Trauma-Focused Approaches in SUD Using EMDR

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Indigenous Land Acknowledgement

- We respectfully acknowledge that we live and work in territories where indigenous nations and tribal groups are traditional stewards of the land. Our California office resides in Tongva territory.
- Please join us in supporting efforts to affirm tribal sovereignty across what is now known as California and in displaying respect, honor, and gratitude for all indigenous people.

Whose land are you on?

Option 1: Text your ZIP code to 1-907-312-5085

Option 2: Access Native Land website via QR Code

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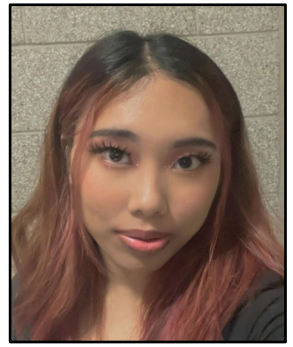

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Learning Objectives

After this training, participants will:

- Gain a general understanding of eye movement desensitization and reprocessing (EMDR) therapy.
- Learn about the application of EMDR therapy in the treatment of substance use disorder (SUD).
- Identify the eight-phase approach to EMDR therapy.

Today's Agenda

- Definition of EMDR Therapy
- Genesis of EMDR
- Experiential Process
- The Adaptive Information Processing (AIP) Model
- The Eight-Phase Approach to EMDR Therapy
- EMDR and SUD Treatment
- Q&A

What Is EMDR Therapy?

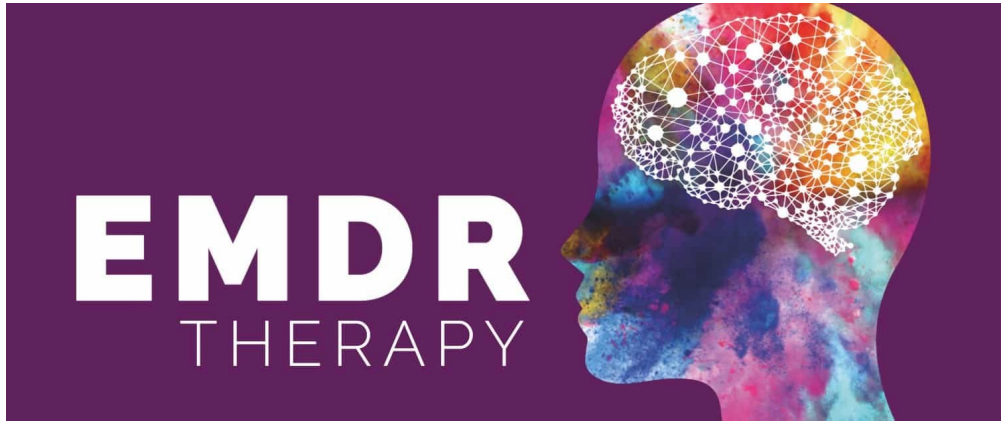


Image: EMDR-THERAPY-1.jpg (1500×630) (squarespace-cdn.com)

The World Health Organization (2013) Definition of EMDR:

“[EMDR] therapy is based on the idea that negative thoughts, feelings and behaviours 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 in the form of repeated eye movements. Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework.” (p. 1)

The EMDR International Association (n.d.a) Definition:

