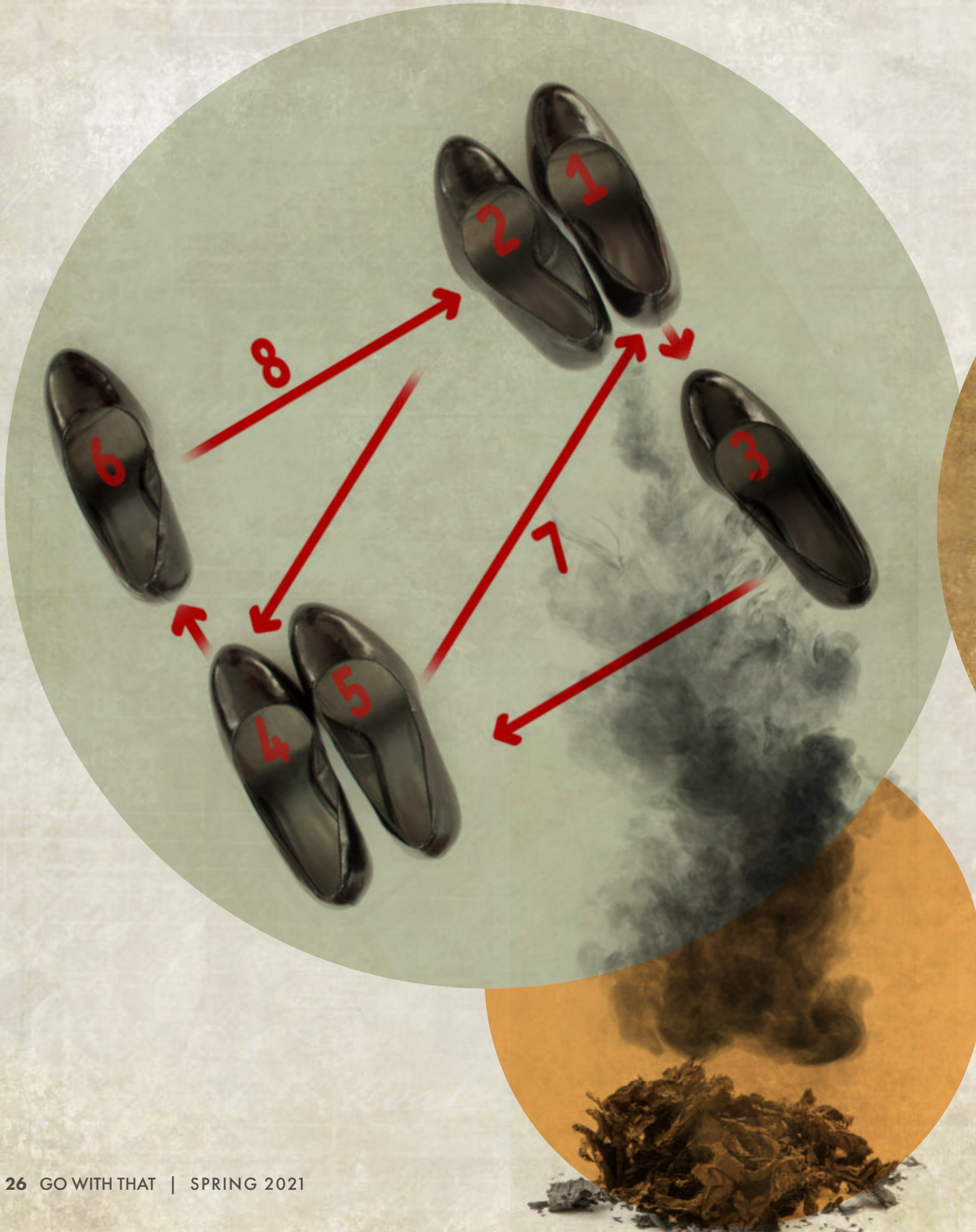
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Stable Enough

