

# EMDR in the Treatment of Addiction

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**SUMMARY.** EMDR offers so much promise and great challenges to addiction treatment providers. It is a powerful tool for trauma resolution, but it must be carefully integrated into addiction treatment. Organizational as well as individual safety structures must be in place so that vulnerable individuals may be offered this opportunity under conditions which maximize their chances for success. Efforts are underway to obtain funding for controlled trials, and it is hoped that these will clarify safety and efficacy questions, as well as many clinical issues that arise as more clinicians work with this method.

## *INTRODUCTION*

It has long been recognized that a significant number of people seeking substance abuse treatment have a history of trauma in childhood, adulthood or both (Najavits, Weiss, & Shaw, 1997; Zweben & Clark, 1994). For many, this results in enduring symptoms of Post Traumatic Stress Disorder (PTSD) that both makes it difficult to achieve extended periods of abstinence and reduces the quality of recovery. These symp-

toms include nightmares, flashbacks, heightened vigilance and reactivity, irritability and a tendency to numb out that may affect everything from interpersonal relationships to intellectual achievement. Many clinicians view PTSD as a major factor influencing addiction treatment outcomes. Developing more effective interventions for this condition therefore becomes the key to improvement. Symptoms of PTSD affect the ability to get clean and sober, stay that way, and create a satisfying life without the use of alcohol and other drugs. Clinicians have also noted that even subthreshold symptoms that do not meet criteria for PTSD can nonetheless interfere with mastering recovery tasks.

Systematic work is underway to develop treatments that can be used in residential, inpatient, and outpatient community-based settings. Lisa Najavits (Najavits, 2001) has been studying and developing her *Seeking Safety* model, a cognitive behavioral approach designed to stabilize clients and give them psychoeducation and other tools for coping with their PTSD symptoms. Elise Triffleman has developed an integrated cognitive-behavioral model combining relapse prevention and coping skills training with psychoeducation, stress inoculation training, and in vivo exposure for PTSD (Triffleman, Carroll, & Kellogg, 1999). Exposure therapy has been combined with an empirically supported treatment for substance use disorders, modified for use with an inner city population (Coffey, Schumacher, Brimo, & Brady, 2005). Although these models are promising, experienced clinicians are also

drawing on developments outside the field of substance abuse in an effort to find effective interventions for reprocessing trauma. Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1995, 2001, 2002) has attracted considerable attention because of the large number of clinicians using it and reporting positive results, and because of the growing body of research evidence documenting its effectiveness in a variety of populations. Although descriptive articles and a small pilot have appeared in the literature on addictions (Henry, 1996; Lazrove, Triffleman, Kite, McGlashan, & Rounsaville, 1998; Shapiro, Vogelmann-Sine, & Sine, 1994), controlled studies of substance abusers have not been published. There is, however, considerable interest in investigating this potentially powerful tool for reprocessing trauma.

### ***EMDR: Process and Procedures***

Although EMDR is the name by which this therapy is widely recognized, it is actually an integrative therapy that encompasses a range of clinical interventions based on the treatment of trauma. (Shapiro, 1995, 2001, 2002)

comprehensive assessment. It is conceptualized as an information-processing model of trauma resolution, in which the standardized procedures and bilateral brain stimulation facilitates entry into an accelerated learning state in which traumatic experiences can be processed effectively and efficiently. Although the eye movements themselves have received an enormous amount of attention, it appears that bilateral and/or focused stimulation is the salient ingredient, and this is frequently achieved by sounds (using earphones) and taps (administered by therapist or a machine). Shapiro notes that she named the treatment EMDR in the early stages of its development, but it would have been more appropriately called “Reprocessing Therapy” (Shapiro, 2001).

