Chapter 5
EMDR Therapy and the Treatment of Substance Abuse and Addiction

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Introduction

Most experts today agree, as do the authors of this chapter, that substance abuse arises from complex interactions between genetics, environment, and experience. "Substance dependence is not a failure of will or of strength of character, but a medical disorder that could affect any human being. Dependence is a chronic and relapsing disorder, often co-occurring with other physical and mental conditions" (World Health Organization 2004).

The question remains, however, "Why has it been that over the course of human history, where people and cultures have had access to alcohol and potent mind-altering substances, that only some become addicted while the rest are able to regulate their use?"

We are closer to answering this question based upon current research that has demonstrated a clear relationship between early adverse life experiences and later addiction—please see Felitti et al. (1998), Felitti (2004) and Shapiro (2005).

Further, the drugs that individuals select are not chosen randomly, but result from an interaction between the psychopharmacologic action of the drug and the dominant painful feelings with which they struggle. Edward Khantzian, M.D., professor of Clinical Psychiatry at the Harvard University, observed that opiates are often preferred because of their powerful numbing action on the affects of rage and

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aggression. Cocaine has its appeal because of its ability to relieve distress associated with depression. Although ill fated, "addicts discover that the short-term effects of their drugs of choice help them cope with distressful subjective states and an external reality otherwise experienced as unmanageable or overwhelming" (Khantzian 1985, p. 1263). Thus emerges a compelling hypothesis, which proposes that people use psychoactive substances in an attempt to control painful symptoms resulting from psychological trauma. This is referred to as "self-medication" (Ibid.).

Some studies in the USA show that more than 50 percent of people with mental disorders also suffer from substance dependence compared to 6 percent of the general population (World Health Organization 2004). It is from our interest in providing integrated treatment for the complex interaction of genes, environment, trauma, and psychological pain as a driving force behind co-existing disorders, that this chapter is written.

Co-occurring Mental Health and Substance Abuse

> "*No one ever died from their feelings, but millions of people have died from taking drugs, alcohol, and other toxic substances to help them avoid their feelings…*" Weinhold & Weinhold

The co-existing problems of Mental Health (MH) and Substance Abuse (SA) disorders ignore age, gender, intellect, marital status, economic, social class, race, and nationality, leaving no one immune from their impact. The prevalence of co-occurring psychiatric and substance use disorders and the dearth of effective treatment interventions leaves individuals in a state of suffering, accompanied by impressive personal, familial, social, and economic consequences.

The correlation between trauma and other adverse experiences, especially when first experienced in childhood, and co-occurring mental health and substance abuse, is strongly established in the literature (Felitti et al. 1998; Kessler et al. 1995; Najavits et al. 1999; National Child Traumatic Stress Network (NCSTN) 2008; Ouimette and Brown 2003). A strict definition of *co-occurring disorders* (COD) states that one or more psychiatric or medical conditions co-exist with one or more addictive disorders. CODs do not simply have overlapping symptoms, but are distinct, and can be independently diagnosed from one another (American Psychiatric Association 2013).

Examples of diagnoses frequently co-occurring with addictive disorders include posttraumatic stress disorder (PTSD) and other anxiety disorders, bipolar disorder, borderline personality disorder (BPD), attention deficit disorder (ADD/ADHD), and major depression. The many possible permutations of addictions and co-existing psychiatric conditions often lead to a complicated clinical picture that is challenging to untangle and treat effectively, particularly when the contributing role of trauma is overlooked.

Co-occurring disorders are also associated with

- Poorer motivation, retention, and treatment outcomes compared to individuals with a single psychiatric disorder
- Faster relapse and greater amounts of substances used
- Less social support
- Under-employment
- Failure at work or school
- Poorer overall health conditions
- Impaired family relations
- Abuse and violence
- Legal difficulties

(Brady et al. 1994; Brown et al. 1996; Felitti et al. 1998; Najavits et al. 1999).

Historically, these areas of mental health have separate treatment, education, training, and funding avenues, creating significant barriers to receiving integrated treatment services. Currently, the development and implementation of effective, integrated treatment services is a public health challenge worldwide.

The purpose of this chapter is to

- Illustrate the relationships between trauma and other adverse life experiences, mental disorders, and the development of substance abuse and behavioral, or process, addictions (Felitti et al. 1998).
- Describe the connections between substance and behavioral addictions (Grant et al. 2006).
- Describe the Adaptive Information Processing (AIP) model as the theoretical framework for case conceptualization in EMDR therapy (Shapiro 1995, 2001, 2007; Solomon and Shapiro 2008).
- Provide a basic understanding of the principles, protocols, and procedures that define EMDR therapy (Shapiro 1995, 2001).
- Illustrate when and how to use EMDR therapy as an integrated treatment approach for co-occurring mental health and addiction disorders.

The Relationship Between Trauma, Mental Health, and Substance Abuse

> "*Nothing is predestined: The obstacles of your past can become the gateways that lead to new beginnings.*" Ralph Blum

Trauma is often the crucible from which psychiatric symptoms and addictions emerge. With trauma, *the past is present.* The Adverse Childhood Experiences (ACE) Study provides retrospective and prospective analysis of over 17,000 individuals, primarily middle-class Americans from Kaiser Permanente's Department of Preventive Medicine in San Diego, California (Felitti et al. 1998). The study examined the effect of traumatic

life experiences during the first 18 years on later well-being, social function, health risks, disease burden, healthcare costs, and life expectancy.

The ten reference categories experienced during childhood are listed in Table 5.1 below, with their prevalence in parentheses.

Scoring the ACE survey is simple: Exposure to any one category above is scored as one point. Thus, an individual reporting sexual molest by one person would score the same as someone who experienced multiple sexual assaults by several individuals. As a result, these findings tend to be under, rather than over, stated. Nevertheless, the study revealed several surprising outcomes regarding the significance of early trauma and other adverse childhood experiences and the development of later substance addiction or troubling behavioral patterns. The study found "strong, proportionate relationships between the number of categories of adverse childhood experiences (ACE score) and the use of various psychoactive materials or behaviors including alcoholism and intravenous drug abuse" (op. cit.). The relationship is evident in the exponential increase in likelihood of a person having a maladaptive response to his ACEs. For example, any person with 4 or more childhood ACEs experienced a 500 % increase in potential that they will become alcoholic, while males with ACE scores of 6 or more showed a step-wise probability increase of 4600 % of becoming an intravenous drug user (Felitti 2004).

Not surprisingly, childhood trauma and neglect disrupts and can dysregulate the brain's information processing systems (Perry 1999; Schore 2002; Siegel 1999;

Table 5.1 Adverse Childhood Experiences Study (adapted from op. cit.)

	Category	Behavior	Prevalence (%)
Abuse			
1.	Emotional	Recurrent humiliation	11
2.	Physical	Beating, not spanking	28
3.	Sexual abuse	Contact sexual abuse	
	Women		28
	Men		16
	Overall		22
Household dysfunction			
4.	Mother	Treated violently	13
5.	Household member	Alcoholic or drug user	27
6.	Household member	Imprisoned	6
7.	Household member	Chronically depressed, suicidal mentally ill, in psychiatric hospital	17
8.	Household member	Not raised by both biological parents	23
Neglect			
9.	Physical	Lack of proper food, clothing, shelter	10
10.	Emotional	Isolation, lack of interaction	15

Van der Kolk et al. 1996). Lesser-known risk factors in the development of a child's brain and quest for mastery over emotional regulation are the significant roles played by the quality of parental attunement and attention (Siegel 1999). Those who are unable to manage emotional responses to everyday stressors are compelled to seek ways to control or numb their affect (Khantzian 1985).