Using EMDR Therapy to Address Trauma and Addiction

By Hope Payson, LCSW, LADC and
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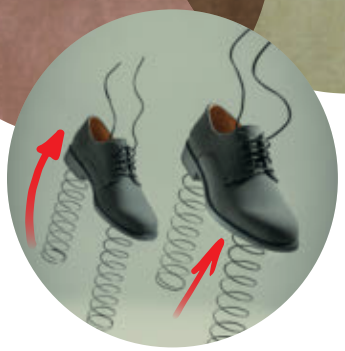
The Kaiser Permanente/U.S. Centers for Disease Control and Prevention Adverse Childhood Experience (ACE) study (https://www.cdc.gov/violenceprevention/aces/index.html) has established the connection between trauma and increased vulnerability to developing an addictive disorder. The fact that Eye Movement Desensitization Reprocessing (EMDR) therapy can assist individuals who struggle with substance use disorders or process addiction is not controversial. The real challenge is determining when and how to start. When do you shift from the History Taking and Preparation two-step shuffle to the more complex dance of Phases 3 through 8?

Individuals struggling with addictions and compulsions describe a confounding mix of intergenerational trauma experiences, skill deficits, and incredible courage in their intake appointments. They also can be natural risk-takers who readily agree to try EMDR therapy. This is especially true when their past experiences in therapy have been unhelpful, which can often be the case with folks who have suffered through years of active addiction and limited treatment success. But, it's easy to get overwhelmed by their multiple layers of traumatic experiences. Those towering histories can make it challenging to see their clinical landscape's reality and difficult to remember that it is not actually the history that determines readiness.

Clients presenting with active addictions are often much more resilient than their histories would suggest.



Addiction can be seen as the smoke that comes from the fire of trauma. As long as the fire is burning, there will be smoke. When there is an addiction, there is pain beneath it—pain from the trauma and pain caused by the experience of living with an active addiction. Addiction is a symptom of trauma that can often instigate more traumatic experiences. Recovery-focused treatment doesn't focus on temporarily clearing the room of smoke. Instead, the objective becomes putting out the fire, while simultaneously building good fire-fighting skills.

Through the lens of the AIP model, addiction memory networks (urges, cravings, and triggers) and underlying trauma networks can be addressed while simultaneously upgrading survival skills to life skills. Life skills are much easier to learn and integrate when a person is less reactive to their past. By desensitizing the addiction and trauma memory networks, we promote new neural pathways to healthier adaptive thought processes. Rather than uploading new skills to a reactionary brain, addressing some of the trauma first can help the brain be more responsive and can allow for the opportunity to practice new coping skills.

As with all work with complex trauma clients, the process is not always linear. One example of this work is the client who uses EMDR therapy to address the memories where they learned that it is not safe to ask for help. Once addressed, asking for help feels safer. Then EMDR therapy can be followed by a traditional talk therapy session where one role-plays and practices asking for help. This activity would be supported by the continued use of EMDR therapy to address current triggers and future challenges around asking for help. After some support systems are in place, the client might want to address a recent strong urge to drink prompted by an upcoming holiday. Then, perhaps moving on to the root memories that make holidays triggering, to begin with. This highlights the beauty and strength of EMDR therapy with this population—the treatment plan can flex to meet the client's needs, and the work is collaborative, which capitalizes on a client's strengths and sense of self-determination. Flexibility, a sense of control, self-determination, and collaboration can be a healing balm for individuals who feel scorched by their history.

WHAT FACTORS INDICATE READINESS FOR PHASES 3 THROUGH 8 OF EMDR THERAPY?

Support Assessment

What support system does the client have in place outside of therapy? This can include other providers, medical professionals, family, friends, or 12 step support. The key is to identify supports that are encouraging to the client's stability. Some clients will indicate having support, but

The Adaptive Information Processing (AIP) model and EMDR Therapy provide us with guidance and coordinates for the journey, but the treatment map we create with our clients will be written in pencil, as the journey is as unique and ever-changing as the individuals in the room with us.

their relationships may reflect their current level of stability; for example, partners or family members still actively using substances or struggling with their own trauma. Helping the client to identify other stable supports allows them to have more than just therapy to rely upon when they experience urges, cravings, and triggers. At times, in treating addictions, there is a focus on whether the client is involved in 12-step support to identify 'readiness.' This is a solid support network for those clients that can walk through the doors. Still, some do not prefer this recovery pathway, while others find that past traumatic experiences block their way.

