Mental health practitioners must be prepared to treat addiction-related issues—affecting up to 50% of mental health clients—whether or not clients present with addiction as a primary concern. This practical roadmap to the treatment of addictions advocates an underutilized—yet highly effective—method of intervention: eye movement desensitization and reprocessing (EMDR) therapy. It is the first book to integrate the Stages of Change Model with EMDR’s phases for successful treatment outcome. The book addresses the scope of problems relating to addiction, including relevant statistics and descriptions of substance and process addictions, and considers the connection between addiction and trauma. While focusing on the use of EMDR therapy in treating addictions, the book also considers traditional models for each stage of treatment so interventions can be individualized according to the needs of each client.

The authors describe in detail the Transtheoretical Model, tracing its development and theoretical foundations. They discuss each of its stages in depth, presenting and integrating EMDR interventions used by therapists in each stage. The interventions are useful for helping clients at any motivational level. Case vignettes in each chapter illustrate how EMDR techniques are used, and several detailed cases are provided at the end of the book. The appendix features additional resources and EMDR protocols. The text will be useful for therapists currently using EMDR for addiction treatment as well as those using other modalities who are seeking an effective alternative.

Key Features:
• Provides a practical roadmap to using the Stages of Change Model and EMDR therapy for effectively treating addictions
• Addresses substance and process addictions in depth
• Focuses on the trauma–addiction connection and treatment options
• Describes each Stage of Change and EMDR protocols and interventions for each stage
• Includes case vignettes and detailed case examples
Nancy J. Abel, LCSW, LADC, is a licensed clinical social worker and a licensed substance abuse counselor with over 38 years of experience. She is presently in private practice in South Portland, Maine, where she specializes in working with addictions, dual diagnosis, trauma, and EMDR. She is an EMDRIA-approved consultant. She was coordinator of family services at Day One (Drug Rehabilitation, Inc.), a highly reputable agency in Portland, Maine, for adolescents with alcohol and drug problems and their families. She was also director of substance abuse services at Shoreline Community Mental Health Services in Brunswick, Maine. For over 14 years she was an adjunct faculty member in the department of social work at the University of Southern Maine. In addition, she taught in the addiction certificate program at the University of New England. She has extensive experience as a speaker and trainer and presents workshops on addictions and EMDR with John M. O’Brien.

John M. O’Brien, PhD, has been a licensed psychologist in private practice in Portland, Maine, since 1998. He specializes in the treatment of substance abuse, grief, trauma, and gay/lesbian issues. Dr. O’Brien served on the American Psychological Association’s Committee on Rural Health and as chair of Sections on LGBT Issues and Independent Practice of Division 17, Counseling Psychology. He is a past president of the Maine Psychological Association and currently serves as the Continuing Education Chair. He is an adjunct faculty member at the University of Maine at Augusta, teaching courses in psychology and addictions since 2000. Dr. O’Brien is an EMDRIA-approved consultant who provides consultation on EMDR, CBT, DBT, and addictions treatment.
TREATING ADDICTIONS WITH EMDR THERAPY AND THE STAGES OF CHANGE

Nancy J. Abel, LCSW, LADC
John M. O’Brien, PhD
To our clients,
who have taught us so much
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NANCY'S STORY

I think I was born to be a social worker. It feels like it is in my blood.

I am one of those unusual people who knew when I was really young what I wanted to do with my life. I remember the exact moment when I knew what my career would be. It was the summer between my junior and senior years of high school. I was doing volunteer work at the Margaret Fuller House in Cambridge, Massachusetts. The “Marga,” as we called it, was a settlement house that served as a community center in a low-income neighborhood and offered myriad services. I worked on the playground with the preschool kids. One day, one of the college work–study students was putting a basketball into the closet and said, “Ah, we social workers have a tough life.” I had never heard of a social worker but I loved that place and I loved the work. I went back to high school and read about social workers in one of the career books. I knew I would spend my life as a social worker.

I went to college and then right on to graduate school in Boston. Upon receiving my MSW, I moved to Maine, where my first job was at a community mental health center. I had a number of jobs before I opened a private practice in the 1980s. I also continued to work in the public sector and taught for years at two local colleges as an adjunct faculty member.

One of my favorite jobs was serving as the coordinator of family services for a local agency for kids and families dealing with adolescent drug and alcohol abuse. Before that job, I didn’t know much about substance use disorders. I received a fast-track on-the-job education. I decided I needed to be more than self-taught and went on to study at the Center for Addiction Studies at Harvard University as a special student. I was lucky enough to have Howard Shaffer as my teacher. He informed my work with and thinking about addiction clients.

My work focused on dealing with addictions and mental health issues. I was fascinated by the challenges of working with this population. I became the director of substance abuse services at a local agency and developed a program for dealing with dual diagnosis.
Meanwhile, I kept hearing about this therapy, Eye Movement Desensitization and Reprocessing (EMDR). Frankly, it seemed like hogwash to me. What kind of therapy had a therapist waving fingers in front of a client’s eyes? Despite the rave reviews I heard from people who had done the training, I was a skeptic and I would not recommend it to anyone. Then one day (it is funny how our lives can change in a moment’s time!), I was on the phone talking to a managed care clinician about a client who had a fear of dentists. The clinician told me a story about a client who had a serious dental phobia. He had an opportunity to observe an EMDR session where the client’s phobia had disappeared.

This got me thinking. What is this therapy? Why is everyone raving about it? I decided to try it out. What better way to see if it worked than to try it myself? I had an old trauma from childhood that had never been resolved. It caused me a great deal of anxiety that would not dissipate, no matter how much I talked about it. In addition, I had a bridge phobia of unknown origin. I was terrified of driving over bridges.

I found a great EMDR therapist, Brenda Sawyer, in Gardiner, Maine, and worked with her on my trauma. Almost immediately, the anxiety around this went away. I felt a weight lift off me. And I started being able to drive over bridges with no problems despite the fact that we didn’t target that directly!

I was sold! I signed up for EMDR therapy training and immediately began to use it with clients. I was astounded by the progress made by my clients. Several years before I was trained, I had a client whose house had burned down. She developed posttraumatic stress disorder (PTSD) and was triggered by the sound of fire engines. She felt better after talk therapy but the trigger was still there. While I was in the training, I thought about her and wished I had EMDR skills when I worked with her. Luckily, she returned to treatment and I offered her EMDR therapy. She got better. No more triggers. I am still astounded by how fast people change and how improved the quality of life is following EMDR.

I began to use EMDR with addiction issues: Resource Development, Affect Tolerance, and the Popky/DeTur protocol. I was sitting in Seattle, Washington, at the EMDRIA annual conference, sort of drifting off, when the speaker began to talk about Michael Hase’s Memory of Addiction Protocol. She mentioned that he would be speaking about it at the next session. I snapped awake. I had not signed up for it but I ran out during the break and changed sessions. After listening to Michael Hase’s talk, I came out of the room and said to my colleagues in attendance, “This is why I came to this conference.” I went home and started using it and again was astounded by how helpful it was for clients in recovery who were dealing with urges and cravings. I used it with my client “Margo” that first week home and she felt immediate relief. Margo became the subject of the first article that I coauthored.