The Adaptive Information Processing model (AIP) (Shapiro, 2001, 2002) that guides EMDR practice states that unprocessed experiential contributors are the basis of most pathology. In order to make sense of the present, a physical information processing system integrates perceptions into existing memory networks. Under circumstances of intense stress the processing system may be unable to function properly and disturbing events remain isolated in

memory networks that are unable to link with anything more adaptive. These unprocessed memories essentially contain the emotions, thoughts, and physical sensations fundamentally unchanged since the time of the event. Current circumstances act as triggers and these aspects of memory arise to color current perceptions, and drive behaviors because of the emotions and physical sensations experienced by the client. Essentially, since the client is feeling the emotions and sensations of these unprocessed events: the past becomes present. The purpose of EMDR therapy is to identify and process the experiential contributors of dysfunction and health.

There are eight phases and specific protocols used to address the presenting complaints (Shapiro, 1995). A careful Client History is taken to evaluate the entire clinical picture. This includes identifying the experiences that will need to be processed in order to address the elements of the negative experiences (dysfunctional cognitive, emotional, somatic and behavioral elements) and incorporate a positive vision of the future. In the Preparation phase, the client is educated about the symptom picture, and given tools to facilitate stabilization and processing. The Assessment phase focuses on the disturbing target experiences and the attendant negative beliefs, emotion and physical sensations. The client specifies current rating of distress using the 0-10 Subjective Units of Disturbance (SUD) scale (Wolpe, 1958), and strength of the desired positive belief using the 1-7 (1 = completely false; 7 = completely true) Validity of Cognition (VOC) scale (Shapiro, 1989).

Once the client is considered ready, standardized procedures for Desensitization, Installation, and Body Scan Phases are used to process the target. The standardized procedures include the bilateral stimulation (e.g., eye movement, taps, tones) and an association procedure that are important elements to producing effective and efficient information processing that will ultimately lead to a reduction of symptoms. During the reprocessing phases clients experience insights and shifts in affective and somatic manifestations of the targeted events. In the Closure Phase the focus is on returning the client to equilibrium, with preparation for any distress between sessions. The Reevaluation Phase, which opens every subsequent session ensures that positive treatment effects have maintained, and guides the clinician to the next target. The standardized protocols for addressing PTSD

and chronic distress both include the targeting of past events that set the groundwork for the pathology, present triggers that elicit disturbance, and positive templates for appropriate future action.

### ***FROM RESEARCH TO PRACTICE***

Eighteen randomized clinical trials have been conducted on EMDR with a wide range of trauma populations and comparison conditions. For comprehensive reviews see Bradley, Greene, Russ, Dutra, and Westen, 2005 (Bradley, Greene, Dutra, & Westen, 2005) (Department of Veterans Affairs & Department of Defense, 2004; Maxfield & Hyer, 2002). A variety of international guidelines have given EMDR the highest level of effectiveness (“A”) rating as a first line treatment for PTSD (American Psychiatric Association, 2004; Bleich, Kotler, Kutz, & Shalev, 2002; Department of Veterans Affairs & Department of Defense, 2003). A comprehensive meta-analysis reported the more rigorous the study, the larger the effect (Maxfield & Hyer, 2002).

In addition to issues of efficacy, clinical efficiency and practicality should also be examined. As noted in an extensive meta-analysis (VanEtten & Taylor, 1998) while EMDR and behavior therapy were superior to psychotropic medication, EMDR was more efficient than behavior therapy, with results obtained in one-third the time. While it has been concluded in the above cited International Practice Guidelines that EMDR is at least equivalent to exposure and other cognitive behavioral therapies (CBT), it should be noted that exposure therapy uses one to two hours of daily homework and EMDR uses none (Perkins & Rouanzoin, 2002; Shapiro & Maxfield, 2002). In fact, the only random-

ized study to find some superiority for exposure therapy (on two of ten subscales) used an additional 48 hours of daily homework along with therapist assisted in vivo exposure (Taylor et al., 2003). In addition, EMDR may also be better suited to the dynamics inherent in a substance abuse population. As noted in the Department of Veterans Affairs/Department of Defense (2004) guidelines, EMDR may take only a few sessions, and unlike

exposure therapies, can be used with clients experiencing guilt. Further, as noted in the American Psychiatric Association guidelines (American Psychiatric Association, 2004), EMDR does not demand a full narrative from the client, and therefore may be particularly useful for those troubled by disclosure and shame issues.