Addictions and other compulsive behaviors temporarily change the experience of painful emotions and body sensations, thereby providing a transitory sense of relief. Often referred to as self-medication, this may be seen by the user as effectively managing distress, thereby promoting a vicious cycle of addictive coping strategies (Brown et al. 1996; Grant et al. 2006; Ouimette and Brown 2003; Volkow 2007). One study (Hien et al. 2010) found that reductions in the severity of PTSD symptoms were likely to be associated with reduced substance use in those with severe symptomotology. Results support the self-medication model and provide empirical support for integrated interventions for PTSD and substance abuse. An illustration of how this works is shown in Fig. 5.1.

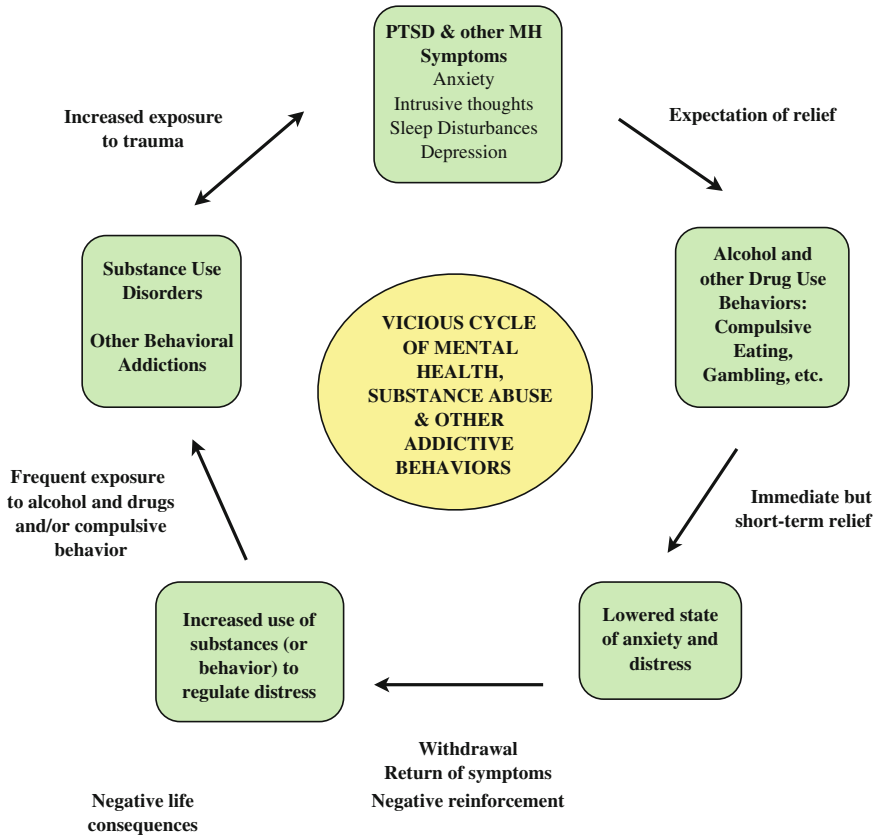

Fig. 5.1 Vicious cycle of mental health, substance abuse, and other compulsive behaviors for emotional regulation. Illustration Copyright 2009 Brown, S. (Adapted from Steward & Conrad, 2002)

The Link Between Substance and Behavioral Addictions

> "*Drunkenness–that fierce rage for the slow, sure poison, that oversteps every other consideration; that casts aside wife, children, friends, happiness, and station; and hurries its victims madly on to degradation and death.*" Charles Dickens

Research suggests a strong neurobiological link between chemical and behavioral, or process, addictions. Perhaps that is because the neurochemistry associated with "reward" or "pleasure pathways" (Grant et al. 2006; Pallanti 2006; Volkow 2007) in the brain lead to the same loss of control and negative consequences, whether it is a drug or a behavior to which the person becomes addicted. Therefore, it is not the substance itself that is addictive, but rather, the individual's response to it. Not all people who use substances become addicted, nor to common behaviors such as gambling, yet they can both lead to similar patterns of misuse.

Research over the past decade has stressed the substantial co-morbidity of impulse control disorders with mood disorders, anxiety disorders, eating disorders, substance disorders, personality disorders, and with other specific impulse control disorders (Hucker 2004). Addictions and compulsions, despite the planning aspects involved, are also associated with a lack of impulse control and often follow similar symptomatic cycles (Grant et al. 2006) as shown in Table 5.2

Table 5.2 Addictions, compulsions, and the similarities between them

Addictions and compulsions	Symptoms and cycles
Alcohol and other substance abuses	Preoccupation (obsession), anticipation (craving), mood modification (regulation), continued use despite adverse consequences, relapse, and potentially life-threatening medical complications
Gambling	Preoccupation, anticipation, mood modification, continued use despite adverse consequences, and relapse
Shopping	Preoccupation, anticipation, mood modification, continued use despite adverse consequences, and relapse
Sex	Preoccupation, anticipation, mood modification, continued use despite adverse consequences, and relapse
Pornography	Preoccupation, anticipation, mood modification, continued use despite adverse consequences, and relapse
Binge-eating and food restriction	Preoccupation, anticipation, mood modification, continued use despite adverse consequences, relapse, and potentially life-threatening medical complications
Compulsive exercising	Preoccupation, anticipation, mood modification, continued use despite adverse consequences, relapse, and potential medical complications
Cutting, Skin picking and hair pulling	Preoccupation, anticipation, mood modification, continued use despite adverse consequences, relapse, and potential serious medical complications

The EMDR Therapy Approach—Treatment of PTSD and Trauma

EMDR therapy is a comprehensive, integrative, A-rated and empirically validated treatment for PTSD (American Psychiatric Association 2004; Department of Veterans Affairs & Department of Defense 2004; National Institute for Clinical Excellence 2005). Twenty-three clinical trials in peer-reviewed journals attest to EMDR's efficacy with PTSD and trauma (see Shapiro, 2014 for a review).

The recent World Health Organization (WHO) practice guidelines (2013) state that EMDR therapy and trauma-focused cognitive behavioral therapy are the only psychotherapies recommended for children, adolescents, and adults with PTSD. As noted in the WHO (2013) practice guidelines, "[EMDR therapy] is based on the idea that negative thoughts, feelings and behaviors are the result of unprocessed memories. The treatment involves standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions and bodily sensations and (b) bilateral stimulation that is most commonly administered in the form of repeated eye movements. Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event. Unlike CBT with a trauma focus, EMDR therapy does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework" (p.1).

EMDR therapy has been found equivalent to prolonged exposure (PE) therapy (Foa et al. 2007) and other cognitive behavioral therapies (CBT) in reducing PTSD symptoms (e.g., Bisson and Andrew 2007). However, EMDR therapy has also been found to be more efficient and more widely tolerated (has a lesser drop-out rate) without the client's need for 1-2 hours of daily homework as in prolonged exposure (e.g., de Roos and De Jongh 2008; Ironson et al. 2002; Jaberghaderi et al. 2004; Lee et al. 2002; Power et al. 2002).