EMDR therapy changed my personal and professional life. The integration of EMDR into my work with addictions has enhanced and complemented my work in a way that has been rich and challenging.

This book is an opportunity to share the culmination of my professional work and what I have learned about integrating EMDR into the work with clients with addictions, trauma, and comorbid disorders. I feel tremendous
passion about this work. From that first moment in the hall of the Marga when I decided to become a social worker until now, I have loved what I do and I feel enormously grateful for my career. It has been exciting, challenging, intellectually stimulating, frustrating at times, and I cherish every moment. I am excited to share what I have learned with you.

JOHN’S STORY

I first became aware of the critical need for working with clients with addictions and their families when I was a high school guidance counselor in the late 1980s. A colleague and I decided to offer a support group for kids from families where alcohol was a problem. The high school was in a very affluent community and we wondered if any students would be willing to attend. The response was so overwhelming that we had to create a group for each of the two lunch periods to accommodate the students. In addition, some of my students were struggling with addictions of their own. I could see that if I was working in the mental health field, I needed to know more about addictions.

I pursued further graduate training at Michigan State University and completed my internship at the Dallas VA Medical Center, including specialty training in addictions. I wanted to learn as much as I could to be of help to clients, whether the problem with addiction was their own or that of a family member. On the final day of my internship, I was stunned when I heard the director of training say, “Now your learning really begins!” What? I have more to learn?

In my first job out of my doctoral program, I worked in a partial hospital program and I was in charge of the dual diagnosis track. I ran psychoeducational and therapy groups and was a case coordinator for patients. My clients quickly taught me what would and would not work in being of assistance to them. I also noticed in their records that many of them had trauma histories. Although we acknowledged these histories in their treatment, we could not address their trauma in any more than a cursory way, given their lack of stability and average 5-day treatment.

I then went on to work in the outpatient department and had clients with histories of trauma and addiction referred to me. I found myself now struggling with how to best meet their needs that were often intense. Many of them required frequent hospitalizations and struggled with sobriety. I sought out training in Dialectical Behavior Therapy (DBT), Seeking Safety, and other Phase-One trauma.

I then heard about EMDR from a colleague and was drawn to this training, mostly out of curiosity. I tend to be research oriented and I was rather doubtful of what some were touting as a “miracle cure.” In the practicum during this training, I decided to choose an old memory that I thought had been fully processed. While targeting this allegedly “resolved” incident, I had a sudden upsurge of affect and found that my resolution of this memory achieved a different level. I was hooked.

Once in private practice, I specialized in treating addictions and trauma. I focused on further developing skills in EMDR. Yet, I wondered how to best
integrate EMDR therapy for clients with addictions. I continued my learning process through further professional development and realized that my internship director was right.

My learning goes on. I’m pleased to share with the reader what my clients have taught me so far and offer ideas about areas for further learning. I hope that you find this book to be a helpful resource in your work.

OUR STORY

Nancy worked at a local university in the Addictions Studies Program. John applied for a faculty position in the program and Nancy was asked to interview him. We met at a local coffee shop and the rest is history.

Our first joint effort was the establishment of a special interest group (SIG) on addictions for our local EMDR community. We decided to train to become EMDRIA-approved consultants and we began to co-lead consultation groups that specialized in addiction and trauma issues. We then branched out to do trainings on addiction and trauma in the local area and around New England. Writing articles together about EMDR with trauma and addictions followed.

We have a unique partnership. We have strengths in different areas; we balance each other out. Although we think similarly about many aspects of psychotherapy, we have different styles in our approaches to working with clients.

This book is the next step in our collaboration.
ACKNOWLEDGMENTS

The authors would like to extend their thanks to

- Everyone at Springer Publishing Company, including our editor, Sheri W. Sussman, Katie Moyer, and our entire team
- Francine Shapiro, for inspiration and support
- Our colleagues in the Southern Maine EMDRIA community
- Our professional colleagues in the state of Maine and beyond
- Our families and friends who have given us so much support
This is a sample from TREATING ADDICTIONS WITH EMDR THERAPY AND THE STAGES OF CHANGE
The issue of addiction and recovery is a complex one: Each individual is unique and it makes sense that each person’s recovery from addiction would also be unique. In addition, the issue of addiction is a serious health concern often overlooked by health practitioners.

**SCOPE OF THE PROBLEM**

One of the challenges of describing the incidence of addiction in the United States lies in its very definition. There are diverse perspectives on addiction and there is no one agreed-upon way to define it (Juhnke & Hagedorn, 2006). Much of the research about substance use or problem behaviors is based on client self-report (van Wormer & Davis, 2013). These factors affect the research on addiction and thus there may be minimization of addiction’s true impact.

Substance Abuse and Mental Health Services Administration (SAMHSA; 2013) National Survey of Drug Use and Health reported that of the population in the United States aged 12 years or older, 22.2 million people were substance abusers or dependent. About 6.5% of Americans reported heavy drinking (5 or more drinks on the same occasion on at least 5 days in the last month), 23.9 million Americans aged 12 years or older were current users of illicit drugs, and 69.5 million Americans aged 12 years or older use tobacco. Approximately, 17.5% of individuals diagnosed with mental illness also met the criteria for a substance use disorder (SAMHSA, 2012). Alcohol, cannabis, and cocaine are the most frequently used substances by individuals with mental illness (Mueser, Noordsy, Drake, & Fox, 2003).

Approximately 50% of all clients who present to mental health professionals have problems related to their own alcoholism or that of a family member (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). These numbers do not incorporate the impact of drug-related or behavioral addictions that would likely increase this percentage significantly. The number of clients affected by other addictions (e.g., gambling, sex, work) is largely unknown due to differences...
of opinion about how to define these disorders (Tamam, Zengin, Karakus, & Ozturk, 2008).

It is very important that all mental health clinicians have an awareness of addictions and a variety of tools to use to deal with addicted clients. Many traditional treatments created to work with this population have proven effective. In addition, Eye Movement Desensitization and Reprocessing (EMDR), developed in the 1980s by Francine Shapiro, is a newer way to think about dealing with addictions. This book will explore both.

HOW TO USE THIS BOOK

This book is meant to provide a practical and useful guide for both experienced clinicians and those new to the addiction field. It offers many useful and helpful techniques and suggestions as clinicians develop individualized treatment plans for clients. The authors hope to encourage clinicians to address these issues directly and with success. The book is based on the theories of Prochaska and DiClemente, incorporating the Stages of Change Model for assessing client motivation to change (1982, 1992). It includes many practical interventions that are both traditional and EMDR therapy in focus.

The authors first wrote about EMDR therapy, trauma, addictions, and the Stages of Change in 2011 when they proposed a Roadmap Model for treatment (O’Brien & Abel, 2011). At that time, they outlined their basic philosophy:

1. The addictions treatment literature has established that not all treatments work for all clients (NIDA, 2009).
2. Addiction treatment must be individualized.
3. All clients presenting for treatment are not in the same place. In other words, they present at different stages and levels of motivation.
4. Trauma underlies addiction for many individuals. When it does, it must be dealt with to promote good, ongoing recovery. The question becomes when and how to do this.
5. Incorporating EMDR therapy into addictions treatment involves complex decisions.