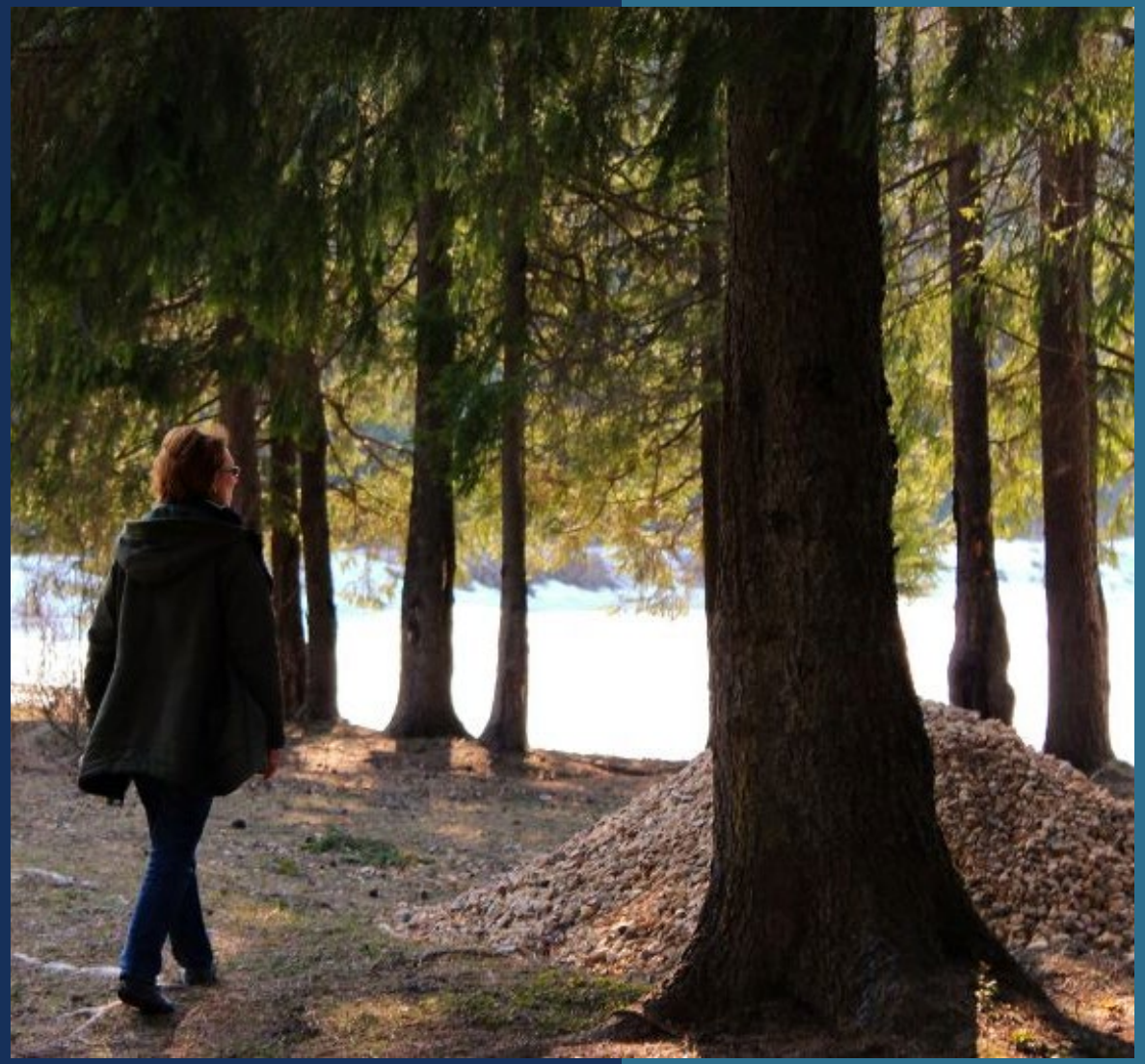
"EMDR is a structured therapy that encourages the patient to focus briefly on the trauma memory while simultaneously experiencing bilateral stimulation (typically eye movements), which is associated with a reduction in the vividness and emotion associated with the trauma memories. [EMDR] therapy is an extensively researched, effective psychotherapy method proven to help people recover from trauma and PTSD symptoms. Ongoing research supports positive clinical outcomes, showing EMDR therapy as a helpful treatment for disorders such as anxiety, depression, OCD, chronic pain, addictions, and other distressing life experiences (Maxfield, 2019). EMDR therapy has even been superior to Prozac in trauma treatment (Van der Kolk et al., 2007). Shapiro and Forrest (2016) share that **EMDR therapists in 130 countries have successfully treated millions**.”

Genesis of EMDR Therapy

Francine Shapiro's Walk in the Park:

"In 1987, Francine Shapiro was walking in the park when she realized that eye movements appeared to decrease the negative emotion associated with her own distressing memories.

"She assumed that eye movements had a desensitizing effect, and when she experimented with this she found that others also had the same response to eye movements. It became apparent however that eye movements by themselves did not create comprehensive therapeutic effects and so Shapiro added other treatment elements, including a cognitive component, and developed a standard procedure that she called Eye Movement Desensitization (EMD)." (EMDR Institute, Inc., n.d.)