As is true for all psychotherapies, the mechanism of action responsible for EMDR therapy's effectiveness is still unknown. A recent meta-analysis by Lee and Cuijpers (2013) examined 26 randomized controlled trials (RCTs) comparing the eye movement component of EMDR therapy to an exposure condition while participants concentrated on a disturbing memory. Pre/post-differences for both conditions demonstrated significant declines in standardized outcome measures, negative emotions, and imagery vividness. Additional studies have examined the effect of the eye movements in EMDR therapy and found that eye movements enhance retrieval of episodic memories and increase recognition of true information (Christman et al. 2003; Ricci 2006). One hypothesis regarding the development of PTSD is the failure to process episodic memory, thereby leaving upsetting memories "stuck" in the past instead of being integrated into semantic networks (Bergmann 2000, 2008; Stickgold 2002). For a more complete review of the

hypothesized mechanisms of action involved in EMDR therapy, see Solomon and Shapiro (2008).

The EMDR model of psychotherapy includes an 8-phase structured protocol that integrates elements of psychodynamic, cognitive behavioral, experiential, interpersonal, and body-oriented therapies (Shapiro 2001). EMDR therapy's theoretical orientation is based on the Adaptive Information Processing model described below (op. cit.).

Theoretical Basis of EMDR Therapy: The Adaptive Information Processing Model (AIP; Shapiro 2001)

> "*A long habit of not thinking a thing wrong, gives it a superficial appearance of being right.*" Thomas Paine

The Adaptive Information Processing (AIP) model explains clinical phenomena, predicts successful treatment effects, and guides the overall practice of EMDR therapy across its wide range of therapeutic applications (Shapiro 2001). It asserts that the brain possesses an intrinsic ability to process information in the moment, interpreting and integrating current perceptions within the existing memory networks. The brain also processes distressing memories to an adaptive resolution. However, high levels of disturbance can interfere with the brain's natural information processing capabilities not only in the moment but also later when cues or triggers reactivate the disturbance.

According to the AIP, symptoms are a result of dysfunctional, physiologically stored, unprocessed memories. Some, or all, parts of the memory (imagery, emotions, body sensations, thoughts, beliefs, attitudes, and perceptions) remain fragmented in present time, distorted, and unassimilated into the more adaptive memory networks. These distortions can negatively influence an individual's thoughts, feelings, and behaviors until reprocessed and integrated into a more adaptive state.

Current situations can trigger these memories causing the individual to experience the disturbing stored affects and perspectives. This in turn influences their perceptions of the present. Externally, a trigger can be a sight, sound, smell, person, or event. Internally, a trigger can be an emotion, body sensation, mood, or dream. The purpose of EMDR therapy is to *access* the traumatic material, *activate* the information processing system, and allow the brain to *move* the dysfunctionally stored material into a more adaptive, present-oriented state.

EMDR therapy distinguishes between "Big-T" and "small-t" traumas. When diagnosing PTSD, Big-T traumas are those designated as Criterion A events (American Psychiatric Association 2013). Examples that might cause intense fear, helplessness, or horror include: experiencing, witnessing, or hearing about

something that is an immediate threat to one's own or a loved one's life or safety. Physical and emotional abuse, or sexual assault or abuse, domestic violence, vehicular accident, combat, terrorism, and natural disasters are commonly identified Big-T events. However, a person can also be severely affected by more ubiquitous, adverse life experiences (small-t life events) such as attachment or attunement problems with parents, and/or siblings, bullying in school, peer problems, the death of a pet, parent's divorce, or the breakup of a romance. In EMDR therapy, unprocessed memories of trauma and other adverse life experiences are viewed as foundational to a wide range of pathology.

In support of this concept, 832 surveyed people (Mol et al. 2005) reported that their PTSD symptoms were more related to common distressing life events than to Criterion A events. The conclusion of the researchers was that the more everyday disturbing life events can generate at least as many PTSD symptoms as events designated as "traumatic" according to Criterion A (op. cit.). In EMDR therapy, these adverse experiences may be referred to as small-t traumas not because they are less traumatic, but because they are so common in our experience that they are frequently overlooked as a cause of later problems (Shapiro 1995, 2001, 2007b). Small-t traumas include some of the adverse childhood experiences previously described by Felitti et al. (1998). EMDR therapy entails identifying, accessing, and reprocessing Big-T and small-t memories that are identified as the foundation of the dysfunction.

Mental Health and Substance Abuse Through the Lens of the AIP

Case Conceptualization

Most of the current randomized controlled research on EMDR therapy focuses on the treatment of PTSD (Lee et al. 2002). However, a growing body of case studies using EMDR therapy for other mental disorders and addictions reveals a history of trauma and other adverse life experiences as contributing factors.

Examples of diagnoses and disorders other than PTSD that were treated with EMDR therapy include:

- Body dysmorphic disorder (Brown et al. 1997)
- Borderline personality disorder (Brown and Shapiro 2006)
- Choking phobia (de Roos and de Jongh 2008; Schurmans 2007)
- Deliberate self-harm (McLaughlin et al. 2008)
- Domestic violence perpetration and victimization (Stowasser 2007)
- Eating disorders (Beer 2005; Bloomgarden and Calogero 2008)

- Obsessive compulsive disorder (Whisman 1997; Whisman and Keller 1999)
- Phobias (de Jongh 2003; de Jongh and ten Broeke 2007)
- Panic disorder (Fernandez and Faretta 2007; Feske and Goldstein 1997; Whisman 1997)
- Pathological gambling (Henry 1996)
- Phantom limb pain (Russell 2008; Schneider et al. 2007; Tinker and Wilson 2005; Wilensky 2006)
- Sex offender treatment (Ricci 2006; Ricci et al. 2006).
- Social phobia (Sun and Chiu 2006)
- Substance use disorder (Brown et al. 2015; Hase et al. 2008; Marich 2009, 2010; Popky 2005; Shapiro et al. 1994; Vogelmann-Sinn et al. 1998; Zweben and Yeary 2006)

Controlled research is needed in all these areas to further determine the efficacy of EMDR therapy with these diagnoses that are implicated as causal or related to substance abuse and compulsive behaviors. However, based on this emerging literature, it does not seem to be a question of whether to consider using EMDR therapy to treat complex disorders with a basis in trauma and other adverse life experiences, but rather when, how, and with whom.

Eye Movement Desensitization and Reprocessing (EMDR): Principles, Protocols, and Procedures

"*Man is made by his belief. As he believes, so he is*." Goethe

EMDR therapy is taught worldwide to licensed clinicians through, for example, Eye Movement Desensitization and Reprocessing International Association (EMDRIA), EMDR Ibero-America, and EMDR-Europe approved Basic Training providers. These trainings tend to be a minimum of 6 full days of instruction and practicum with an additional 10 hours of consultation.

EMDR therapy uses a 3-prong approach within an 8-phase model to sequentially target:

(1) *past* experiential contributors that laid the groundwork for the current symptoms;
(2) *present* triggers that activate current cognitive, affective, and/or somatic symptoms; and
(3) *future* desired states and behaviors. (see Table 5.3).