It behooves clinicians to be thoughtful, educated, and aware of all the options for dealing with these complex issues.

Part I of this book explores the theories applicable to this work, including the scope of the problem. There are chapters on addiction, assessment, trauma, EMDR therapy, and the Stages of Change that provide clinicians with the theoretical material that is the foundation for making sharp clinical decisions.

In Part II, the authors discuss each Stage of Change and offer both traditional and EMDR therapy interventions for each stage. Clinicians may pick and choose from these interventions to develop appropriate treatment plans for clients.

In Part III, several cases are presented as examples of how the work can be accomplished. Finally, resources and protocols are presented for use with clients.

The authors have found that working with this population may be extremely rewarding. Despite its challenges, the work can be very gratifying.
when clients succeed in getting into healthy recoveries and resolve serious traumas. By the time many clients come to our offices, they feel hopeless and in despair. It is important that we hold hope for all of our clients. Although the relapse rate is high, an individualized approach based on analyzing motivation for change and providing appropriate interventions can give clients an increased chance of succeeding in their recovery.
Part I of this book focuses on a review of research and theory regarding eye Movement Desensitization and Reprocessing (EMDR) therapy and addiction. We will examine the current literature on EMDR therapy, addictions, the Stages of Change, trauma, and assessment of both trauma and addiction. Each chapter ends with learning points that provide an overview of the conclusions from the literature.

Many clinicians have a negative view of anything that relates to science or evidence-based practice (EBP). They erroneously believe that it will require them to use a treatment manual that dictates interventions for each session, perhaps even with a script of what to say. This is far from the truth. EBP is defined as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (American Psychological Association [APA] Presidential Task Force, 2006, p. 273). Research is one important component of effective treatment but the experience and expertise of the clinician are critical, as is incorporating the unique needs and preferences of the client.

Even if we know that research and theory are important, it is difficult for clinicians to stay up to date on the current developments in their specializations. Barriers to adopting EBP include negative beliefs about EBP or inadequate training in EBPs and poor understanding of what changes to make or why these changes are important (Lundgren et al., 2011). Clinicians may not get enough supervision or reinforcement of newly developed skills (Carroll, 2012; Lundgren et al., 2011). Those in private practice are not the only ones struggling to use science as a foundation for their work. Even large, specialty addiction treatment centers are slow to integrate EBPs (Fitzgerald & McCarty, 2009; LaPaglia, 2011).
Despite this resistance to change, the majority of clinicians recognizes the value of research and wants to provide good care to clients. Many of us get trained in EBP in graduate school or through professional development and believe that we integrate them effectively into the treatment.

Even though clinicians believe that they are doing “evidence-based treatments,” they engage in more informal discussions with clients than they realize and these discussions may interfere with the application of evidence-based treatment skills (Bamatter et al., 2010; Martino, Ball, Nich, Frankforter, & Carroll, 2009). In one study, 20% of the clinicians engaged in informal discussion with a client for 75% or more of the duration of their sessions (Martino et al., 2009).

So, why are theory and research important? If we want to be effective clinicians, we need to not only believe that we are engaging in effective interventions that are scientifically based but also to actually do them! That is where intentionality comes in. Intentionality is “purposeful behavior toward some conscious outcome” (Owen, 2009, p. 175). As psychotherapists, we need to utilize intentionality to be mindful of what we are doing in sessions with our clients and to integrate the best research into our work. Psychotherapy is both an art and a science; clinicians need to be well prepared in both realms (Friedlander, 1992). Part I of this book provides you with the scientific foundation that you need to artfully provide informed and effective interventions with your clients.
CHAPTER 1

EYE MOVEMENT DESENSITIZATION AND REPRESSING THERAPY

Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy model that was originally developed in the late 1980s by Francine Shapiro for the treatment of trauma. Since its initial creation, EMDR therapy has grown to be a treatment approach that has a wide variety of applications. In this chapter, we examine the origins of EMDR therapy, its theoretical underpinnings, EMDR techniques and protocols, and finally, the current status of the research to support its use.

EMDR clinicians undergo specific, comprehensive training in order to practice this form of treatment. This book is for informational purposes only and should not be viewed as a substitute for that training. Therapists are encouraged to complete EMDR training with the EMDR Institute and to engage in consultation to ensure ongoing fidelity to the model. More information about this can be found in the Resources chapter of this book.

EMDR THERAPY DEVELOPMENT

Dr. Francine Shapiro is the originator of EMDR therapy. In 1987, she was walking in the park near her home and noticed that she was reflecting on some disturbing thoughts about her life. At one point, she noticed that her eyes began to spontaneously move in a diagonal direction. She then found herself refocusing on the disturbing thoughts that she had been experiencing and she noticed that they did not seem to have as much affective potency. She was curious about this effect and tried it several more times. Each time she used this process, she noticed the same effect (Luber & Shapiro, 2009; Shapiro, 2012).

Dr. Shapiro then conducted informal investigations with others and asked them to try this same process, using eye movements, and she found that they
experienced similar effects. She discovered that some individuals needed different types of eye movements (diagonal/horizontal) and a varied pace of the movements. Once again she was intrigued by this but remained unclear about what was happening. She decided to try the application of this technique with a volunteer client to see if what she had found might have a clinical application. She tested the procedure with a combat veteran by targeting a single trauma. In one session, she found that the client was able to eliminate the disturbance associated with this memory (Leeds, 2009).

Dr. Shapiro then proceeded to complete a formal study of 22 individuals who were experiencing posttraumatic stress disorder (PTSD) symptoms related to a variety of traumas. She found that this technique reduced the disturbance associated with a target memory significantly. Her initial work was known as eye movement desensitization (EMD; Shapiro, 1989).

This led Dr. Shapiro to study EMDR in more controlled and formulaic ways. She developed a specific protocol that was used to standardize the treatment and began to present her work at professional conferences. In 1991, EMD was renamed EMDR in order to capture the idea that this treatment is about linking traumatic events to other life experiences (Maxfield, 2009a).

Since her original work, the EMDR Institute was established to standardize this treatment. Thousands of therapists have been trained worldwide in EMDR therapy and its applications. Protocols have been developed for many different presenting complaints beyond trauma, including anxiety, performance, and most notably for our purposes, addiction.

WHAT IS EMDR THERAPY?

EMDR is a specific treatment protocol that has been empirically validated for the treatment of trauma. We explore the research that supports its applications later in this chapter.

Specifically, the EMDR Standard Protocol for trauma involves the client holding an image of a trauma, a negative belief about self, the emotions that are stirred up by the trauma, and the location of the trauma in the body while experiencing bilateral stimulation. Initially, the bilateral stimulation was eye movements. The therapist holds his or her fingers in front of the client and moves them back and forth in front of the client’s eyes. The client follows the movements with his or her eyes and then reports what images thoughts or feelings occurred during the process. The process repeats until the trauma is desensitized or the client has a neutral reaction (EMDRIA, 2012).