Eight-Phase Approach to EMDR Therapy

1. Phase 1: Client History and Treatment Planning
2. Phase 2: Preparation
3. Phase 3: Assessment
4. Phase 4: Desensitization
5. Phase 5: Installation
6. Phase 6: Body Scan
7. Phase 7: Closure
8. Phase 8: Reevaluation

Experiential Exercise: Positive Cognitions

Excerpted from The "Greatest Hits List" of Problematic Beliefs (Negative and Positive Cognitions) Developed by Jamie Marich, Ph.D.
(May be duplicated for use in clinical settings)

Responsibility

I did the best I could.
I do the best I can with what I have.
I did/do my best.
I am blameless/I am not at fault.
I can be trusted.
I am okay/I do my best.

Choice

I am in control.
I have power.
I can help myself.
I have options.

Safety

I can trust myself.
I can choose who to trust.
I am safe now.
I can create my sense of safety.
I can show my emotions.

Power

I can get what I want.
I can handle it.
I can succeed.
I can stand up for myself.
I can let it out.
I am powerful.

Value

I am good enough.
I am a good person.
I am restored / I am sacred.
I am whole.
I am worthy.
I am significant / I am important.
I am a success.

I deserve to live
I deserve good things.
I am smart.
I can belong.
I am special.
I am beautiful / My body is sacred.

Experiential Exercise—Phase 1: Negative Cognitions

The "Greatest Hits List" of Problematic Beliefs (Negative and Positive Cognitions), developed by Jamie Marich, Ph.D. (May be duplicated for use in clinical settings)

Responsibility
I should have known better.
I should have done something.
I did something wrong.
I am to blame.
I cannot be trusted.

Safety
I cannot trust myself.
I cannot trust anyone.
I am in danger.
I am not safe.
I cannot show my emotions.

Choice
I am not in control.
I have to be perfect/please everyone.
I am weak.
I am trapped.
I have no options.

Power
I cannot get what I want.
I cannot handle it/stand it.
I cannot succeed.
I cannot stand up for myself.
I cannot let it out.
I am powerless/helpless.

Value
I am a bad person. / I am terrible.
I am permanently damaged.
I am defective.
I am worthless/inadequate.
I am insignificant.
I am not important.
I deserve to die.
I am alone.
I deserve only bad things.
I am stupid.
I do not belong.
I am different.
I am a failure.
I am ugly.
My body is ugly.
I am alone.

Image: Les Haines

Experiential Exercise—Phase 2

Resourcing in EMDR

Self-Tapping

and

The Light Stream Exercise

The Adaptive Information Processing Model (AIP)

"The [**AIP**] is the model that EMDR Therapy founder Dr. Francine Shapiro created to explain how unhealed traumatic memories are stored in the brain and ultimately lead to maladaptive responses. Until these unhealed memories are processed, maladaptive responses are likely to continue.

". . . Shapiro cites the work of Peter Lang (1977, 1979, 2000), Stanley Rachman (2000), Gordon Bower (2000), and Edna Foa & Michael Kozak (1986) as forerunners to the AIP model. The behaviorist work of Gagnè from the 1960's (for a good review, see Gagnè & Medsker, 1996) also bears many similarities to the AIP model." (Marich, 2015)

The AIP Model

This Is Your Brain:

- "The neurobiological information processing system is intrinsic, physical, and adaptive.
- "This system is geared to integrate internal and external experiences.
- "Memories are stored in associative memory networks and are the basis of perception, attitude, and behavior.
- "Experiences are translated into physically stored memories .
- “Stored memory experiences are contributors to pathology and to health.”

(Marich, 2015)

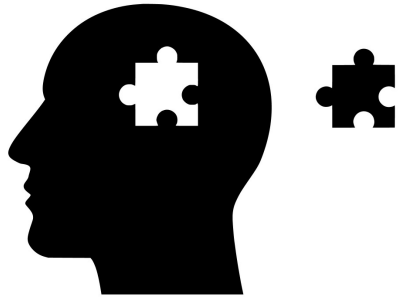
The AIP Model

This Is Your Brian on Trauma:

- “Trauma causes a disruption of normal adaptive information processing, which results in unprocessed information being dysfunctionally held in memory networks.”
- "New experiences link into previously linked memories which are the basis of interpretations, feelings, and behaviors.
- "If high levels of disturbance accompany experiences, they may be stored in the implicit/non-declarative memory system.
- “These memory networks contain the perspectives, affects, and sensations of the disturbing event and are stored in a way that does not allow them to connect with adaptive information networks.
- "When similar experiences occur (internally or externally), they link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise.”