Following the principles of the AIP, EMDR therapy is a treatment that recognizes that false negative beliefs or Negative Cognitions (NCs) about oneself result from dysfunctionally stored, unprocessed memories and the attendant emotions,

Table 5.3 Overview of EMDR therapy phases (Shapiro 2005)

Phase	Purpose	Procedures
1. Client history	Collect background information Assess suitability for EMDR Identify-specific treatment targets from history	Standard history taking keeping the AIP in mind Review EMDR inclusions/exclusions/client resources Elicit: (1) past events related to symptoms, (2) present-day triggers, and (3) future desired outcomes
2. Preparation	Prepare clients for EMDR processing Stabilize and increase access to positive affects	Educate about symptom development Teach stabilization techniques such as a "safe/calm place"
3. Assessment	Activate the chosen targets for reprocessing	Elicit the following: Distressing image Negative belief currently held (assess SUD 0–10) Desired positive belief (assess VOC 1–7) Current emotions Current physical sensations
4. Desensitization	Process past experiences and current triggers to an adaptive resolution (SUD of 0) Fully desensitize all channels Incorporate positive future templates	Process past, present, future Standardized EMDR protocols, including sets of bilateral stimulation, allow for spontaneous emergence of insights, emotions, sensations, and other memories If processing becomes blocked, use Cognitive Interweave to activate more adaptive information "Stay out of the way" of client's natural processing
5. Installation	Increase connections to positive cognitive networks Increase generalization effects within associated memories	Have client identify the best positive cognition (initial or emergent) Continue processing until positive cognition is a 7 on the VOC scale
6. Body scan	Complete processing of any residual distress associated with target	Concentration on physical sensations and processing any residual distress
7. Closure	Ensure client stability at the end of an EMDR session whether completely reprocessed or not	Use relaxation or guided imagery to leave client in comfortable state to leave office Ask client to monitor what happens between sessions
8. Reassessment	Evaluation of treatment effects to ensure comprehensive reprocessing	Explore what has emerged since last session by re-accessing the previous target Evaluate integration after all targets processed

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body sensations, and behavioral patterns they can generate. NCs are clustered under the headings of Responsibility, Safety, and Choices. These negative beliefs are not the cause of the dysfunction; they are a symptom of the unprocessed memories at the root of pathology. Rather than directly challenging the beliefs, as in cognitive behavioral therapy (CBT) for example, EMDR therapy identifies these core, irrational, negative beliefs along with the memories that give rise to them. The desired Positive Cognitions (PCs) that the client would prefer to believe and feel are true are also identified and are measured at a "gut level" by the Validity of Cognition (VOC) scale. For genuine change to occur, the memories generating for example, the incorrect belief, "I am not good enough" must be fully reprocessed at cognitive, affective, and somatic levels such that the correct belief, "I am fine the way I am" or "I am good enough" is integrated into the nervous system until experienced as true at a "felt-sense" level.

The Use of Bilateral Stimulation in EMDR Therapy

EMDR therapy's Standard Protocol incorporates alternating bilateral stimulation (BLS) of the senses using preferably eye movements, or tactile taps or audio tones. BLS is used during the preparation Phase 2 to install and/or strengthen and enhance any needed client resources and positive affective states, such as in the Safe/Calm Place exercise. Short and slow sets of BLS are used to strengthen and enhance positive resources, rather than access and activate potentially associated negative material, which may occur naturally when faster and longer sets BLS are conducted.

EMDR therapy is organized around the principles of a client-centered model, meaning the client's internal pathways for healing override the interpretations and directives of the therapist. In EMDR therapy, clinicians do not assume they know the precise way the client needs to heal because the client's memories are linked in ways that are not always evident to the clinician or the client. Within the desensitization and reprocessing Phases 4–6, the clinician utilizes standardized protocols that encourage and support the client's internal associations regarding their targeted memories.

During desensitization and reprocessing (phases 4–6), longer and faster sets of BLS are used to access, activate, desensitize, and reprocess the distressing elements of the target. This type of purposeful activating, accessing, and moving of material liberates a person's previously painful or disturbing reactions and behaviors. Reprocessing continues until the material is integrated and a coherent narrative emerges in present time. This resolution allows the person's own intrinsic drives toward mental, physical, and spiritual health to emerge and take the place of addictive patterns.

The Treatment of Co-occurring Disorders with EMDR Therapy

The concept of a tri-stage model for treating complex trauma was first introduced by Pierre Janet in 1907 and then again by Judith Herman in 1992. The tasks of this type of model are (1) safety and stabilization; (2) trauma processing and mourning; and (3) reconnection and reintegration (Herman 1992; Janet 1907). Relapse prevention for addiction is an essential part of Janet's and Herman's 3rd stage, and EMDR therapy's 2nd and 6th phases, primarily. Please note that with complex treatment populations, neither the phases of EMDR therapy's 8-phase Standard Protocol nor the stages of the 3-stage complex trauma model are rigid or discrete, but continually intertwine and overlap as needed throughout treatment.

EMDR therapy is highly effective and efficient. However, it is also emotionally evocative in the initial phases and potentially poses an additional, though temporary, risk of relapse with addiction. Therefore, initial and concurrent attention to safety, support, and resources is paramount. Clients and family members need thorough education about the relationship between trauma and addiction. The therapist explains that EMDR therapy conceptualizes cravings and the use of substances or other behaviors as symptoms resulting from unresolved trauma. Nightmares, flashbacks, and hyper-arousal, for example, can trigger the desire to medicate with drugs and/or alcohol (National Child Traumatic Stress Network (NCSTN) 2008; Steward and Conrod 2003). It is proposed that once EMDR therapy reprocesses disturbing traumatic memories they will no longer hold any physical, emotional, or cognitive distress, and there will be less interest in and need for self-medication, thereby ultimately reducing the risk of relapse. Not all psychiatric disorders are life threatening, but because substance use and abuse can be, it is recommended that EMDR therapy is conceptualized and administered as a tri-stage model within its established 8-phase Standard Protocol.

Tasks of a Phased, Integrated Model of EMDR Therapy

STAGE ONE (Phases 1 and 2 in EMDR Therapy)

History, assessment, motivation, safety, and stabilization

- Safety and stabilization skills (Najavits 2002; Shapiro 2001)
- Motivation (Miller and Rollnick 1991; Prochaska and DiClemente 1983)
- History gathering and diagnostic assessment

Phase 1 of EMDR Therapy: History

Client history is gathered with the AIP in mind, using the designated 3-prong approach to identify (i) the past experiences causing the dysfunction, (ii) the current situations triggering disturbance, and (iii) skills needed for adaptive future functioning. It is just as important to identify, strengthen, and enhance internal and external resources to which the client has access, as it is to uncover adverse experiences. This ensures that the client will be prepared for the reprocessing phases of memory work. Reprocessing is defined as unlinking maladaptive connections and forging positive neurophysiological connections between the targeted memory and more adaptive networks. If the client does not have access to positive memory networks, there may be little to connect their dysfunctionally stored material to and reprocessing would not be expected to go smoothly or speedily (Shapiro 2001).