In short, more than enough research evidence has been amassed to warrant the study of EMDR in substance abusers in random assignment clinical trials.

### *Use of EMDR in Clients with Substance Abuse*

EMDR can be useful in a variety of ways during the recovery process. The recovery process encompasses a number of tasks: enhancing motivation, becoming abstinent, addressing and preventing relapse, and enhancing the quality of recovery. If tailored appropriately for the individual, EMDR can help facilitate all aspects of recovery, including abstinence. Although many substance abusers enter addiction treatment in too fragile a state to permit reprocessing major traumas, there are a number of other ways to begin using EMDR. As noted previously, EMDR engenders a “processing” or “learning” state that targets the experiential contributors of dysfunction and health. Negative imagery, emotions and thoughts are targeted during trauma processing and transform to a positive state. Likewise, EMDR can be used to accentuate and increase the client’s access to positive affective states. A standard preparation phase in EMDR includes the utilization of a Safe Place exercise that uses imagery to evoke a positive affect (see Shapiro, 2001). Extensions of this protocol called EMDR Resource Development and Installation have been evaluated in a case series (Korn & Leeds, 2002) and found to increase stabilization.

The therapist can use the resource development process to help the client build the support system, emotional stability, and self-soothing capacity to begin to address the traumatic experiences. For example, clients have a variety of reasons to avoid self-help participation. A process for increasing a sense of security can be used to assist clients to overcome important resistance:

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Marie began having serious addiction problems as an adolescent and was hospitalized. She always had a difficult time using the 12-step system because she felt so unable to socialize. She would go to meetings, feel bewildered and preoccupied with what others were thinking, hypervigilant for evidence they were judging her harshly. She achieved sobriety for a period of time, but relapsed in college and returned home and entered outpatient treatment. The therapist explored her feelings in social situations, and she shared that she had felt painful awkwardness most acutely on the play-ground in elementary school.

The therapist asked her to think of her favorite color and imagine being surrounded by it. She replied that her favorite color was pink, and described a bubble. The therapist asked her to picture being in the pink bubble, using the bilateral stimulation. After she was comfortable and relaxed in her body, the therapist suggested that she picture herself in the pink bubble while at a 12-step meeting, and notice how her body felt. She was then able to use this image when she went to meetings to create a sense of safety and develop more internal resources. The anxiety she felt diminished, and over time, she realized that she was able to be more comfortable at meetings.

Although Marie's anxiety originated in childhood, it was not necessary to address those images directly in order to strengthen her confidence. In this case, the therapist felt that much work was required before other kinds of processing of the painful experiences could be undertaken, but that resource installation (Shapiro, 2001) could be beneficial in moving the patient forward.

It should also be noted that at times, the apparent affect dysregulation may actually be the product of insufficiently processed traumata. For instance, a recent study (Brown & Shapiro, in press) of a client with Borderline Personality Disorder/Complex PTSD indicated that a client who had been seen for a number of years using CBT and psychodynamic therapy presented again for treatment because of on-going difficulties. The clinician, now trained in EMDR, inaugurated treatment. Once the client had been taught the Safe Place exercise, standard EMDR trauma processing brought all scales on

the Inventory of Altered Self Capacities (Briere, 2004) into the subclinical range. These included scales initially indicating a high level of dysfunction related to affect control (Affect Dysregulation, Affect Instability, Affect Skills Deficits, and Tension Reduction Activities). One should discriminate between affect dysreg-

ulation caused by organic deficits, and those caused by experiential contributors.

EMDR can also be used to target traumatic experiences that trigger cravings (Saladin et al., 2003; Vogelmann-Sine, Sine, Smyth, & Popky, 1998). Although most clinicians agree that stability is necessary to do significant trauma work, many clients may never get clean and sober unless some of the emotional charge is taken out of their traumatic past. As noted by Shapiro (2001) the use of EMDR to assist in establishing abstinence is different from its use to address relapse after a significant period of abstinence. Clients are encouraged to become good detectives, discover their triggers, work on them in sessions, and use EMDR between sessions to neutralize urges until the desire fades. They are also asked to remind themselves of their positive goals, and to monitor urges between sessions.