(Marich, 2015)

The AIP Model



This Is How to Heal:

- “Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks and a transformation of all aspects of the memory.
- "Non-adaptive perceptions, affects, and sensations are discarded.
- "As processing occurs, there is a posited shift from implicit/non-declarative memory to explicit/declarative memory and from episodic to semantic memory systems. (Stickgold, 2002).
- "Processing of the memory causes an adaptive shift in all components of the memory, including sense of time and age, symptoms, reactive behaviors, and sense of self.”

(Marich, 2015)

EMDR and SUD

“While . . . varied viewpoints regarding what addiction is about are important, one crucial piece that is often missing is the sufferer’s experience of unresolved trauma (Marich and Dansiger, 2022). People often begin to use substances or engage in a behavior that helps to cope with the pain that underlies the experience of trauma. When substances or behaviors begin to interfere with relationships and responsibilities, then these coping skills have likely shifted to compulsive behavior or addiction.

"In other words, addiction involves an ongoing engagement with a behavior that in the short-term results in a positive feeling, but in the long term has negative or destructive consequences (Knipe, 2019).

“Addictions can also develop when positive feelings become rigidly linked to specific behaviors. This linkage is called a ‘feeling state,’ and positive feelings such as excitement, satisfaction, and power (among others) occur in connection with activities surrounding the use of substances (Miller, 2012). Some people struggling with addiction will report positive feelings regarding not only the substance use, but activities surrounding the substance. . . . Some people report a feeling of belonging when they smoke with friends. As a result, they continue their behavior to try to reach again that same sense of belonging.”

(EMDR International Association, n.d.b)

Image: MattysFlicks

EMDR and SUD

“Addiction is complex because it involves brain chemistry, genetics, life experiences, and environmental factors. Addiction is chronic and sufferers are prone to relapse because functional changes occur in brain circuits involving stress, reward, and self-control. People suffering from addiction crave and seek out substances despite the risk of damaging their relationships, health, finances, and career.”

(EMDR International Association, n.d.b)

EMDR and SUD

"According to Shapiro, the standard EMDR protocol for treating addictions involves reprocessing the earlier (traumatic) memories that set the basis for the dysfunction (including contributing elements to the development of addiction), the present triggers that activate disturbance, and the development of future templates for more adaptive behavior, which is essentially a form of relapse prevention for this population. Strategies for addressing specific targets related to the addiction are a valuable addition.

"Other addiction-specific modifications of standard EMDR procedures have been proposed by Vogelmann-Sine et al. (1998) and Popky (2005). Omaha (2004) introduced an approach using bilateral stimulation while bypassing standard EMDR procedures. In Europe, a rationale for applying EMDR in addicted patients that more closely follows the EMDR standard protocol has been proposed. Anecdotal reports on clinical experience have been published (Hase, 2003, 2006)." (Hase et al., 2008)

Where There's Smoke, There's Fire

“Addiction can be seen as the smoke that comes from the fire of trauma. As long as the fire is burning, there will be smoke. When there is an addiction, there is pain beneath it—pain from the trauma and pain caused by the experience of living with an active addiction. Addiction is a symptom of trauma that can often instigate more traumatic experiences. Recovery-focused treatment doesn’t focus on temporarily clearing the room of smoke. Instead, the objective becomes putting out the fire, while simultaneously building good fire-fighting skills.” (Payson & Osborne, 2021, p. 28)

Addiction “can be addressed while simultaneously upgrading survival skills to life skills. Life skills are much easier to learn and integrate when a person is less reactive to their past. By desensitizing the addiction and trauma memory networks, we promote new neural pathways to healthier adaptive thought processes. Rather than uploading new skills to a reactionary brain, addressing some of the trauma first can help the brain be more responsive and can allow for the opportunity to practice new coping skills.” (Payson & Osborne, 2021, p. 28)

"Teaching the client about the multiple pathways to recovery, healthy relationship boundaries, how to assess their support system and ask others for help are the foundational skills needed to create a healthy support system. Since addiction is a 24/7 issue and having support is crucial, this may be the focus of the first EMDR treatment plan, remembering that the work can be titrated through EMD or EMDR if there are stability concerns.” (Payson & Osborne, 2021, p. 29)

EMDR and SUD Treatment

“Some important areas to assess are:

• **“High-Risk Behaviors.** What high-risk behaviors are they engaging in? How do these behaviors work for them? What is their motivation to change these behaviors? Have they had any success in changing the pattern of using (behaviors or substances)?