Clinicians are cautioned to gather history slowly when presented with lifelong, complex trauma cases in order to minimize the potential triggering of highly charged emotional material. Gradual, paced history taking is preferred, as "too much too soon" can increase the risk of relapse. The following guidelines are recommended:

- Assess for and provide any needed self-control or affect management techniques
- Gather the client's bio/psycho/social history including mental status, strengths, chronological trauma history, PTSD, anxiety, and depressive symptoms
- Assess for the presence of co-occurring disorders
- Initially screen for dissociative disorders using the Dissociative Experiences Scale (DES; Bernstein and Putnam 1986) and if indicated, seek a more formal diagnostic assessment for dissociation such as the Structured Clinical Interview for Dissociative Disorders (SCID-D; Steinberg et al. 1990). It is important to note that the presence of a dissociative disorder is contraindicated for treatment using EMDR therapy without both the specialized expertise of the clinician and readiness of the client (Forgash and Copeley 2008; Shapiro 2001)
- Elicit a detailed history of substance use/abuse/dependency/addiction and behavioral compulsion
  - Note all substances used and pattern of use, e.g., binge, regular use, increasing amounts, and maintenance
  - First use: "What was happening at the time client first started using?"
  - Assess current triggers and urges to use substances or other addictive behaviors
  - Assess relapse patterns
- Evaluate past treatment attempts and outcomes
- Assess level of readiness for treatment: precontemplation, contemplation, preparation, and action (Miller and Rollnick 1991; Prochaska and DiClemente 1983)

- Educate the family about the nature of addiction as a brain disorder and untreated trauma's contributing role—this is considered a key to successful treatment
- Assess level of support from family, friends, and co-workers—each family member's role in either supporting or undermining the treatment process should be assessed, addressed, and treated, whenever possible (Shapiro 2007)

Case Example: PTSD, Bipolar Disorder, Marijuana and Alcohol Abuse, and Compulsive Use of Pornography

Sheila referred her 33-year-old husband John (not their real names) for EMDR therapy because she had become fearful about his "rapidly deteriorating emotional state." She reported that during the last 6 months he had become increasingly more depressed, anxious, withdrawn, physically and emotionally abusive, and expressed occasional suicidal ideation and intent. His marriage was at risk of failure.

John reported that 1 year ago he had attended a family gathering where he unexpectedly saw an older cousin who had molested him between the ages of 11 and 13. He had not seen that cousin in 10 years and thought he had "already dealt with the molestation." He was upset to find he was still powerless over his reactions. His parents dismissed his distress by asking him why something from "such a long time ago" would bother him now. Admittedly attempting to "deal with" the symptoms listed below, John self-medicated with alcohol and marijuana and pornography on and off since the sexual offenses made against him during his early adolescence. These behaviors and moods again escalated after encountering his cousin and were now threatening his job and marriage.

John's History

Presenting Symptoms

- *Sleep disturbances*
- *Severe marital discord with emotional and physical rage outbursts*
- *Mood swings*
- *Self-injurious impulses*
- *Compulsive use of pornography*
- *Marijuana and alcohol abuse*

Past: To be reprocessed during initial stage of the 3-prong protocol

- *Family history of alcoholism, depression, and suicide.*
- *Extreme parental mis-attunement and emotional neglect, e.g. John's isolated, unsafe conditions at home frightened and overwhelmed him. When he tried to communicate his fear to his parents, they minimized him and told him "how easy he had it compared to them".*

Table 5.4 John's negative and positive cognitions and cluster types

Negative cognitions (NC)	Positive cognitions (PC)	Cluster types
"I am permanently damaged"	"I am fine as I am"	Responsibility
"There's something really wrong with me"	"I am fine as I am"	Responsibility
"I'm not safe"	"I can keep myself safe now"	Safety
"I can't trust"	"I can learn to trust"	Safety
"I am powerless"	"I have choices now"	Choices
"I can't stand it"	"I can handle it"	Choices

- *This ongoing invalidation was later revealed as the earliest contributor for the present-day over-reactivity to wife's communications with him.*
- *Extended periods of isolation and loneliness.*
- *Sexual assault from age 11 to 13 by his 18-year-old male cousin.*

John reported that his preoccupation with pornography and substance abuse emerged in his early teens, shortly after the molestation began. This is the most commonly reported temporal relationship between trauma and substance abuse (Steward and Conrod 2003).

Early relational mis-attunement, poor attachment, parental neglect, and extended periods of isolation would be expected to decrease John's developing ability to manage affect in childhood and into adulthood (Perry 1999; Schore 2002; Siegel 1999; Van der Kolk et al. 1996). The Adaptive Information Processing (AIP) model would see John's symptoms as being an expression of his genetic, environmental, and experiential factors that fostered the later development of his mood disorders and substance abuse (Felitti et al. 1998; Shapiro 1995, 2001).

The negative, irrational beliefs or Negative Cognitions (NCs) that often emerge from a history such as John's are a focus of treatment in EMDR therapy. Both the SUD level and the VOC rating are re-assessed and re-measured after the reprocessing and installation phases 4–6 of EMDR therapy. A decrease in the SUD rating to "0" or ecological validity associated with the memory, along with an increased, felt-sense rating of the VOC to a 7, indicates a positive treatment effect as a result of reprocessing traumatic material in EMDR therapy.

John's negative belief clusters related to the sexual assault are listed below. Each belief was targeted through the complete 3-prong approach of past contributors, present triggers, and desired future states and behaviors (Table 5.4).

Present triggers: To be processed during the second phase of the 3-prong protocol

1. *Feeling "criticized"*
2. *Feeling "misunderstood" and "not able to be heard"*
3. *Feeling "unimportant" to his wife*

Phase 2 of EMDR Therapy: Preparation

Safety, stabilization, and resource development

Readiness for EMDR therapy reprocessing (Phases 4–6) includes:

- The ability to access and use safe coping skills (Najavits 2002; Shapiro 1995, 2001) to soothe high levels of distress
- The ability to have a dual awareness of the past traumatic material while still maintaining present-moment orientation
- The willingness to engage available resources such as a 12-step program, sober living, family, and/or other personal support systems—this is crucial when clients are still using substances
- Sobriety of at least 30 days or until symptoms of withdrawal are minimized, whenever possible—this recommendation has exceptions, see the section "Early Trauma and Other Adverse Life Experiences Treatment in Addictions: Guidelines and Exceptions" later in this chapter

Safety and stabilization with any population comes first in treatment, but because of the potentially evocative nature of EMDR therapy, and the risk for relapse with co-occurring disorders, the timing of the reprocessing (phases 4–6) is carefully assessed. When EMDR therapy is used to treat single incident traumas, such as a motor vehicle accident, dog-bite, or a one-time assault, reprocessing with EMDR therapy can be an exceedingly brief, effective intervention consisting of 1–3 (90-min) sessions (Marcus et al. 1997; Rothbaum 1997; Shapiro 2001). There are also clients who have strong personal strengths and resources who may not need a lengthy preparation phase. Sobriety and self-soothing are often enough to move forward into trauma processing when clients have less complex histories.

For clients with complex trauma histories

For those who have confounding variables of long-term, complex childhood trauma, and exhibit a more severe and chronic course of symptoms, extensive preparation is *strongly recommended* to promote the safest trauma reprocessing experience. Here, reprocessing with EMDR therapy may have both a longer preparation phase and longer reprocessing phases.

