protocol (such as the PC and VOC) if a client struggled with it, as is sometimes suggested for younger children (Morris-Smith & Silvestre, 2014). Others referred to the introduction of visual scales, using concrete examples of the safe space or resources, working with emotions in the moment, using drawing and techniques such as story-telling (Logie et al., 2020). These variations are usually only taught in relation to working with children, meaning that those who work only with adults are less likely to have experience of this sort of flexibility. Therapists reported making these adaptations in a flexible way, responding to the characteristics of an individual client, rather than simply adopting an approach they would use with children. Autistic people vary greatly in their levels of ability as well as their neurocognitive profile, and therapists will need to be aware of this and ready to adapt accordingly. This research suggests that the adaptations usually thought of as for children only may have a wider application and perhaps should be introduced to all EMDR therapists.

Autism-specific knowledge was said to be important, particularly by clinical supervisors. Therapists mentioned differences in sensory experiences and introspection, and the need for supervisors to have ideas about how to accommodate these within the EMDR therapy. They discussed the importance of an awareness of the difficulties that living an autistic life can involve, and the ways in which people have had to adapt to live in a world that they often experience as uncomfortable and alienating. Autistic people are more likely to experience trauma as well as more likely to experiences daily events as traumatic, both of which can lead to an accumulation of trauma symptoms. They are also very likely to experience shame, particularly given their frequent experiences of being repeatedly misunderstood by others and socially isolated. The importance of getting alongside the client and being ready to adapt to their needs was emphasized.

Several therapists mentioned that as they have become more aware of neurodiversity, they have started to be aware that some of their clients, both past and present, may have unrecognized autism. This raises an interesting issue, since if many therapists are working with undiagnosed autistic clients, they may not be aware of the need to seek extra supervision. This suggests that perhaps an awareness of neurodiversity and the many ways in which autism can present would be useful for EMDR supervisors, even those who do not see themselves as specialists in this area.

Study Limitations

There are several limitations of this research. We asked therapists about the adaptations they used but did not ask autistic clients about their experience of having EMDR. We also did not evaluate the effectiveness of the EMDR offered and so are not able to comment on whether these modifications enhance the usefulness or effectiveness of EMDR therapy for autistic clients. Our data did not allow us to compare therapists who had more or less experience with EMDR or autism, nor to look at the effect of being supervised by a consultant who had experience in autism. We did not look at the difference in adaptations made for clients who had or did not have an intellectual disability, and we were not able to look at how different cognitive profiles required

different accommodations. We conducted an online survey which meant that we cannot look at whether the therapists we surveyed were representative of the wider population of EMDR therapists.

The need to incorporate autistic differences within a case conceptualization and the difficulty which therapists had with this was an important theme in the research. This appears to be a training need for both therapists and supervisors. Future work could involve developing and evaluating such training. It would also be useful to evaluate the effectiveness of different modifications from the perspective of autistic clients.

In summary, developing knowledge around how to use EMDR with autistic clients is something for which there is a clear need. This current study looks at how therapists are adapting in order to work with the client group and will hopefully contribute to knowledge of how to improve EMDR therapy for autistic clients in the future.

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