After some initial work, clinicians found that not all clients could tolerate the use of eye movements throughout a session, especially if the individual wore glasses. Some clients’ eyes would tire and some would have difficulty staying with the treatment. It was determined that it was bilateral stimulation of both sides of the brain that was the likely underlying mechanism of action as opposed to eye movements specifically. Clinicians started to use bilateral tones in the left/right ears and bilateral left/right tactile stimulation (accomplished by tapping on the client’s knees or hands or by using tappers).
EMDR is a treatment that can also be blended with many other theoretical approaches. Clinicians who are oriented to various treatment approaches such as psychodynamic, cognitive, behavioral, humanistic, and existential (as well as many others) can easily integrate this approach into their work with clients. EMDR allows the clinician to maintain his or her primary approach and provides a mechanism to help clients heal from trauma and other presenting complaints (Shapiro, 2001).

EMDR THERAPY: WHAT IT IS NOT

EMDR has been a source of controversy since its original development. Many leaders in the field of trauma treatment were suspicious of this approach. Because EMDR was not developed empirically, these detractors believed that it was akin to “reading tea leaves” and that it was not a valid approach to treatment. There was initially a body of research that disparaged this approach, calling it pseudoscience and indicating that it was not effective (McNally, 1999, 2001; Philip, 1996; Rosen, McNally, & Lilienfeld, 1999). Reports surfaced that EMDR was harming patients (Shapiro, 1991). Proponents of EMDR were dismayed to hear about this research (Greenwald, 1999; Leeds, 2009).

Closer examination of these “treatment failures” showed the reasons for these results. Most notably, the clinicians who were providing “EMDR therapy” had never been formally trained by Francine Shapiro. These clinicians were taught by others who had been through the formal training and who then decided to teach it on their own. These events led Dr. Shapiro to formalize her expectations and initially restrict training to those sessions that she would personally conduct until she was able to publish a text on EMDR that outlined the treatment model (Shapiro, 1995).

Today, the EMDR Institute has very strict guidelines about the definition of EMDR and what constitutes this treatment (EMDRIA, 2012). Without proper training, a clinician may do more harm than good to a client, particularly if the therapist does not know what to do or how to handle the clinical material (intense emotions, distorted cognitions, etc.) that emerges.

EMDR therapy is not simply waving your fingers in front of someone’s eyes and seeing what happens. EMDR is not a technique that someone can learn from a 3-hour workshop. In order for a clinician to be minimally trained in EMDR therapy, he or she must attend two trainings provided by the EMDR Institute that are separated by at least 3 months. In between these trainings, he or she must treat clients and receive at least 10 hours of consultation from an Institute-approved consultant. Even after formal training, clinicians benefit from ongoing professional development around EMDR.

EMDR as a treatment approach requires that a clinician have sound clinical training as a foundation. EMDR therapy training does not replace the need for a broad clinical background in how to work as a psychotherapist. Clinicians need to have good judgment and ethical decision-making skills as a precursor to EMDR’s use. EMDR training and consultation presupposes that the clinician bring these skills to his or her work with clients. No treatment or technique will
provide all of the answers about how to manage clients. The clinician needs to be prepared to stop the use of bilateral stimulation and utilize his or her clinical skills if problems come up for the client with the implementation of EMDR or the processing of specific memories.

Adaptive Information Processing Model

EMDR therapy is based on the Adaptive Information Processing (AIP) Model. This model describes how information is processed in the brain, how disruptions in the processing can affect individuals, and how to resolve these blocks. This model is founded on the following three principles (Leeds, 2009):

1. Humans have an information processing system that allows them to naturally respond to problematic or dysfunctional life experiences and resolve the distress associated with them.
2. A traumatic event may disrupt the usual AIP system and, if this happens, this unprocessed information leads to disturbance.
3. EMDR combines a focus on specific information about the traumatic event with bilateral stimulation to bring resolution to the previously unresolved traumatic event.

All of our experiences are organized in associated memory networks in our brains. As we go through life, the things that we experience that we judge to be important are stored with similar events in metaphoric “files” in the brain. Our perceptions at the time, our behavior and that of others, and our emotions are all linked and stored together. We catalog experiences in our brains in this way and these memory networks are automatically activated as we engage with similar situations in the present (Solomon & Shapiro, 2008).

Disruptions in the usual functioning of AIP are what create symptoms and problems in current life. Shapiro (2001) stated that some experiences may be inadequately processed; some experiences that are distressing are not cataloged in the brain in the usual way. Instead, these memories remain stuck and are stored with the negative affect and perceptions that the person experienced at the time of the incident. The result of this dysfunctional process is that the person will respond to current life situations that are similar to this memory with potentially inappropriate affect, thoughts, perceptions, and behaviors. In this way, previous life events are experienced not as being in the past but rather as being in the present, consciously or unconsciously (Shapiro, 2001).

For example, someone who was driving a car when a car accident occurred may get stuck on the idea that “I am a failure” for not preventing the event. Regardless of the facts of the situation, the person may perpetuate this belief and its associated negative view of his or her behaviors and negative emotions. Driving in a car, being on a highway, or witnessing another accident could all potentially reactivate that belief and associated feelings if the initial event were not adequately processed. Other life events that activate this belief will become stored together in a dysfunctional memory network. Unprocessed events could lead to serious mental health symptoms, including PTSD.
It is these dysfunctional memory networks that EMDR targets with the goal of connecting them with more adaptive memory networks stored elsewhere in the brain. By doing so, the memories that had been dysfunctionally stored are altered and are no longer isolated from more adaptive information and responses to current life events. Memories and information that have been appropriately processed in this model provide the foundation for good mental health (Solomon & Shapiro, 2008).

**Bilateral Stimulation**

As its name indicates, EMDR was originally developed as a technique that utilized eye movements. Clinicians were trained to have clients follow their fingers as they moved them back and forth in front of the client’s eyes. Some clients found that their eyes would quickly tire from the repetitive movement. Clinicians were finding that their arms and shoulders also became tired from the need to maintain these movements throughout the session, especially when they were conducting multiple sessions daily.

Over time, other types of bilateral stimulation were developed. Clinicians were trained to also use bilateral tones and tactile stimulation (tapping on the client’s knees or hands) as these forms of stimulation proved to elicit the same response in clients. Machines were developed such as the light bar and Tac/AudioScan that would produce bilateral stimulation in a way that was easier for both clinician and client.

Controversy over EMDR’s exact mechanism still exists, especially about whether the eye movement component is necessary at all (Gunter & Bodner, 2009). However, EMDR therapy has been shown to be more effective than no treatment at all (Högberg et al., 2007) and equally as effective and faster than forms of exposure therapy in treating PTSD (Ironson, Freund, Strauss, & Williams, 2002; Rothbaum et al., 2005). Some critics argue that bilateral stimulation is not necessary and that EMDR is simply another form of exposure treatment. However, there is evidence that eye movements do provide a unique component in treating trauma (Nowill, 2010; Schubert et al., 2011). In addition, some evidence suggests that eye movements may provide a superior effect in relation to other forms of bilateral stimulation (Jeffries & Davis, 2013). However, as of this writing, there are no definitive conclusions that one type of bilateral stimulation is more effective than others and more research will be necessary to firmly establish both the necessity of eye movements in EMDR and the relative superiority of types of bilateral stimulation (Nieuwenhuis et al., 2013).