Additional resource development is needed when clients are missing resources that may interfere with their ability to tolerate reprocessing. Resource Development and Installation (RDI; Korn and Leeds 2002), for example, which accesses and incorporates a variety of positive affective and somatic states, can accomplish this. Other grounding and self-soothing exercises may include visualizations in which people are able to imagine themselves behaving in a more positive, adaptive way. This manner of preparation for trauma treatment is a variation of the 3rd-prong, or Future Template, of EMDR therapy.

More structured interventions may be integrated with EMDR therapy in environments where group work or more intensive individualized preparatory experience is needed prior to individual trauma processing, for example: Seeking Safety

(Najavits 2002), Motivational Interviewing (M.I.; Miller and Rollnick 1991), Desensitization of Triggers and Urge Reprocessing (DeTUR; Popky 1998), and Dialectical Behavior Therapy (DBT; Linehan 1993).

John's Preparation

Personal strengths and resources

- *Creative and artistic*
- *Intelligent*
- *Sensitive and warm*
- *Long-term friendships from high school*
- *Supportive wife*

Resources needed

- *Ability to self-soothe (Safe Place)*
- *Willingness to commit to sobriety*

When John initially sought treatment, he was not sober and had suicidal thoughts. Substance abuse can confound assessments and trigger or prolong symptoms; therefore, a psychiatrist conducted a medical evaluation and concluded, in collaboration with the treating therapist, that John required medically managed stabilization prior to initiating any trauma processing with EMDR therapy. John agreed to take medication and enter into a course of sobriety to allow the clinical picture to clear. He was able to remain clean for 30 days and the co-occurring Bipolar, PTSD, and Substance Use Disorders were confirmed.

John was now able to demonstrate, along with other self-soothing techniques, his use of the Safe/Calm Place exercise and an ability to shift from a state of high distress to a state of calm. This, along with his sobriety and medical stabilization, allowed the client and clinician to move forward and reprocess his first EMDR therapy target.

STAGE TWO (Phases 3–6 in EMDR Therapy)

Phases 3–6 in EMDR Therapy (assessment, desensitization, installation, body scan) use the 3 prongs of past, present, and future

- Assess, desensitize, and reprocess all *past* adverse life experiences and *present* symptoms and triggers until they no longer cause cognitive, affective, or somatic distress
- Teach necessary skills and imaginally rehearse future reactions and behaviors with BLS in order to develop *future* templates for more adaptive choices

Phase 3 of EMDR Therapy: Assessment

John collaborated in his treatment planning, and with the clinical agreement of his therapist, chose the first of the sexual assaults against him as his first target for memory reprocessing.

Setting up and activating the target

- Identify the most disturbing image associated with the event:
  The first time he was held captive in a closet and sexually assaulted by his older cousin
- Identify the irrational negative belief (NC) related to the event:
  "There's something really wrong with me"
- Identify the desired positive, more accurate belief (PC):
  "I'm fine the way I am"
- Assess the Validity of Cognition (VOC) with the image held in mind, on a scale of 1–7, where 1 feels totally gut-level false and 7 feels completely gut-level true *now*:
  John reported a VOC of 2
- Assess the Subjective Units of Distress (SUD) on a scale of 0–10, where 0 is no disturbance and 10 is the highest disturbance imaginable:
  John reported a SUD of 9
- Identify where in the body the distress is noticed:
  John reported tightness in chest, nausea, stomach cramping, and "head spinning"

Phase 4 of EMDR Therapy: Desensitization

The desensitization and reprocessing phases use an initial set of 18-24 eye-movement passes while asking the client to mindfully "just notice" what is emerging during and between sets. The length of subsequent sets of eye-movements is based upon the clinician's assessments of the client's affective and cognitive responses. A deep breath is taken when BLS is stopped, and the client then reports what is being experienced. The clinician then helps guide the client to the focus of attention for the next set. After approximately 20 sets, John stated with clear conviction that he was only 11 years old, that his cousin was "almost an adult" at 18, and that he could not imagine an 11-year-old child "causing or being responsible for their own molest." He also noted that the "absence of his parents' supervision" during much of his childhood left him at greater risk for exploitation. Clearing those networks revealed John's additional NCs such as "I'm unimportant" and "I can't trust" and the insight that he inappropriately managed "feeling misunderstood or unduly criticized" by becoming explosive and abusive toward his wife.

The Treatment of Present Triggers and Urges to Use

John's present triggers and urges to use alcohol, marijuana, pornography, and verbally abuse his wife were reprocessed. It should be emphasized that in order to prevent relapse, it is also necessary to reprocess any other early memories and their triggers that might contribute to setting the groundwork for pathology (Table 5.5).

When exploring John's triggers, they were revealed to be directly associated with the experiences and emotions he had first felt as a child in response to his parents' behavior. His parents' insensitive responses to him frequently left him feeling misunderstood, unheard, unimportant, and extremely frustrated.

In EMDR therapy's Standard Protocol, triggers are identified and reprocessed as an individual EMDR target. For example, the "feeling of being misunderstood" was set up as follows:

Target image	Arguing with his wife
NC	I'm not important
PC	I am important and deserve to be heard
VOC	3
Emotions	Extreme frustration, anger, sadness, fear
SUD	8
Location	Tightness in chest and stomach

The target was reprocessed to SUD of 0 and VOC of 7 with clear body scan.

As a result, John saw that his parents were "good people" who often communicated with criticism due to their own anxiety, not his shortcomings. They also left him alone for long periods of time because both worked long hours to support the child they loved, not because he was unimportant. These clarifications spontaneously emerged during reprocessing and were keys to John's establishing positive, loving connections within and for himself and for his wife.

Additional outgrowths of reprocessing included desensitization of his triggers. They no longer activated his urge to use substances or pornography and his nervous system was cleared of the old feelings associated with the belief that he didn't matter. As expected, he also no longer incorrectly perceived his wife's intentions as critical, demeaning, or mistrustful. John was then able to respond more appropriately and non-defensively to her communications and her needs and their marriage improved.

Table 5.5 Triggers and addictions of choice

Triggers	Addiction of choice
Perception of being criticized	Marijuana (calming)
Feeling misunderstood	Marijuana, alcohol (calming, and to relieve tension)
Social events	Marijuana and alcohol (felt more social)
Loneliness and isolation	Pornography (felt more connected)

Phase 5 of EMDR Therapy: Installation

Once a SUD of 0 (or with some ecological exceptions, a 1) is reported, installation of the PC is continued until a VOC of 7 is reached. John's original NC was, "It's my fault." John's PC evolved into, "I was just a child; it wasn't my fault" and was reported to be felt at a VOC of 7.

Phase 6 of EMDR Therapy: Body Scan

During the body scan the client brings up the original target, their positive belief, and scans their body for any remaining distress or sensation. If anything even slight is reported, reprocessing continues until no remaining discomfort or body sensations can be identified. John reported he was clear and had no remaining bodily distress.

Future Template: At this point, if possible, a future imaginal rehearsal can be conducted. In John's case, he was asked to think about a future time that he might run into his cousin and notice whether he sensed any distress connected with that possibility. John was able to imagine the scene without much problem, until the therapist tested his Future Template by suggesting that he visualize his cousin chatting with another young male family member. This triggered some distress and feelings of protectiveness toward the younger male family member. John stated that, as an adult, he would do whatever might be necessary to keep a child safe from his cousin. The visualization was continued until John could imagine himself thinking, feeling, and behaving as he wished: calmly and assertively with no physical, emotional, or cognitive disturbance.

