EMDR and Addiction: Essential Skills Beyond Basic Training

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OBJECTIVES

1. Identify the origins of addiction from the AIP perspective and challenges specific to addiction clients;
2. Learn and practice creation of a treatment plan from the AIP perspective for addiction clients;
3. Identify several unique resourcing options to prepare addiction clients for reprocessing;
4. Identify at least three protocols specifically for use with chemical and/or process addictions;
5. Determine when to use a specific protocol with an addiction client.

ADAPTIVE INFORMATION PROCESSING (AIP)¹

Current emotional & behavioral problems (not caused by organic deficit or physical insults) are conceptualized as the result of incompletely or inappropriately processed memories of disturbing/adverse/traumatic experiences.
ACE Study

- Adverse Childhood Experiences Study conducted by the CDC and Kaiser Permanente with 17,000 participants, beginning in 1995.

- The study was conducted to assess associations between childhood maltreatment/trauma and problems later in life with health and well-being.

As the number of adverse childhood experiences increases, the risk for the health and wellness problems increases in a particularly strong manner.

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
• Liver disease
• Risk for intimate partner violence
• Multiple sexual partners
• Sexually transmitted diseases (STDs)
• Smoking
• Suicide attempts
• Unintended pregnancies
• Early initiation of smoking
• Early initiation of sexual activity
• Adolescent pregnancy

The ACE study outlines 10 categories of adverse experiences: physical, emotional & sexual abuse, neglect, abandonment, DV, parental alcoholism/drug abuse, psychiatric problems, or prison (ACE score = 1 for every category client experienced)

Example: ACE score of 5 equates to a 4660% increased risk of IV drug use

Biggest concern in the addiction field: potential for client relapse in dealing with trauma in early recovery

Challenges to trauma work include: alexithymia, affect phobia, and inability to regulate affect

These challenges must be addressed in the preparation phase to reduce risk of relapse
• Utilization of specific EMDR addiction protocols can help reduce the risk of intense trauma memories opening up.

• Clinician must understand means by which to restrict processing if intrusive trauma material is present and client is not ready to process it.

WINDOW OF TOLERANCE

Hyper-Arousal Zone

Optimal Arousal Zone

Hypo-Arousal Zone

Hyper-Arousal Zone

• Emotional reactivity
• Hypervigilance
• Psychomotor agitation
• Hyperactive defensiveness
• Flashbacks
• Intrusive images/emotions
• Obsessive cognitive activity
• Flat affect
• Tired/sleepy
• Decreased interest
• Numb
• Cognitively disabled
• Collapsed
• Disabled defensive responses

Hypo-Arousal Zone

After adverse experiences, the optimal zone will narrow, resulting in dysregulation.

Optimal arousal zone is where healing takes place.

The system is readily triggered into extreme states by reminders of the original events; the addict knows how to regulate by using

Our Goal: help the client learn how to stay in the optimal zone to assist with relapse prevention and reprocessing.
Alexithymia

- “Emotional blindness”
- Difficulty identifying feelings and bodily sensations of emotional arousal
- Difficulty describing feelings to other people
- Difficulty using the imagination

Possible solutions:

- Affective education – help the client learn to identify feelings and the bodily sensations that go with emotional arousal
- Support group or therapy group with affect expression and tolerance exercises (including DBT)
- Explore possible blocking beliefs/experiences when they were taught emotions aren’t okay, etc.

- Mindfulness - every time the client appears to have a feeling, ask what it is, where they feel it, etc.
- Exercises in which the individual is asked to describe what they “get” when describing life experiences; they will come to recognize visual memory with practice and time
- Somatic empathy by the therapist

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The individual goes out of their way to avoid the affective experience.

The individual develops specific thoughts and behaviors to guard against unwelcome affect, including substance and process addictions, self-attack, numbing, etc.

Phobia often extends to negative and positive affect.

We learn affect tolerance and regulation skills in infancy and early childhood through attachment to caregivers (mirroring, caretaking, & containment). Adverse childhood experiences impact the opportunity to learn these important skills because an infant with an inadequate caregiver will neglect, fail to mirror, be inconsistent, etc.

The individual learns to be terrified of the overwhelming emotional experience for which they have no resources.
• This leads to “fear of the fear” or of shame, anger, sadness, pain, hurt, love, etc.

• The grown adult has the phobic response to the experience of emotion because the emotion is too terrifying to experience, from the infant “ego state” or memory network; no link between adult memory network and child memory network.

• The “affective circuits” are “quarantined” by these overwhelming experiences.

• Jaak Panskepp8, 9 postulates that we have a few basic emotions which are hardwired in the brain in affective circuits.