For those further along in recovery, processing of painful experiences can be part of addressing relapse:

Judy began drinking at age 10, and her alcoholism progressed steadily for ten years. She got sober in her 20's and was very involved with 12-step recovery activities, but avoided dealing with her painful childhood with highly neglectful parents. After 14 years of sobriety, unexpected events brought back her childhood difficulties, and she began drinking again and became suicidal. Her outpatient therapist referred her to an inpatient program and recommended that they utilize EMDR to assist her in reprocessing her early family trauma. She entered an inpatient trauma program that offered EMDR sessions, which she found to be most helpful.

When she returned to her own community, she agreed to continue the EMDR sessions on an outpatient basis. Her therapist typically used EMDR processing in about one out of four sessions, with the sessions in between

used for discussion of the material that had emerged. She uses 2-3 sessions to continue integrating the information in discussions with her therapist following each EMDR session.

Judy's recovery tools were strong, but her recovery collapsed because her PTSD interfered with maintaining ongoing recovery. Although she had a strong 12-step support system with a sponsor, a supportive family and years of recovery, her traumatic history prevented her from being comfortable in the world. Given the right circumstances, it was inevitable that she would become triggered and lose the resources necessary to

maintain sobriety. The pain was too overwhelming and she regressed. EMDR assisted her in reprocessing the early memories so they would be less potent as a trigger to use. This will hopefully reduce her vulnerability to further relapse. If the client has not returned to extended periods of alcohol and other drug use, and has not deteriorated too greatly in functioning, targeting the trauma in an outpatient setting may help re-establish abstinence as well as address previously unfinished business. Additional cases of EMDR trauma treatment (Shapiro & Forrest, 1997) indicate that the need for the self-medication caused by the earlier traumata may be the cause of chronic relapsing and can be addressed through appropriate processing. As noted earlier, the AIP model indicates that the stored perceptions color present reactions. Those clients that have feelings of helplessness and hopelessness emerge from the stored experiences may not be able to resist self-medication. Once the earlier events are processed, the client is able to make healthier choices.

The overall treatment for addictions includes using EMDR protocols to address the past experiences that set the groundwork for the dysfunctional behavior. These are generally experiences that give the client the sense that s/he is defective, unsafe, or not in control (Shapiro, 2001). The current triggers including people, places, or things that elicit the desire to use (Shapiro & Forrest, 1997). These are processed along with new skills and behaviors for the future. Finally, EMDR is a valuable tool to enhance quality of recovery in

clients who are stable in their abstinence and working on a variety of issues in their psychotherapy.

### ***INTEGRATING EMDR INTO OUTPATIENT AND RESIDENTIAL TREATMENT***

Currently, it is much more likely for patients to have access to EMDR if they are in treatment funded by private insurance or they can pay themselves. However, the high prevalence of trauma history among clients in the indigent care system has stimulated interest in bringing it there. How EMDR can be used depends on the level of the client's functioning and presence or absence of a strong support system. Programs can incorporate EMDR by hiring trained therapists to work with clients on a consultant basis, by bringing them onto their regular staff, or by training existing staff. It is important to remember that the addiction field is very diverse, with strong subcultures, in the sense of beliefs, norms and practices, in particular modalities. Therapists brought in from the outside may have some understanding of addictive disorders,

but it will still be necessary to orient them carefully to the program's philosophy and approaches, and provide mechanisms for ongoing communication about clinical issues. When outside clinicians become too isolated from the program, problems inevitably result. Inasmuch as EMDR involves working with intense feelings, it is especially important that clinical care coordination does not become lost in the demands of busy schedules or fracture from the schism of differing clinical philosophies.

Residential treatment represents a highly desirable setting for EMDR, because the safety structures are more extensive for unstable clients. Nonetheless, these programs vary widely in structure, with therapeutic communities offering the highest level of structure, coordination of clinical activities, and duration of stay (DeLeon, 1995). These programs may represent an optimal setting for clients who are fairly impaired in their functioning. The inpatient treatment system largely funded by insurance or managed care often serves higher functioning clients who can utilize EMDR sessions despite the relatively shorter length of stay. Explicit procedures for outside therapists to report to the regular staff after each EMDR session are

crucial. Staff must have clear plans for what to do if the client appears to become more upset, dissociated or unstable in the hours or days following an EMDR session. The EMDR therapist must be able to add special sessions in acute situations. This is particularly important in less structured residential settings, such as alcohol recovery homes, which aim to provide a protected setting rather than intensive clinical intervention.