Phase 7 of EMDR Therapy: Closure

Close down complete or incomplete sessions by using the Safe/Calm Place and positive resources developed and strengthened by the client in the preparation phase of EMDR therapy. John's session, having arrived at a SUD of 0 and VOC of 7 with a clear body scan, was closed down safely. The desensitization and reprocessing of his triggers and Future Templates would come at later sessions. John left the session confident in the truth of his words, "I was just a child; it wasn't my fault."

Phase 8 of EMDR Therapy: Re-evaluation

Treatment targets are re-evaluated at the following session to see whether any change has occurred. The client is asked to "bring up the memory" that was worked on and "notice what comes up for you today." If the client reports any distressing imagery, thoughts, feelings, or body sensations, they are reprocessed until complete (SUD of 0, VOC of 7) using the same procedures noted during assessment and

desensitization. When no further disturbance is reported, Phase 3 is revisited and the next target in the treatment plan is selected.

At John's follow-up visit, the target was reassessed and remained at a SUD of 0, a VOC of 7, with a clear body scan. He also reported he experienced a sense of "lightness" between sessions when he would think of the molestation, as if the weight of a boulder had been lifted from his chest.

STAGE THREE All Phases of EMDR Therapy's 8-phases and 3-prongs

Reconnection, Integration, and Relapse Prevention

Reconnection and reintegration takes place in all phases of EMDR therapy. When traumatic memories are successfully reprocessed and one's personal strengths and resources are fully accessible, this then allows for the freedom to be a more honest, open, and authentic "self."

Stage 3 involves and may result in:

- A felt-sense of integration with oneself, along with an enhanced ability to connect or reconnect with others which is believed to be a natural result of reprocessing and integrating distressing material
- Preparation of the neural networks for future adaptive action—without the use of substances or other self-destructive behaviors

Future Template: 3rd-prong of the 3-prong Protocol

Use of the Future Template (imaginal rehearsal) gives clients an opportunity to systematically *imagine* the future, as if running a movie, focusing on potentially relapse-triggering situations, people, places, rituals, and/or internal states. These targets are reprocessed with bilateral stimulation until they can be imagined without distress and the positive, self-referencing statement (e.g., "I am deserving") feels true at a "felt-sense" level.

The therapist asks: "With respect to these issues, how would you like to see yourself thinking, feeling, and behaving in the future?"

- *Calm and rational communications with wife*
- *Able to hear and receive feedback without interpreting it all as critical*
- *Clean and sober from substances and pornography*
- *Able to be alone or connect with others and be comfortable either way*

John's Future Template Target: Remaining calm when in disagreement with his wife.

John was asked to imagine a movie scene of he and his wife disagreeing about the social plans she made without first consulting him. This triggered his belief, "I don't matter" along with anger and tension in his chest. The image, emotion, and body sensation were reprocessed until he reported they were neutral and no longer disturbing. Asked if there was any level of urge to use substances at the thought of arguing with his wife, John said, "No." It is expected that successful use of the Future Template will lower the risk of relapse because it reduces or eliminates identified motivators to self-medicate.

Early Trauma and Other Adverse Life Experiences Treatment in Addictions: Guidelines and Exceptions

Treating clinicians must be experienced as both chemical addiction and behavioral compulsion specialists in addition to EMDR therapy, or be under close supervision of someone with those qualifications. The common guideline in addiction treatment has been to wait for a period of stabilization and sobriety, generally 30 days, before working through disturbing memories. However, although there clearly are risks in treating trauma prior to sobriety or early in recovery, there are also cases where reprocessing a traumatic memory can reduce the risk that unresolved trauma will interfere with attempts to sustain sobriety (Zweben and Yeary 2006).

Case Example: EMDR Therapy Before the Client Has Attained Sobriety

Jeannie (not her real name) had a rocky childhood with adoptive parents who had decided, "They really didn't want a child after all." She was physically cared for but was emotionally neglected and verbally berated. An alcoholic, sex, and cocaine addict since her teens, she was now 41, married, with a teenage son.

At 15 years of age, Jeannie's parents, who often fought violently with one another, went through a bitter divorce. She blamed herself for their marital failure since she was often the subject of their fights. Jeannie lived with her mother who made it clear that she was not to open the door to her father if she was not present. Her father, who suffered from severe emphysema, came by one day hauling his oxygen tank behind him. He became angry and escalated into a rage when Jeannie refused to open the door. The angrier he got the more impaired his breathing became. Terrified of her mother, Jeannie did not let him in. Later that week, her father was hospitalized and died shortly thereafter. She blamed herself for his death and her mother blamed her as well. Jeannie soon began to use substances to cope with her perception of these childhood events, and her addictions quickly spiraled out of control. She found herself unable to manage without the use of substances.

Jeannie had numerous previous attempts at counseling and sobriety, but when sober, the flashbacks and anxieties stemming from her childhood overwhelmed her. After several months of phased preparation: teaching safe coping skills, strengthening inner resources, and developing emotional management skills, she was still unable to establish sobriety for more than a few days and could not maintain a serious recovery program. While sobriety is preferable before beginning EMDR therapy reprocessing phases, in Jeannie's case the therapist and client collaboratively decided to proceed and target her belief that she was responsible for her father dying, in the hope that lessening the distress of that memory would promote her efforts at sobriety.

The reprocessing was successful within two sessions and freed Jeannie from her 26-year belief that she caused her father's death. She also came to know that the way her parents treated her in childhood was not because something was wrong with her, but was a consequence of her parents' own issues which were not her fault. With these deeply felt perceptual changes, Jeannie was finally able to enter into and sustain recovery. She said that resolving that experience had given her hope that the remainder of her traumatic past could be reprocessed as well. It took over a year to target her remaining issues with one relapse early in recovery. Jeannie is now in her tenth year of uninterrupted sobriety.

An Integrated Trauma Treatment Program (ITTP) Using EMDR Therapy and Seeking Safety in an American Drug Court Program

An Integrated Trauma Treatment Program (ITTP; Brown et al. 2015) combining two evidence-based, empirically validated treatments: EMDR therapy (Shapiro 2001) and Seeking Safey (Najavits 2002), was implemented as an enhancement to the Thurston County Drug court program in Olympia, Washington, which previously had no trauma-focused component. The ITTP included 3 phases (early, middle, and later recovery) over a period of 12–18 months and offered treatment in lieu of incarceration to nonviolent individuals arrested for drug-related offenses. Data was collected from 220 participants from 2004–2009. Since unresolved trauma is believed to underlie addiction, the objective of the ITTP was to determine if adding a trauma-specific treatment component to the program as usual (PAU) would improve program outcomes such as graduation and recidivism. Drug court program completion and graduation are the strongest predictors of lower post-program recidivism rates (National Institute of Justice 2006).