• “Updating the Affective Circuits”6 is a resource exercise developed by Katie O’Shea and Sandra Paulsen in which the client “clears out” the circuit (or desensitizes to the emotion itself).

• Finally, the emotion is just the emotion, not a terrifying thing that gets triggered with adverse experiences or reminders of past experiences.

• We begin to learn affect tolerance and regulation skills in infancy through attachment to caregivers.

• Adverse childhood experiences impact the opportunity to learn these important skills.

• An infant without an adequate caregiver will not learn these skills, and will be terrified of the overwhelming emotional experience for which they have no resources.
Video Demonstration: 
Containment, Safe State, 
Updating Affective Circuits 
(23:35)

DEVELOPING AFFECT TOLERANCE & REGULATION

- Phase 2 of EMDR (Preparation) 
  and throughout, as needed
- Safe/calm place exercise is diagnostic (positive affect phobia, alexithymia, etc.)
- Develop/install safe place or alternatives:
  - Successes
  - Positive experiences

- Sponsor
- Higher Power
- “The Team”
- Meetings
- Pets
- Hobbies
- Colors
- A Fun Time
- RDI
- Sober Self (next slides)
“Sober Self” resource:

1. Ask the client for their goals – how do they want to behave/feel in the future, what do they want to achieve? (write this down)

2. Ask the client to close their eyes and listen as you slowly read back their goals – ask them to see if a vision of their future self arises (use slow, lower intensity BLS only if you are sure of the client’s ability to contain negative material – audio or tactile; stop at end of the goals)

3. Give them a moment, say “take a breath, what comes up?”

4. Go with whatever comes up that is positive as it strengthens, a few short slow sets.

5. Ask what that future self looks like, what they are wearing, make it real. Use BLS until it no longer strengthens.

6. If what comes up is negative, consider that negative material is leaking in, blocking beliefs or feeder memories, and briefly explore this. Choose another resource if this one is associated with negative material.

7. Practice this resource with the client, ask them to practice it between sessions, make sure it has a name (e.g., “Sober Susie” etc.).

8. Once positive “sober self” is installed, test with cued distress
Video Demonstration:
Sober Self
(9:31)

- Development and installation of resources enhances positive networks, which are necessary for reprocessing and between-session stabilization
- Use Cuing of Distress to build positive state-change “muscle”

- ANYTHING positive can be developed and installed as a resource.
- ANY recent positive experience, including a nice conversation, a moment of gratitude, a good meeting, a moment of hope, etc.
- This builds affect tolerance and affect regulation skills
• Listen for the positive, then fetch your EMDR equipment (fingers) and just ask, “where do you feel that inside?”

• Whatever the client says, do a short, slow set. “Go with that…”

• If positive response, continue with short slow sets and anchor with cue word.

• If negative response, just take note and move on

• Have a relapse-prevention plan in place in which the client has a list of all their resources, external and internal, that they will use to maintain recovery

  • Plan should include use of the resources you have developed in session

  • Install the plan as a resource as well

**Addiction Protocols**

• Multiple addiction protocols can be found in EMDR literature (books, journal articles) and advanced trainings

• We will discuss four EMDR protocols and when to use them (Standard, DeTUR, FSAP, CravEx)
STANDARD PROTOCOL
TREATMENT PLAN

1. Presenting Issue: drinking, drug use, etc.
2. Emotions when thinking about this issue?
3. Negative beliefs when thinking about this issue?
4. Body sensations when thinking about negative cognition?
5. Direct questioning – when have you felt this way before?

7. Float back - when was the first time you remember feeling this way?
8. What other times have you felt this way about yourself?
9. What are the present situations/people/ triggers/reminders that make you feel this way NOW?
10. How would you like to feel about yourself/ behave in the future?

This is your road map/treatment plan with Standard Protocol:

Past/Present/Future

Standard protocol is grounded in the premise that addictive behaviors are based on unprocessed experiences from the past.
• Use Standard Protocol to process first/worst/other events that underlay the addiction

• Process past events, then present trigger and future template

• Include using/drinking experiences or consequences as targets, too

Video Demonstration:
Standard Protocol
Treatment Planning

• Sometimes called the “Addiction Memory” protocol, developed by Michael Hase

• The addiction memory (AM) contains the memory of loss of control, or cravings, and/or the memory of use of a specific drug

• The AM outlasts periods of drug deprivation (explaining why relapse may occur after years of abstinence and they pick up right where they left off)
• Internal or external cues can trigger the AM, resulting in craving and use

• Target memories of relapse or of intense cravings as these are an indicated that the AM is activated

• Reprocessing the AM leads to reduced cravings (cravings will, however, increase during reprocessing, but this is temporary)

• No special stabilization is needed, just standard safe place

• Even if there was previous trauma; the trauma did not appear to get triggered

• Shorter treatment was required, 2 sessions of 60 minutes in the research

• Standard Eight Phase protocol\(^1\) is utilized, with the exception of the target itself being the AM, not a “trauma”

**Detur**\(^2\)

• “Desensitization of Triggers and Urges for Relapse,” developed by A.J. Popky, Ph.D.