**EIGHT-PHASE MODEL**

EMDR is an eight-phase model of treatment. Each of the phases has specific goals and tasks that the clinician should accomplish when utilizing EMDR with any client. Each of the eight phases is described in detail below. Please also see Table 1.1 (see Leeds, 2009, p. 42).
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Phase 6
Body Scan
• Verify any residual disturbance associated with the target is fully reprocessed.
• Allow patient to reach higher levels of synthesis.
• Provide discrete sets of bilateral stimulation while patient focuses on reprocessing any residual physical sensations until there are only neutral or positive sensations.

Phase 7
Closure
• Ensure client stability and current orientation at the close of each reprocessing session.
• Use self-control techniques if needed to ensure stability and current orientation.
• Brief patient about treatment effects.
• Request patient to keep a log of self-observations between sessions.

Phase 8
Reevaluation
• Verify whether all aspects of the treatment plan are being addressed.
• Adjust treatment plan as needed based on patient reports from log.
• Recheck target(s) to ensure stable treatment effects.

EMDR, Eye Movement Desensitization and Reprocessing; SUD, Subjective Units of Disturbance Scale; VoC, Validity of Cognition Scale.

Phase 1: History Taking

The initial goal in EMDR therapy is to establish a therapeutic alliance with the client. This should be based on trust and openness, allowing the client to be honest about his or her reactions to the process of EMDR. Without a strong alliance, EMDR therapy is not going to be effective. The client needs to feel safe and protected by the clinician as this is a potentially very difficult and destabilizing process (Shapiro, 2001).

History taking includes gathering information about the client’s presenting complaints and goals as well as his or her medical and psychosocial status. The clinician needs to gain a clear understanding of his or her issues in order to formulate an overall treatment plan (Shapiro, 2007a).

Some clients are not appropriate candidates for EMDR therapy. Phase 1 includes screening for these exclusions. Because EMDR is a powerful treatment that must be used with caution, using this treatment with clients who are not stable may result in retraumatization of the client and a treatment failure (Shapiro, 1991).

Clients who are actively dissociating are likely not appropriate for immediate trauma processing. Although some exceptions exist, these clients generally need assistance with skill building and development of strategies to manage dissociation in order to be ready for trauma processing (Forgash & Copeland, 2008; Leeds, 2009).

Those who are actively suicidal are also inappropriate for this treatment. Moving too quickly to process traumatic material in this case can further exacerbate suicidality in the client. Clients may need to be evaluated for psychiatric medication to help to stabilize depression (EMDRIA, 2012; Shapiro, 2001).

Clients who are actively psychotic, with personality disorders, engaged in self-harming behaviors, and those with certain medical conditions may not be appropriate for EMDR treatment. Consultation and/or supervision are essential in considering these cases and deciding the next steps in treatment (Leeds, 2009; Shapiro, 2001).

The Three-Pronged Protocol

Once the assessment of the client is completed, the clinician will develop the treatment plan based on a three-pronged protocol. This protocol utilizes past, present, and future as a way to organize the targets of treatment. The clinician identifies the appropriate memories to process from the past and works with the client to desensitize them. Once these are processed, the focus turns to present triggers that could still activate dysfunctional responses and to skill building for the future to prevent a return to old coping patterns. It is in this initial phase that the clinician can develop a general plan for each of these “prongs.”

The clinician develops a plan for each of these prongs using different strategies. Some clinicians arrange the associated memories by age and take a developmental approach. Others may arrange memories based on the unifying cognition or the unifying affect. Many use the approach of “first,” “worst,” and then all the rest of the memories. Regardless of the model that is used, it is essential to have a map of memories established in preparation for the next phases (Leeds, 2009).
Phase 2: Preparation

Phase 2 of EMDR treatment involves specific strategies to adequately prepare the client for EMDR trauma processing. Appropriate preparation is essential. Clinicians should guard against overlooking the importance of this phase.

Clients need to give informed consent about EMDR treatment and the fact that, like any treatment, it may not help at all and could potentially make the client feel worse. During the desensitization phase, clients may feel quite destabilized. They need to be prepared for this. Clients will also need psychosocial education about EMDR and the AIP model as well as the effects of trauma and the mechanism of PTSD. This helps to orient the client to what he or she is experiencing and what he or she can expect in treatment.

Bilateral stimulation is introduced in this phase. The client is presented with the option for eye movements, alternating tones, and tactile stimulation, depending upon the mechanisms available to the therapist. Client comfort with and preferences for each of these modalities should be explored and documented. If a client becomes stuck in processing a memory while engaged in an EMDR session targeting a trauma with one of these modalities, the clinician may want to shift to another type of processing. Exploration and documentation of bilateral stimulation that works more or less effectively for the client will make those situations much easier to manage.

It is also in this phase that the client is introduced to some essential skills that will be needed in EMDR processing. The clinician ensures that the client has appropriate self-regulation skills. Coping skills are reviewed and the client is taught self-management skills to manage physiological arousal, such as progressive muscle relaxation (Conrad & Roth, 2007), diaphragmatic breathing (Fried, 1999; Nelson, 2012), or grounding, a technique that directs attention away from internal reactions to external stimuli (Forgash & Knipe, 2012; Najavits, 2002). The first EMDR therapy protocol, Safe/Calm Place, is installed with the goal of shoring up the client’s coping and assessing the client’s response to bilateral stimulation. (See Appendix B1 for a description of this technique.) The client is also taught to think about the trauma processing by using metaphors such as “viewing scenery on a train” or “watching a video on a television screen” in order to provide some distance from the material (Leeds, 2009). The length of time needed for clients to develop these skills will vary based on his or her presentation (Forgash & Knipe, 2012).

The client also learns how to stop the processing at any point by identifying a specific way that he or she will signal the need to do so. It is critical to identify this in advance. Some clients may utter words during processing that are part of reactions to the events being reexperienced (e.g., “Stop!” or “I can’t do this”) as opposed to a desire to end the processing. The “stop” signal helps to clarify this up front (EMDRIA, 2012; Shapiro, 2001).

Clients are also encouraged to create a weekly log for themselves. This log can take various forms, depending upon client willingness and preference. It can provide an important foundation for awareness of what associations are emerging during EMDR treatment, including old memories as well as the emergence of new, previously repressed memories or other associated reactions. In addition, this provides a way to double-check on previously processed memories to determine if there are any parts of the trauma issues that remain unresolved.
**Phase 3: Assessment**

In this phase, the clinician and client select a specific memory to be processed. The choice of memory will be guided by clinical judgment as well as client preference.