Seeking Safety (SS) is a manualized, CBT-based treatment program for PTSD and substance abuse that focuses on the present rather than delving into past trauma. SS can be conducted as a group intervention or individually by trained, non-licensed support staff. SS has demonstrated signficant treatment effects (Hien et al. 2010; Najavits and Hien 2013). See www.seekingsafety.org for a comprehensive list of SS studies. SS is

listed as a Best Practice through the Substance Abuse and Mental Health Services Administration (SAMHSA 2005) and is composed of 25 topics that provide education, safety skills-building, and stabilization techniques. Same-gender groups were a mandatory addition to the PAU for those endorsing a trauma history. Fifteen pre-selected topics were used in the ITTP as a more formal part of Phase 2 in EMDR therapy (Preparation, Safety, and Stabilization) to prepare participants for individual trauma treatment with EMDR therapy, including exploration and reprocessing of past trauma. Completion of all SS groups was required prior to receiving voluntary EMDR therapy. Participants' sobriety was assessed via random urine drug screens throughout the entirety of the drug court program.

Out of the 220 participants assessed with either the Clinican Administered Posttraumatic Stress Scale (CAPS; Blake et al. 1995) or the Detailed Assessment of Posttraumatic Stress (DAPS; Briere 2001), 68 % endorsed a criterion A trauma sometime in their life. Program graduation outcomes revealed that participants in the PAU who did not endorse any trauma history graduated at a rate of 60 %. Those who endorsed trauma and completed the Seeking Safety portion of the ITTP but declined EMDR therapy, graduated at a rate of 57 %. Those who went on to complete EMDR therapy, graduated at a rate of 91 %. Post-program recidivism rates were 10 % for PAU graduates, 12 % for those receiving EMDR therapy and 33 % for those completing SS groups but declining individual EMDR therapy.

Case Example of Drug Court Participant

One Drug court participant, Tom, (not his real name) had been arrested 14 times for felony drug possession. He was in his third, and final, Drug court program opportunity when EMDR therapy was introduced. His history revealed two alcoholic parents, and other adverse childhood experiences, including his father's early death from cancer. Tom's substance abuse began in adolescence and included alcohol, marijuana, and his primary drug of choice: methamphetamine. At the age of 31, Tom and his brother were cross-country tractor-trailer truck driving partners. They engaged in a bitter argument while driving drunk. In a fit of rage, Tom's brother unbuckled his seat belt and stepped out of the truck as it was going 65 miles (105 km) per hour. He died in Tom's arms at the side of the road.

Tom blamed himself for his brother's death. His addictions increased and led to the loss of his family, business, and freedom. Tom never had treatment for his traumatic past, nor did he know that unprocessed adverse experiences fueled his addictions. Successfully targeting and reprocessing the death of his brother with EMDR therapy was the beginning of a long-lasting recovery for Tom, now 12 years sober. One of the first successful participants of the ITTP, Tom has been an avid spokesperson and role model for the program and often speaks publically to inspire other Drug court participants.

The following case example illustrates the importance of considering small-t traumas, or adverse life experiences, as well as the Big-T traumas when treating this population.

Case Example: Co-occurring Panic and Substance Use Disorder Rooted in a Small-T Trauma

Karen (not her real name) was 47 years old when she was referred for EMDR therapy. She was nine months sober from poly-substance abuse, but was still sexually compulsive and continued to have panic attacks, that despite several trials of psychotropic medication, caused her to use again. She thought choosing her own drugs was more effective than medication, even though using only deepened her sense of guilt, shame, and isolation.

She had more than 10 years of unsuccessful treatment for her panic attacks before her earliest memories of them were targeted and reprocessed with EMDR therapy. She focused on the "fear in her body" as the target and within a few moments connected with a memory from age four of being dropped off at a park with instructions to care for her 2-year-old sister. It seemed to Karen that her parents left her there the entire day. By the time they returned, Karen was in a panic, vomiting, sobbing, and unable to catch her breath. Her father screamed at her to "knock it off and quit acting like a baby." Her panic shifted to shame and humiliation when his rage changed to laughter about how "wimpy" she was.

The developing brain of a child requires a certain level of attunement and safety in order to develop its emotional regulation capacities (Schore 2002; Siegel 1999) without which a child is more vulnerable to later substance use (Linehan 1993). Thus, 4-year-old Karen tried to regulate her emotions in the absence of supportive parenting. In less than a year, at age 5, Karen took her first sip of beer at an unsupervised party of her parents and from that point, continued to drink as opportunities at home presented themselves. At age 12, she began smoking marijuana. She entered treatment for alcohol and marijuana abuse at age 46.

More serious traumatic and adverse experiences occurred throughout her childhood, including multiple molestations by her brother's friends such as sexually inappropriate touching. However, Karen states she experienced the park incident as the first and most overwhelming experience that set the tone for the "rest of my life." That memory felt just like the panic attacks she continued to experience in adulthood and attempted to medicate with drugs, alcohol, and compulsive sex; by all clinical standards the adverse childhood experience at the park was a small-t trauma.

The intensity and frequency of Karen's panic attacks diminished after reprocessing of this pivotal memory easing her urges to use marijuana and alcohol to medicate them. This case underscores the importance of reprocessing memories responsible for not only the faulty cognitive beliefs one holds about one's self, but

also the body sensations that are reported, such as in panic attacks, that may or may not have a specific negative cognition associated with them. This example illuminates the importance of not only reprocessing Big-T traumas, but also all of the relevant adverse life experiences we consider to be small-t traumas.

Conclusion and Summary: Why Use EMDR Therapy to Treat Co-occurring Disorders?

"*Although the world is full of suffering, it is also full of overcoming it*." Helen Keller

As research and clinical experience suggest, the incidence of co-occurring disorders within the criminal justice system (Substance Abuse and Mental Health Services Administration (SAMHSA) 2005) and substance abuse treatment centers across the nation indicates the need for specialized treatment programs designed specifically for this challenging population. The personal, family, social, health, and economic consequences as a result of failing to treat these individuals have been staggering and seems remediable.

Co-occurring disorders are a unique treatment challenge and EMDR therapy is a unique response to that challenge. EMDR therapy's 8-phases and 3-prongs, along with the informing AIP model, predicts that early trauma and other adverse life experiences are primary contributors to the emergence of clinical symptoms and disorders, and are often the leading causes for the use of substances designed to regulate distress. The 3-prong approach of EMDR therapy is ideally suited to the treatment of co-occurring disorders and targets: (1) the *past* experiential contributors to present-day symptoms, (2) *present*-day triggers that activate distress, and (3) *future* templates of desired states and behavior.

The third prong (Future Template) in EMDR therapy gives clients an opportunity to imagine encountering many possible relapse-triggering situations (people, places, and things) as well as internally triggering negative emotions in the future. These future targets are then reprocessed with BLS until the future can be visualized without distress and the client's positive self-referencing statements feel true at that "felt-sense" level. It is believed that the treatment effects observed with EMDR therapy offer co-occurring disordered clients an extra measure of protection against future relapse with drugs, alcohol, or other self-destructive behaviors originally intended to help the client "feel better." The temporary solution of addiction eventually displaces a person's true self with a sense of powerlessness and self-loathing that impacts the not only the individual, but their family and the next generation in the vicious cycle introduced at the beginning of this chapter. Therefore, we call to attention the hypothesis that society's number one problem is not substance abuse and other harmful behaviors, but rather, unresolved trauma, neglect, and other adverse life experience that with effective treatment can transform a person and allow for a life free of past suffering and worth living substance free.

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