Teaching the client about the multiple pathways to recovery, healthy relationship boundaries, how to assess their support system and ask others for help are the foundational skills needed to create a healthy support system. Since addiction is a 24/7 issue and having support is crucial, this may be the focus of the first EMDR treatment plan, remembering that the work can be titrated through EMD or EMDR if there are stability concerns.

Therapeutic Relationship

The strength of the therapeutic relationship is another critical area when considering readiness. As we have all experienced, the amount of time it takes to build this varies. Some areas to consider when assessing rapport:

- Are clients able to attend sessions sober?
- Are they able to be radically honest about their current levels of use (behaviors or substances)?
- Are they able to tolerate the distress and discomfort when you are together and remain in the window of tolerance for most of the session? Or can they recognize and report when they feel they are at the edge of their tolerance in session so you can work together on this?
- If they are experiencing dissociation symptoms, are there grounding techniques that work for them?
- Each bulleted area can define your current treatment goals with the client. Working on attachment issues or phobias of the therapeutic relationship is traditionally one of the first tasks of the engagement process—and it is a process—full of ups, downs, and in-between places, where everyone (therapist included) has the opportunity to test their window of tolerance skills.

Regular Assessment

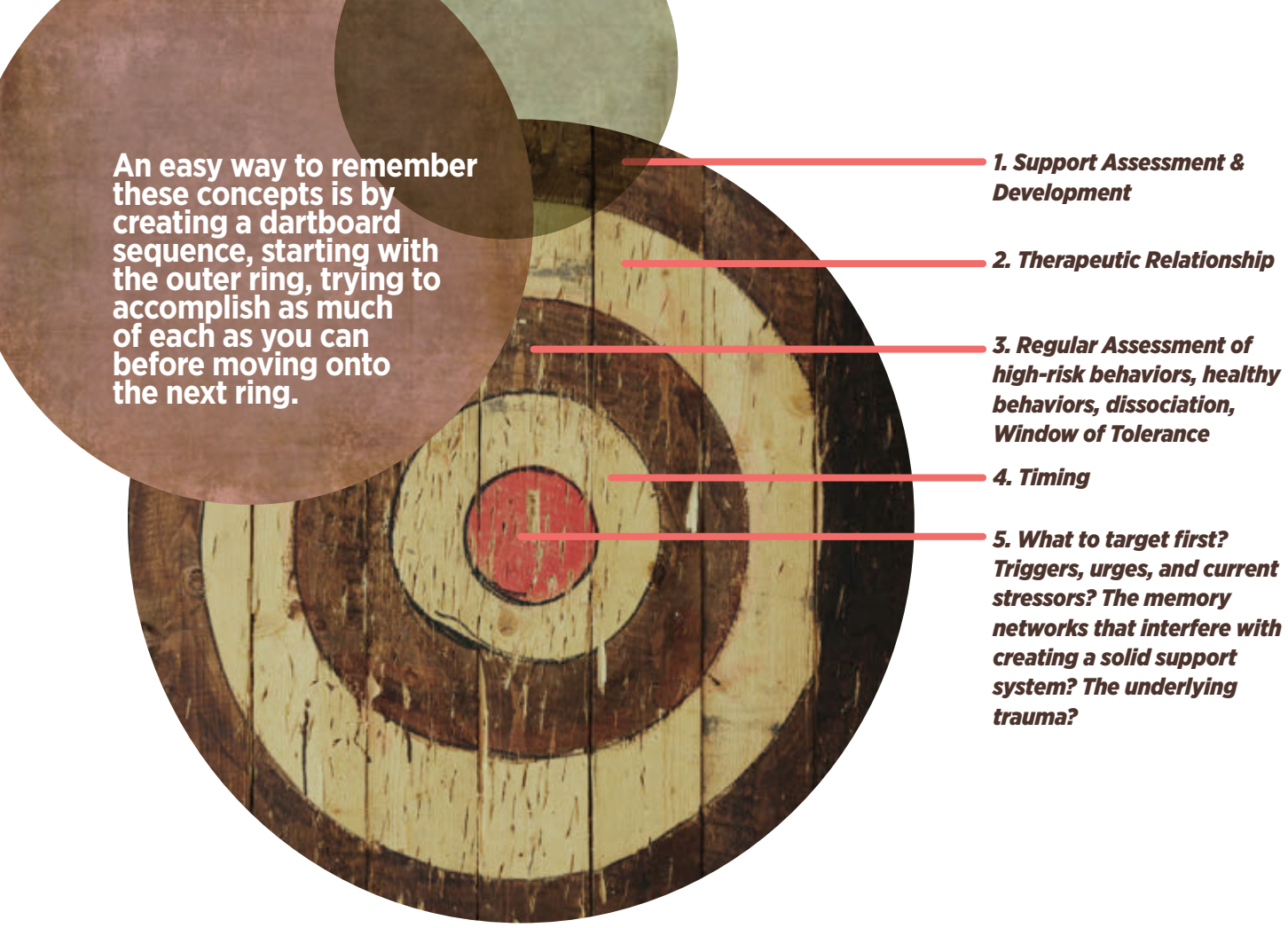
As you move toward EMDR therapy with a client with an addictive disorder, it is important to continually reassess the client's symptoms and skills as they will change significantly depending on the client's use of their coping skills (healthy or unhealthy). Some important areas to assess are:

- *High-Risk Behaviors.* What high-risk behaviors are they engaging in? How do these behaviors work for them? What is their motivation to change these behaviors? Have they had any success in changing the pattern of using (behaviors or substances)?
- *Healthy Behaviors.* What healthy behaviors work for them? Do they use them regularly? What gets in the way of using them? Some clients benefit from creating a "Top 5" list of healthy behaviors that they can reference and access easily when triggered. These healthy behaviors or resources can be enhanced with BLS as creating a "safe/calm" place. Resources can be brought into the future using the future template—allowing the client to visualize and step into the use of these skills and address potential barriers to using them.

Barriers to Success

1. Current life stress increases
2. Unexpected or increased dissociation occurrence
3. Increase in high-risk behaviors

- *Dissociation.* Did you complete the DES-II? Do the clients understand what dissociation is, how it presents in their life, can they articulate their experiences of it? Does the client present with dissociation in session or between sessions? Are they aware of how dissociation works for them? Do you need to do further, more comprehensive screening for dissociation?
- *Assessing for and increasing the bandwidth of their Window of Tolerance.* Are clients able to identify triggers, urges, or cravings that push them outside of the Window of Tolerance? Have they identified any healthy behaviors that can help them stay within the Window of Tolerance? Can they recognize signs or symptoms of being above or below the Window of Tolerance? If so, do they have strategies in place for how to get back? It can be helpful to create a plan with the client that identifies these areas and maps out their specific Window of Tolerance. Some clients benefit from tracking this throughout the day to help them better understand their patterns.



Timing

A large part of the success of starting EMDR therapy is about timing. In addition to a dialogue about the process of EMDR therapy and the potential effects the client might experience between sessions, it is essential to help the client assess, based on their current life circumstances, is this the correct time to start certain phases of EMDR therapy?

Issues to consider when helping clients decide if the timing is right might be:

- Do they have any current active crisis occurring that needs to be addressed in session?
- Do they have the ability to attend sessions regularly?
- If they are attending sessions virtually, do they have the ability to have uninterrupted privacy for the session's duration? Do they have a virtual connection that is stable enough not to freeze or drop out during the session? Nothing disrupts EMDR quite like having to exit and restart the session.
- Can they access and use a "safe/calm" place, "container," or another state changer so that sessions can be ended in a grounded way?
- Can they use a "stop signal" or have a way to communicate that they need to stop or pause in the work when they have been pushed outside the window of tolerance?

What to Target First?

Seen through the lens of the AIP Model, the client's trauma history, history of addiction (behavioral or substance), and the behaviors that come with addictions, are stored in memory networks. Current circumstances can spark these networks triggering mal-adaptive responses (active addictions). Addressing those networks with EMDR therapy allows the client to be responsive vs. reactive to current triggers allowing for the assimilation of a broader range of healthier responses.