• Addiction behaviors are maintained by the stress relief associated with using (elimination of negative experiences)

• Focuses on resourcing and desensitization of triggers in order to reduce the level of urge to use/act out
• Identify & install external/internal resources to be used to maintain sobriety
• Identify & install a positive goal state (PGS), a present statement about desired recovery goal
• Identify & rate triggers (LOU=0-10)
• Process triggers to LOU=0 (or ecological)
• Pair each trigger with PGS & strengthen

✓ Use the quick reference in your handouts.
✓ Especially helpful for clients who “have no trauma”!

• During processing of the triggers, client’s trauma may arise.

• Example: a young adult female client had a trigger for drinking of being at a party. While processing trigger, client suddenly reported she had been raped at a party, which was previously undisclosed. Rape needed to be reprocessed before the trigger could be desensitized.

Video Demonstration:
DeTUR
(____)
FEELING-STATE ADDICTION PROTOCOL

• Developed by Robert Miller, Ph.D.
• Addiction is created when positive feeling states become wired to specific behaviors
• Abstinence is not the goal; loss of interest in the behavior is the goal
• www.FSAProtocol.com

What a Positive Feeling State Looks Like:

The Highlight of My Night
(0:33)

• After standard preparation, identify specific positive feeling state (PFS) associated with using/compulsion
• Identify image & intensity of PFS (0-10)
• Identify body sensation
• Process until PFS=0 (using EMD)
• Then identify NC associated with PFS
• Identify body sensation associated with NC
• Use float back to identify 1st time client felt this way
• Process incident with standard protocol

Video Demonstration:
FSAP
（___）

GUIDELINES FOR USE

1. See handout “Quick Reference” for suggestions
2. Cravings will emerge during processing; that’s a good thing! Just keep going!
3. Do not leave the client in the middle of a craving if you have to end the session as incomplete. Make sure you have plenty of time to process through it, or take more time than scheduled as this is very important.
4. Re-evaluation is essential for each session; adjust resources or change protocols as needed.

5. Interweave resources and development of new resources as needed, especially if client struggles between sessions or slips with addiction.

6. The therapist is in charge of the pace and level of associations made during processing.

7. Reduce associations or slow pace with restricted processing (EMD, slower or shorter sets, more frequent returns to target, etc.)

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**EMD**

- First discovery by Dr. Shapiro (1989)
- For symptom reduction related to a specific memory
- Minimizes spontaneous associations to other experiences
- Increases client stability & down regulate affect
- Stop-gap measure

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- Clients who do not meet selection criteria or readiness for EMDR are also not appropriate for EMD.
- Selection Criteria: safety/acute presentations; timing; medical; clinical relationship; diagnostic concerns
- Readiness: access to positive networks; ability to change state; ability to stay present; truth-telling agreement
EMD Procedural Steps:

1. Identify memory or part of a memory
2. Use standard Phase 3 Assessment, identifying components of the memory
3. Apply short sets of BLS (12-15)
4. Return to target after each set and take SUD. IF OTHER ASSOCIATIONS ARISE, SHORTEN SUBSEQUENT SETS
5. Process until desired shift has occurred (will not be SUD=0)
6. Identify a positive belief that reflects the client's shift and what feels true NOW (e.g., I can handle my feelings" or "I can feel safer") and install to VOC=7 or as true as ecologically possible
7. Postpone body scan as it will not be clear until you do full reprocessing on this memory
8. Once client can tolerate the full reprocessing, begin again at Phase 3 Assessment, and process through all phases of standard protocol

CLIENT USING DURING TX

1. Safety first – is a higher level of care appropriate?
2. No processing will take place when client is acutely under the influence
3. Boundaries – 24 hour abstinence before/after
4. Utilize FSAP to reduce client’s interest in using
5. Use DeTUR to reduce reactivity to triggers
6. Meet more frequently for longer sessions if possible to get more done and quickly reduce the response to triggers
7. Use CraveEx to reduce addiction memory/shame
8. If trauma is specifically pushing the relapse, consider inpatient EMDR treatment

References
References (Cont.)


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