Once a specific memory is selected, the memory is assessed in preparation for processing. The client is asked to identify the worst or most disturbing part of the incident and an image that best represents it. If a client cannot identify a specific image, the clinician can ask the client to identify a bodily sensation or other sensory experience that occurs when he or she thinks about the incident.

Cognitions that are related to the incident and the disturbing image are then explored. The negative cognition (NC) captures the presently held self-referencing negative belief that this incident activates. Examples of this could include “I am worthless,” “I am inadequate,” or “I am not good enough.” A positive cognition (PC) is also then identified as the belief that the client would like to be able to connect the incident with a more adaptive view of self once desensitization is complete.

The client then rates the PC on the Validity of Cognition (VoC) Scale ranging from 1 to 7; 1 is seen as completely false and 7 represents completely true. Most often, VoCs will be low in this phase. If a client’s VoC is high when thinking about the incident, the clinician should reexamine the cognition and the client’s understanding of the process.

While considering the disturbing image and negative belief, the client then reports on other emotions that he or she experiences in thinking about the incident. This is important to understand as the emotions the incident triggers initially may change over time. For example, a client who was abused may experience terror and helplessness when he or she thinks about it initially. Later in the session or in future sessions focused on this memory, the emotions related to the incident may change.

The client then rates his or her level of disturbance on the Subjective Units of Disturbance Scale (SUDS) rating from 0 to 10 where 0 is neutral or no disturbance and 10 is the highest level of disturbance that the client can imagine experiencing. Use of this scale helps the clinician to track client progress and/or identify when a client remains stuck in processing (EMDRIA, 2012).

The final component of the assessment phase relates to the body. The client is asked to consider the disturbing image, the NC, and the emotions connected to the memory and then identify places in the body that are activated by the memory. Changes in bodily sensations will be another important aspect to track as clients enter the desensitization phase (Shapiro, 2001).

**Phase 4: Desensitization**

Once the target memory has been assessed, the clinician will proceed to desensitize the memory. As mentioned previously, the clinician may utilize various forms of bilateral stimulation including eye movements, tones, or tactile stimuli (or some combination thereof). The clinician then summarizes the memory components that have been identified for the client to be sure that the memory is activated and asks the client to “just notice what happens” during the bilateral
stimulation. It is important to clarify for clients that they should “just let whatever happens happen.” Otherwise, some clients can misunderstand the task and may unwittingly hamper processing efforts by remaining focused on the highly disturbing material and not allowing the mind to move to other places. A good number of clients worry about whether or not they are doing the processing correctly. Clients often need to be reassured that there is no wrong way to do this. They may need to be encouraged to relax into the process (if they can) and just let what happens happen. This is an example of why a strong therapeutic relationship is a necessary component of EMDR; the clinician must have a strong alliance with the client in order to provide this reassurance.

The client is then encouraged to focus on the material for a “set” of bilateral stimulation that will vary in its speed and length based on clinical judgment and client preference. At the end of each set, the client is encouraged to take a breath and is then asked, “What do you notice now?” or “What are you getting?” The client is then asked to summarize as best as possible what he or she has experienced with regard to the incident. The goal of these verbalizations is to help the clinician understand where the client is in the processing. Ideally, the clinician stays “out of the way” and lets the client experience associated images, affect, and bodily sensations without interfering. This process continues until the client reports that the incident is no longer disturbing and is rated as a “0” on the SUDS. There are exceptions to this. On rare occasions, a client may not be able to reach a “0” on the SUDS due to the extreme disturbance of the event. Clinicians should get consultation about cases such as this.

Cognitive Interweave
Most issues for clients who are experiencing the effects of unresolved trauma are organized around three issues: safety, responsibility, and choice. As clients process a memory, clinicians may often hear these themes in this order as clients move to resolution. After attributing appropriate responsibility for their part in an event and their feelings about the event, clients can recognize that the event no longer is occurring and that they can be safe now. This will help them choose to move forward in life (Shapiro, 2001).

In some cases, the natural process of healing described previously that underlies EMDR therapy gets stuck. In these instances, the client begins to “loop” in the processing, repeating the same material over and over much like a skipping record. The clinician may offer brief verbalizations designed to help the client access awareness of issues related to responsibility, safety, and choice, depending upon the theme of the client’s verbalizations. This will help to jump-start the process and ideally help the client move forward in the processing (Hensley, 2012; Leeds, 2009; Shapiro, 2001).

Phase 5: Installation

In this phase, the client is asked to reevaluate the PC that was identified in the assessment phase. The client is asked to think about the original incident and rate the PC on the VoC Scale (1–7). Bilateral stimulation is utilized while the client holds the original experience and the PC in mind until the client rates the VoC as 7 (or in rare instances, 6).
It is not unusual for the PC to shift as a result of processing. Clinicians should not be surprised if the client spontaneously indicates that a different adaptive cognition has emerged. If this occurs, the new PC is still rated on the VoC scale and processing continues as noted above.

Phase 6: Body Scan

The body scan is the last component of reprocessing. Trauma theorists have posited that “the body keeps the score” (van der Kolk, 1996). The body scan is completed to ensure that the incident is completely processed and that there are no remaining effects of the memory.

The client is asked to close his or her eyes and to focus on the incident with the installed PC. The client is directed to notice any sensations that emerge while scanning the body. If disturbing sensations do emerge, the client is directed to focus on them while additional bilateral stimulation is utilized. This process is continued until the disturbing sensations are no longer present. If, on the other hand, positive sensations emerge, the client may be encouraged to focus on them as bilateral stimulation is utilized. This can be done to further accentuate the positive results of the memory work (Shapiro, 2001).

Phase 7: Closure

If a client is able to process an incident in one session, then the closure process will simply be to direct the client to notice any associated dreams, memories, or other associations that emerge in the week ahead. As noted in Phase 2, clients have been encouraged to keep a weekly log. This log may help clients track any further associations to the target or other information that emerges that may reactivate the disturbance associated with the memory.

In some cases, clients will not completely process a memory in one session. This results in what is known as an “incomplete session.” In these instances, the client is guided in closing down the neural network and reorienting him- or herself to the present (EMDR Institute, 2012; Leeds, 2009). Skills that were identified and developed in Phase 2 are called upon to help the client regulate him- or herself. The client is encouraged to contact the therapist if additional disturbance comes up during the week that is unmanageable or to check in with the therapist as needed.

Phase 8: Reassessment

Reassessment is completed when a client returns for the next session. The client is asked about his or her reactions to the processing in the previous week and any new information that has emerged. If the previous session was incomplete, the client is guided in reevaluating the original incident and Phase 4 desensitization continues, following the phases noted.
EMDR THERAPY PROTOCOLS

Over time, many protocols have been developed for use in EMDR processing. As previously mentioned, EMDR applications are being used with a wide variety of presenting complaints. There are a myriad of protocols and treatment options. For our purposes, we will restrict our discussion to the protocols that we have chosen to use in our work with clients presenting with trauma and addiction-related concerns. For further exploration of other protocols and applications, the reader is directed to protocol collections gathered by Marilyn Luber (2009, 2010). In addition to the standard protocol for trauma, the following protocols used in treating clients who present with addictions are reviewed: Safe/Calm Place (Shapiro, 2001); The Two-Handed Interweave (Shapiro, 2005); The Standard Protocol (Shapiro, 1995, 2001); Resource Development Installation (RDI; Korn & Leeds, 2002); Affect Tolerance (York & Leeds, 2001); Desensitization of Triggers and Urge Reprocessing (DeTUR; Popky, 2005); and CRAVEX/Memory of Addiction (Hase, 2010).