Outpatient treatment represents a much greater challenge. It is more difficult to gauge the quality of the support structure outside the program itself. Although it is preferable to begin such work when the client has achieved stable abstinence, many with trauma histories are unable to stop drinking and using for long periods of time. Some clinicians have described success in using EMDR early in treatment, resulting in progress in achieving abstinence. The risks of using such a powerful approach with an unstable client must be weighed against the frustration of a motivated client who seems unable to progress beyond brief periods of abstinence. In order to increase resilience and stability, this population is ideally suited for the EMDR resource work previously described.

Outpatient treatment requires that the clinician set a standard of safety and assess the degree of stability of the client, as this determines how EMDR can be used. In the early stages of addiction recovery, it is critical that the client develops resources for maintaining abstinence, and tolerating feelings without drinking or using. The EMDR protocol for re-

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source development is a wonderful tool to teach self-soothing skills in order to facilitate abstinence. However, Shapiro has emphasized that “preparation is not processing.” As demonstrated by Korn and Leeds (2002), increase in stabilization does not decrease the symptoms caused by the underlying trauma. The affects that cause the desire for self-medication and relapse potential are inherent within the unprocessed memories and should be dealt with the standard EMDR protocols that address the past experiences, current triggers, and templates for appropriate future action.

An addiction specialist who is proficient in EMDR offers an ideal skill set for working with clients with a trauma history. However, this is currently a rare combination. At present, it is more likely that this resource can be brought into addiction treatment by collaboration. It is necessary for the therapist doing EMDR to work closely with other out-patient staff to maximize attentiveness and support for the client during the period when sessions are taking place. As in residential treatment, it is important for the EMDR therapist to understand as much as possible about the resources and limits of the addiction program, and to have clear communication protocols established from the outset. If an acute reaction occurs, the collaborating therapist should be willing to provide support and consultation to the staff.

### ***TRAINING AND ONGOING SUPERVISION***

EMDR is a complex treatment approach that requires significant training. In order to understand the principles, procedures and protocols of EMDR, the mental health professional is required to undertake 18 didactic hours and 13 supervised practicum experience hours with a trained EMDR clinician. This training is designed to insure safety, and maximize the treatment outcome. After therapists have completed the formal training, it is recommended that they continue with on-going case consultation from an EMDR trained supervisor when they first begin using EMDR in their practice to insure a broad understanding of the process. It can also be helpful to have other colleagues to talk with on an informal basis about how EMDR is utilized in their practices.

EMDR training is open to mental health professionals who are licensed, certified or registered for independent practice. The training is also open to advanced graduate students, interns and other mental health professionals on a licensure track, with a letter of support from their su-

pervisor. As with any other therapeutic approach, the more the therapist uses EMDR, the greater the understanding of its use and application. Information about training can be obtained by contacting the EMDR International Association ([www.emdria.org](http://www.emdria.org)). The EMDR Humanitarian Assistance Programs ([www.emdrhap.org](http://www.emdrhap.org)) is a non-profit organization that provides low cost trainings for mental health agencies and can facilitate such integration

and supervision. More information and relevant updates on research can be obtained through a website devoted to such functions ([www.emdrnetwork.org](http://www.emdrnetwork.org)).

## **CONCLUSION**

EMDR offers much promise and great challenges to addiction treatment providers. It is a powerful tool for trauma resolution, but it must be carefully integrated into addiction treatment. Organizational as well as individual safety structures must be in place so that vulnerable individuals may be offered this opportunity under conditions which maximize their chances for success. Efforts are underway to obtain funding for controlled trials, and it is hoped that these will clarify safety and efficacy questions, as well as many clinical issues that arise as more clinicians work with this method.

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