• **“Healthy Behaviors.** What healthy behaviors work for them? Do they use them regularly? What gets in the way of using them? Some clients benefit from creating a ‘Top 5’ list of healthy behaviors that they can reference and access easily when triggered. These healthy behaviors or resources can be enhanced with [bilateral stimulation (BLS)] as creating a ‘safe/calm’ place. Resources can be brought into the future using the future template—allowing the client to visualize and step into the use of these skills and address potential barriers to using them.”

(Payson & Osborne, 2021, p. 29)

EMDR and SUD Treatment

• **“Dissociation.** Did you complete the [Dissociative Experiences Scale-II (DES-II)]? Do the clients understand what dissociation is, how it presents in their life, can they articulate their experiences of it? Does the client present with dissociation in session or between sessions? Are they aware of how dissociation works for them? Do you need to do further, more comprehensive screening for dissociation?

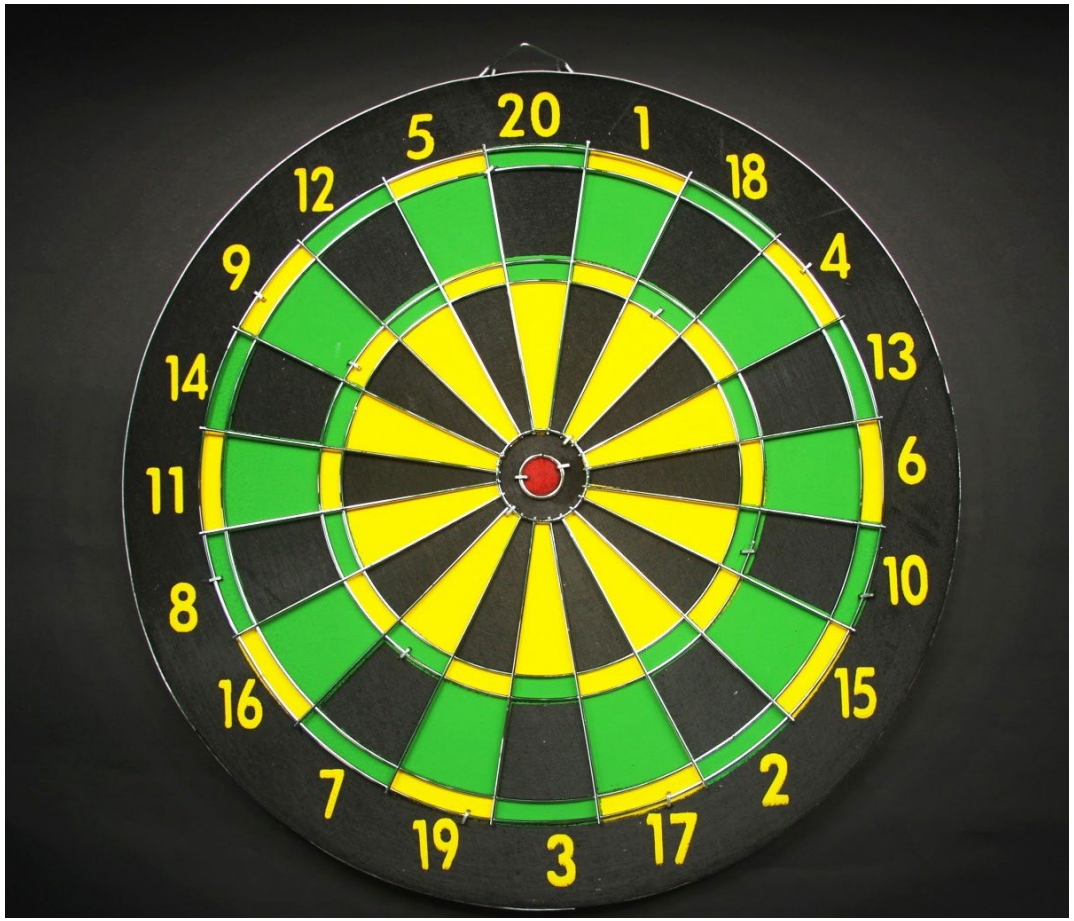
• **“Assessing for and increasing the bandwidth of their Window of Tolerance.** Are clients able to identify triggers, urges, or cravings that push them outside of the Window of Tolerance? Have they identified any healthy behaviors that can help them stay within the Window of Tolerance? Can they recognize signs or symptoms of being above or below the Window of Tolerance? If so, do they have strategies in place for how to get back? It can be helpful to create a plan with the client that identifies these areas and maps out their specific Window of Tolerance. Some clients benefit from tracking this throughout the day to help them better understand their patterns.”