The Safe/Calm Place Exercise

The Safe/Calm Place exercise was originally developed to help combat veterans who experienced intense anxiety responses when asked to use relaxation exercises. This activity was originally known as the “safe” place, but because many trauma clients could not imagine any place in the world where they could experience safety, the name was changed to the “calm” place for these clients. A client’s lack of positive response to the safe/calm place may indicate that he or she will have a more difficult time with EMDR treatment and require more from the clinician (Leeds, 2009).

In this exercise, the client identifies a safe or calm place in imagination. Once he or she has developed an image and focused on its associated emotions and sensations, the clinician uses bilateral stimulation to strengthen the image. Short sets with a slower pace are used in an effort to minimize the chance for activation of traumatic material (Leeds, 2009). A cue word is identified and paired with the image. This can then be used to help the client access this place to deal with minor disturbances in the past and to deal with future issues.

The Two-Handed Interweave

The Two-Handed Interweave, developed by Robin Shapiro (2005), is an extremely helpful technique to use with clients who are ambivalent or having difficulty making a decision. The client “places” one idea or thought or issue in one hand, then places the other, opposite idea, thought, or issue in the other hand. The client opens one hand, then the other, while focusing on the idea in the open hand. The therapist may use bilateral stimulation, if that is preferred. The processing stops occasionally and the client discusses what has been observed or decided. Traumatic material may surface during this process and the clinician must then make a decision as to whether it is appropriate and timely to use the standard protocol to process what
has emerged. Use of this technique usually leads to a fruitful discussion; some clients make decisions about change following the use of this interweave.

**Standard Protocol**

The standard EMDR protocol (Shapiro, 1995, 2001) is the central component of EMDR treatment. The eight-phase model already described is this protocol. It is critical for clinicians who are being trained in EMDR therapy to become clear about the application of the standard protocol before they expand their expertise to other protocols.

**Resource Development Installation**

There are many different ways that clients can develop self-regulation skills or enhance ego-strengths and coping mechanisms. The authors utilize the Resource Development Installation (RDI) protocol (Korn & Leeds, 2002) and find it to be quite useful for clients with addictions.

The initial step in the RDI protocol is to have the client identify a challenging present-life situation. The client then rates this stressor using the SUDS (0–10; 0 = no disturbance, 10 = most disturbance). The client identifies a quality that is needed to deal with the stressor (e.g., strength, centeredness). There are then three ways to create the resource needed. The client may identify a personal situation in which he or she exhibited the quality, a resource figure embodying the quality, or an image or symbol that represents the quality. One or more of these resource exemplars is then further developed by identifying images, sounds, and body sensations that best represent it. Bilateral stimulation is then used to reinforce these representations. The client then returns to the stressor identified at the start of the protocol and imagines using the newly developed resources to cope with it.

**Affect Tolerance Protocol**

Both addiction and trauma have been identified as disorders of affect and affect regulation (Verdejo-García, Pérez-García, & Bechara, 2006). Cummings, Gordon, and Marlatt (1980) identified poorly managed affect as a primary trigger for relapse. The Affect Tolerance Protocol (York & Leeds, 2001) may be helpful in stabilizing a trauma client in Phase 1 trauma treatment, helping a client to develop the skills to prepare for change, or assisting a client in recovery to prevent relapse. This protocol is especially useful when the client comes to session experiencing an affect that is difficult to manage or manifests the affect in the session as the result of some issue being addressed.

The client identifies a feeling that is distressing and then determines the worst part of it. He or she then develops an image of the worst part of the feeling as well as identifying a negative cognition and positive cognition as well as associated body sensations. The client rates the VoC of the PC and the SUDS level of the worst part of the feeling. The client identifies “feelings about the feelings” and locates the feeling in the body. The overall goal of the protocol...
is to help the client reduce the level of distress associated with the affect (i.e., increase the ability to cope with/tolerate the feeling).

The clinician uses bilateral stimulation to desensitize the feeling. Ideally, the SUDS will go down either due to desensitization or to the client’s spontaneous use of coping skills. The clinician checks the SUDS level after two to three sets. If the distress does not reduce, the clinician helps the client to use other affect management strategies that have been successful for the client in the past (breathing, grounding) or begins to teach new ones. The PC is then installed. No body scan is used at the end of the session.

As noted, Affect Tolerance is an essential skill for those in recovery from addiction and trauma. Other protocols may also be used to help clients develop these skills (e.g., Leeds, 2011).

ADDITION-SPECIFIC PROTOCOLS

DeTUR Protocol

Popky (2005) developed the DeTUR Protocol to assist clients with addiction. The protocol is used to help clients focus on reinforcing positive coping in recovery and reducing the impact of relapse triggers. The client is encouraged to strengthen motivation for change before tackling the triggers of his or her addiction.

The client initially focuses on the Positive Treatment Goal, that is, the image that represents what life would be like if changes were successful. After identifying in general how much better life will be without active addiction, the client creates a visual representation of life without addiction (or with successful harm reduction). This picture is then enhanced with bilateral stimulation. The client and clinician work together to help the client to develop and/or reinforce both internal and external resources to support behavior change.

Next, the client develops a list of triggers for relapse; each trigger is broken down into its component parts. For example, if the client says that driving home from work is a trigger, the client lists all elements of that experience as part of the triggering event, such as leaving the office, opening the car door, driving on the highways, and so forth. The client is told that the entire process must be desensitized for this to be effective. The clinician then uses bilateral stimulation to desensitize the relapse triggers identified by the client, one at a time. Clients are taught to use bilateral stimulation on their own if urges come up outside of session.

Hase Memory of Addiction/CRAVEX Protocol

Hase (2010) created the Memory of Addiction/CRAVEX Protocol. Each episode of use/addictive behavior is seen as related to an addiction memory (AM). According to this view, addiction is conceptualized as a repetitive activation of the same neural network that relates to the initial reasons that clients became addicted. The goal of the protocol is to desensitize the AM and to link this network with healthier coping.
The client initially identifies his or her last craving, urge, or relapse related to addiction. The standard protocol is a general outline for treatment. Once an image for the urge/relapse is selected, the client then identifies PCs/NCs, the VoC, emotions, and body sensations. Instead of the SUDS, the client rates his or her level of urge (LOU) on a scale from 0 to 10, where 0 is no urge and 10 is the highest urge that one can imagine. Bilateral stimulation is used and the LOU is tracked until it reduces to a 0. Once the urge/relapse is desensitized (LOU = 0), the PC is installed.