What you target first is dependent on each client's unique needs. If you and the client decide to start with the smoke (addiction) piece, contemplate whether to address the risk or the protective factors first. First, addressing the risk factors could involve targeting the triggers, cravings, urges, and high-risk behaviors using the standard protocol approach or ad-

EMDR and Addiction Acronyms to Know

You may be wondering… what are all these new letters? I thought I learned all the necessary EMDR therapy acronyms with BLS, DAS, NC, PC, SUD, and VOC… there's MORE? If you want to work with clients fighting addictions, yes there are more acronyms! You will want to seek out training and gain knowledge regarding these additional treatment approaches.

DeTUR: *Desensitization of triggers and urge reprocessing* protocol developed by the late Dr. A.J. Popky. This protocol focuses on desensitizing triggers to reduce cravings and includes establishing a positive treatment goal for the client to work toward.

- **LoU:** L*evel of urge.* A measure regarding the level of urge to use or act out.
- **PTG/PG:** *Positive treatment goal.* A positive resource for the client to work toward not associated with the addiction.

Resources:

Popky, A. J. (2005). DeTUR, an urge reduction protocol for addictions and dysfunctional behaviors. In R. Shapiro (Ed.), *EMDR Solutions: Pathways to Healing* (pp. 167-188). New York, NY: W.W. Norton.

Popky, A. J. (2010). The desensitization of triggers and urge reprocessing (DeTUR) protocol. In M. Luber (Ed.), *Eye movement desensitization and reprocessing (EMDR) scripted protocols: Special populations* (pp. 489-511). New York, NY: Springer Publishing

CravEx: *Craving extinguished* approach developed by Michael Hase. This approach hinges on reprocessing the addiction memory which ideally results in the craving being extinguished. This approach also uses the LoU measure.

- **AM:** *Addiction memory* is a memory network that develops specific to the client involving the craving and compulsion to use or act.

Resources:

Hase, M., Schallmayer, S., & Sack, M. (2008). EMDR reprocessing of the addiction memory: Pretreatment, posttreatment, and 1-month follow-up. *Journal of EMDR Practice and Research,* 2(3), 170-179. Open access: https://doi.org/10.1891/1933-3196.2.3.170

Hase, M. (2010). CravEx: An EMDR approach to treat substance abuse and addiction. In M. Luber (Ed.), *Eye movement desensitization (EMDR) scripted protocols: Special populations* (pp.467-488). New York, NY: Springer Publishing Co.

LoUA: *Level of urge to avoid* discussed by Jim Knipe in his work with dysfunctional positive affect. LoUA, sometimes seen as LoU-A, can be used to target ambivalence about letting the substance or behavior go.

Resources:

Knipe, J. (2005). Targeting positive affect to clear the pain of unrequited love, codependence, avoidance, and procrastination. In R. Shapiro (Ed.), *EMDR Solutions: Pathways to Healing* (pp.189-212). New York, NY: W. W. Norton.

Knipe, J. (2010). Dysfunctional positive affect. In M. Luber (Ed.), *Eye movement desensitization and reprocessing (EMDR) scripted protocols: Special populations* (pp. 451-466). New York, NY: Springer Publishing.

FSAP: *Feeling-state addiction* protocol developed by Robert Miller. This protocol involves identifying parts of the addiction experience that feel good to the client but are ultimately part of the addiction they wish to cease.

Resources:

Miller, R. (2010). The feeling-state theory of impulse-control disorder and the impulse-control disorder protocol. *Traumatology,* 16(3), 2-10. https://doi.org/10.1177/1534765610365912

Miller, R. (2012). Treatment of behavioral addictions utilizing the Feeling-State Addiction Protocol: A multiple baseline study. *Journal of EMDR Practice and Research,* 6(4), 159-169. Open access: https://doi.org/10.1891/1933-3196.6.4.159

Tsouta, A., Fotopoulos, D., Zakynthinos, S., & Katsaounou, P. (2014). Treatment of tobacco addiction using the feeling-state addiction protocol (FSAP) of the eye movement desensitization and reprocessing (EMDR) treatment. *Tobacco Induced Diseases,* 12(Suppl 1):AA25. DOI:10.1186/1617-9625-12-S1-A25. Open access from: www.tobaccoinduceddiseases.org/Treatment-of-tobacco-addiction-using-the-Feeling-State-Addiction-Protocol-FSAP-of,66666,0,2.html

PEIA: *Palette of EMDR interventions in addiction* is a concept developed by Markus & Hornsveld (2017). The PEIA provides a framework for understanding EMDR and addictions treatment aims. The authors also introduce the idea of two lenses of EMDR and addiction treatment strategies: TF-EMDR and AF-EMDR.