(Payson & Osborne, 2021, p. 29)

EMDR and SUD Treatment

1. “Support Assessment & Development
2. “Therapeutic Relationship
3. “Regular Assessment of high-risk behaviors, healthy behaviors, dissociation, Window of Tolerance
4. “Timing
5. “What to target first? Triggers, urges, and current stressors? The memory networks that interfere with creating a solid support system? The underlying trauma?”

(Payson & Osborne, 2021, p. 30)



EMDR and SUD Treatment—CravEx

"The **CravEx** protocol sticks very closely to the basic methods and stages of EMDR but is formatted specifically for people with [SUD]. CravEx uses the concept of "addiction memory" (AM) because it closely resembles the maladaptive memory found in people with PTSD. This similarity makes EMDR a great way to treat addiction.

"Instead of focusing on a specific traumatic memory, CravEx targets memories of past cravings and relapses. It also focuses on the present instead of the past in order to address triggers and help clients remain sober. Creating a 'future template' is also very important, as it helps a client plan for future situations and know how to approach them to maintain their abstinence. Like basic EMDR, CravEx also helps to 'facilitate adaptive behavior' so that the client is able to manage their AM and triggers better in the future.

"CravEx works best when used at the same time as 'usual' treatment for addiction, like group therapy, family therapy, and peer recovery coaching. This joint approach is very effective, with clients reporting a significant reduction in cravings after one month. In addition, patients who used CravEx and typical treatment approaches were less likely to relapse after six months than clients who only received typical treatment approaches."

(FWR Staff, n.d.)

EMDR and SUD—DeTUR

Another approach of “EMDR for addiction recovery is desensitization of triggers and urge reprocessing, or **DeTUR**. This protocol differs more from basic EMDR than CravEx does.

“First, instead of one therapist, DeTUR uses a treatment team to provide more comprehensive care. Second, unlike both regular EMDR and CravEX, DeTUR works from the past to the present instead of the other way around. Third, instead of focusing on positive emotions or beliefs to address memories, DeTUR ‘accesses positive experiences through positive body states.’

“The reason for working from past to present is to get to the root triggers. Desensitization to these triggers influences the future goals for the treatment of other triggers. This approach also seems to help increase self-confidence, which increases the likelihood of staying sober.

“DeTUR also uses 12 steps instead of the eight used in EMDR and CravEx. They follow the same basic structure but focus more on client support and trigger desensitization. These steps are:

- Rapport
- History, assessment, diagnosis
- Support resources
- Accessing internal resource state
- Positive treatment goal
- Associated positive state
- Identify urge triggers
- Desensitize triggers
- Install positive state
- Test and future check
- Closure and self-work
- Follow-up sessions

(FWR Staff, n.d.)

EMDR and SUD—DeTUR (cont'd)

"A plus to DeTUR that may appeal to some clients is that it can be used by people with SUD early in treatment without too much fear of causing a relapse. Even if a client relapses, DeTUR doesn't treat it as a failure but as a new target for future treatment sessions."

(FWR Staff, n.d.)

Q & A

Thank you!

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Upcoming Events

October, November, and December Events	Time	Date
MIP Administrative Coaching Call	11:30 a.m. – 1:00 p.m.	10/15/2024
Cross-Collaborative Webinar: Human Trafficking Prevention and Mitigation	12:00 p.m. – 1:00 p.m.	11/18/2024
MIP Closeout Administrative Coaching Call	11:30 a.m. – 1:00 p.m.	12/03/2024
MIP Combined Final Learning Collaborative Celebration Session (All Cohorts)	12:30 p.m. – 1:30 p.m.	12/13/2024

MIP Hub and Past Events

Looking for past event recordings? Want to register for future events?

MIP Hub
Username: mipgrantee
Password: 2miP@hp

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