EMDR Research

When EMDR was first introduced in 1989, critics charged that it was nothing more than “finger waving therapy” (Maxfield, 2009b). Despite these critiques, research has been ongoing into the efficacy and effectiveness of EMDR.

Schubert and Lee (2009) provided an overview of the three phases of research on EMDR therapy. Initial research focused on the effectiveness of EMDR as a treatment for PTSD compared to a control group that was placed on a waiting list (Högberg et al., 2007; Jensen, 1994; Rothbaum, 1997). The second wave of research on EMDR focused on its effectiveness in comparison to wait list controls and other treatments for EMDR (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Edmond, Rubin, & Wambach, 1999; Edmond & Rubin, 2004; Scheck, Schaeffer, & Gillette, 1998). In both cases, EMDR emerged as a valid treatment and as equally efficacious as compared to other first-line treatments for PTSD.

EMDR therapy is also being utilized by clinicians for a wide variety of psychiatric symptoms including obsessive-compulsive disorder (Marr, 2012), migraines (Konuk, Epözdemir, Atçeken, Aydin, & Yurtsever, 2011), panic disorder (Leeds, 2012), and grief (Solomon & Rando, 2012). At present, research has established only that EMDR therapy is a valid and effective treatment for PTSD. Other applications of EMDR are still being studied to support their clinical utility for disorders beyond PTSD (Maxfield, 2009a).

Research at present is focused on issues related to exploring the exact mechanisms for EMDR. Although we know that EMDR works, we still cannot determine the exact mechanisms of the change processes that occur during treatment. Current hypotheses about the active mechanism of EMDR include that it is a process akin to REM sleep, that it creates increased hemispheric communication, or that it provides psychological distancing (Gunter & Bodner, 2009). Ongoing research will help clinicians continue to explore whether the change process in EMDR is about REM-related processing of information, increased communication between left/right hemispheres of the brain, or other mechanisms yet to be clarified (Gunter & Bodner, 2009; Schubert & Lee, 2009).

EMDR Therapy and Addiction

Research on the use of EMDR therapy with addiction is limited but growing. The only randomized control trial of the use of EMDR in clients with addiction
was published by Hase, Schallmayer, and Sack (2008). The study utilized “treatment as usual” with and without EMDR. Components of the treatment as usual included detoxification, motivational interviewing, assessment of social support/adjustment, relaxation skills, group therapy, and art therapy. Treatment lasted 14 to 21 days and clients were then referred to a rehabilitation program and 12-step meetings.

The experimental group of patients received treatment as usual with the addition of EMDR targeting the “addiction memory,” which was viewed as the core of their addiction. Findings indicated that treatment enhanced with EMDR decreased cravings more effectively than treatment as usual. In addition, rates of relapse at 1- and 6-month intervals were lower in the EMDR treated group as compared to the control group. Finally, patients who received the EMDR treatment reported lower levels of depressive symptoms posttreatment, whereas those who received treatment as usual had no such effect.

Cox and Howard (2007) described the use of EMDR therapy to treat a case of sex addiction. They described how early traumas often underlie sex addiction and trigger relapses. They discussed a single case to demonstrate that sex addiction may be effectively treated with EMDR. The client was treated with sex addiction education, 12-step meetings, working with a sponsor, and EMDR therapy that targeted past sexual abuse. Once old traumas were processed, the client was treated with EMDR that targeted current life situations that were triggering shame and urges to act out sexually. Other techniques (letter writing, empty-chair technique, relapse prevention skills) were used to enhance his ongoing recovery. Treatment was successful in helping to resolve the distress associated with his history of sexual abuse and preventing relapse.

Marich (2009) reported on the use of EMDR in treating a cross-addicted female client with a history of sexual assault, who met criteria for alcohol dependence, cannabis dependence, sedative dependence, and PTSD. When this client came for treatment, she had just received her third Operating a Vehicle Intoxicated (OVI) conviction. She had several previous attempts at sobriety, the longest being 4 months, and had tried both inpatient and outpatient treatment over a 12-year period. After the client achieved sobriety, the author used the EMDR standard protocol to target shame-based experiences that were interfering with her recovery. The client was guided in the use of the future template (the third prong of the three-pronged protocol) to enhance PCs in order to reinforce these beliefs to solidify her recovery process. At 18th-month follow-up, the client had maintained sobriety.

Abel and O’Brien (2010) reported on the use of EMDR to treat a female client who presented with PTSD and alcohol dependence. This client could not maintain sobriety without processing an important traumatic event. The standard EMDR protocol was used to help the client to deal with the aftereffects of her husband’s suicide. Once this event was processed, the client was able to achieve solid sobriety in a way that she had not previously been able to do. These authors argued that certain clients need to process their underlying traumas in order to achieve and maintain a sober life.

Marich (2010) reported on the potential role of EMDR therapy in continuing care for women in recovery from addiction. Ten women were interviewed
about their experiences with addiction and their recovery process. All of the participants described how EMDR therapy contributed to their successful recovery to varying degrees. The author highlighted the critical role that the therapeutic relationship played in successful EMDR treatment.

O’Brien and Abel (2011) presented an outline for intervening with clients who present with addictions. These authors integrated the Transtheoretical Model (Prochaska & DiClemente, 1982, 1992) with EMDR-based interventions used to intervene with clients who present with varying levels of motivation to change behavior. The decisions about if and when to use the standard EMDR protocol to process trauma in clients with addictions and the factors to consider in making this determination were discussed.

Bae and Kim (2012) reported on treatment of Internet addiction utilizing the DeTUR Protocol. A 13-year-old male with Internet addiction and comorbid depression was treated with four sessions using the Popky protocol. Seven triggers of Internet use were targeted. At the end of treatment, the client reduced his Internet use to 1 hour per day and clinical depression was reduced to a subclinical level. These gains were maintained at 6- and 12-month follow-up.

SUMMARY

In this chapter, the authors explored the historical foundations of EMDR therapy harkening back to its beginnings in 1987. EMDR was defined and the AIP model was described. The eight phases of EMDR were discussed in detail. The protocols that the authors have chosen to use to treat addictions and trauma were each described. Finally, we have summarized the current research on EMDR in general as well as the developing literature on EMDR treatment of addiction.

LEARNING POINTS

1. EMDR is a treatment developed to treat PTSD and can be easily integrated into a wide array of theoretical approaches to psychotherapy.
2. There are eight phases that encompass EMDR treatment. In order for this treatment to be successful, clinicians need to follow the standard guidelines of treatment, including the targeting of present and future triggers of traumatic events.
3. A number of protocols may be of use in the treatment of clients with PTSD and addiction. Protocol selection will vary based on client needs and preferences.
4. Extant research has demonstrated that EMDR is an efficacious treatment for PTSD. Research is still developing to substantiate the use of EMDR therapy with addiction and a wide variety of psychiatric diagnoses. The available research on EMDR and addictions treatment was described.
5. The protocols currently being used by the authors to treat addictions were described in detail: Popky/DeTUR, Hase/CRAVEN, RDI, Affect Tolerance, Safe/Calm Place, and Robin Shapiro’s Two-Handed Interweave.