- **TF-EMDR:** *Trauma-focused EMDR* uses standard EMDR therapy to target aspects of the past.
- **AF-EMDR:** *Addiction-focused EMDR* strategies typically focus on reducing cravings, fears of change, and creating stability, which can be added on or integrated with the standard EMDR protocol.

Resource:

Markus, W., & Hornsveld, H. K. (2017). EMDR interventions in addiction. *Journal of EMDR Practice and Research,* 11(1), 3–29. Open access: https://doi.org/10.1891/1933-3196.11.1.3

diction protocols. Addressing protective factors can be done by targeting memories that inhibit the client's engagement in healthy behaviors. An example would be doing a "float back" using the emotions, body sensations, and negative thoughts when considering a step that could increase support. This can help you and the client access a series of memories that can be processed to decrease the internal resistance to taking this critical step. Directly addressing and decreasing urges and cravings and using the AIP model to assess and address the memories that have made seeking support possible are often excellent first steps when focusing on addressing the addiction first.

Suppose you and your client decide to address the fire (trauma) piece

Like any client, clients with addictive disorders may not move as smoothly through the process as anticipated.

first. In that case, the question is often about the feasibility of addressing the "first" or "worst" memories as normally suggested when using EMDR Therapy. With this, and other populations struggling with complex trauma, it can help address the trauma by peeling it back in layers, starting with the outer, more current experiences, and then addressing the "worst" inner sections. This can allow the client time to build confidence in the process while also learning how to stay within their window of tolerance during and between sessions. It also allows the therapist to regularly assess the client's high-risk behaviors, healthy behaviors, dissociation, and reprocessing style while moving closer to the "worst" targets.

WHAT IF IT ALL FALLS APART?

Like any client, clients with addictive disorders may not move as smoothly through the process as anticipated. There can be various interferences; current life stressors can heat up, a higher level of dissociation occurs unexpectedly, or there may be times when you and the client notice an increase in high-risk behaviors. This should be anticipated as part of the process and seen as an opportunity to revisit and fine-tune the client's treatment plan. It is important to normalize this as part of the process.

Clients with addictive disorders have likely stumbled in their recovery path in the past; reminding them of past times they have moved forward despite a setback can help them tap into their strengths versus falling into the sticky tar pit of shame. This is also a good time to reassess their current use of their support network, any high-risk or healthy behaviors, experiences with dissociation, ability to identify and remain in the Window of Tolerance, and the process's timing. Collaborate with the client to identify opportunities for improved stability. Continuing to provide this consistent support will allow the client to feel safe enough to return to work on their readiness for continuing phases 3 through 8 of EMDR therapy.

An easy way to remember these concepts is by creating a dartboard sequence, starting with the outer ring, trying to accomplish as much of each as you can before moving onto the next ring.

Clients presenting with active addictions are often much more resilient than their histories would suggest. Crafting a solid foundation in recovery involves an increased ability to access and use life skills vs survival skills, the desensitization or triggers, urges and cravings, and eventually putting out the fires of the underlying trauma. Depending upon your work setting and the stage of change your client is in, you may be able to assist your clients in achieving all of these goals; for others, perhaps only some of them will be achieved.

Any achievement, or even the inability to achieve certain parts of the work, will inform both you and your clients of the next steps in the process. The Adaptive Information Processing (AIP) model and EMDR Therapy provide us with guidance and coordinates for the journey, but the treatment map we create with our clients will be written in pencil, as the journey is as unique and ever-changing as the individuals in the room with us. As we often remind our clients who with struggling with addiction—taking one step at a time, change is possible.

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Reference

The Kaiser Permanente/U.S. Centers for Disease Control and Prevention Adverse Childhood Experience (ACE) Study www.cdc.gov/violenceprevention/aces/index.htm