ADDICTIONS AND OTHER COMPULSIVE BEHAVIORS

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This section is offered for clinicians already trained and experienced in working with addictions. Caution is advised in the same way that one must beware of the risk and harm of treating dissociative clients without familiarity and training: If you do not know the intricacies of working with this complex population be sure to get supervision, advanced training, or refer them. "First, do no harm."

Although more controlled research is needed, a randomized controlled study targeting "addiction memory" (Hase et al. 2008), multiple published case reports (Abel & Obrien, 2010; Bae & Kim, 2015; 2012; Cox & Howard, 2007; Henry,1996; Marich, 2010) and the results of a Drug Court study (Brown et al. 2015) suggest that EMDR therapy can play an important role in the treatment of addictive and compulsive behaviors. EMDR targets the underlying "push" of trauma and the negative emotions, while also addressing the "pull" of rewarding, positive associations that are linked to a specific behavior or substance, generating a rigid pattern of triggers, cues, and responses directed toward the addictive behavior. Alternative adaptive responses are developed and strengthened, while concurrently eliminating the memory networks of experiences that drive the addiction, reinforcing powerlessness and generating hopelessness. The ultimate goal is to help the client develop a positive sense of self and a life that has meaning – often for the first time – A life worth staying abstinent for.

- Addiction is most frequently referred to as a primary, chronic *disease* of brain reward, motivation, memory, and related circuitry leading to characteristic biological, psychological, social, and spiritual manifestations; impairment of behavioral control, craving, and denial of significant problems with one's behaviors and interpersonal relationships; involves cycles of relapse and remission; is progressive, and without treatment can result in disability or death (American Society of Addiction Medicine [ASAM]).

- From an AIP standpoint, addiction is understood as a genetically *influenced, neurodevelopmental* (bio-psycho-social) *disorder* of memory, learning, and chronic affect dysregulation associated more with maladaptive neuroplasticity than a medical *disease*.

- Behaviors associated with escape from distress, or a positive reward state (e.g., euphoria, relief) may lead to functional and structural brain changes which narrow the focus of interest, motivation, and behavior solely toward the pursuit of the desired substances or behaviors.

- Once a cycle is established, addictive behavior is habituated; control over use is lost.

- Most often beginning in adolescence, addictions are strongly correlated with early childhood trauma/neglect and disordered attachments (ACE Study: Felitti et al. 1998).

- Negatively impacts the establishment of a "core sense of self" and the ability to *connect* with others (addiction is sometimes referred to as an attachment disorder [Flores 2004]).

- Co-morbidity with other disorders such as PTSD, anxiety, panic disorder, depression, bipolar disorder, ADD/ADHD, dissociative symptoms/ DDNOS and DID.

- Begins as a "solution" to otherwise unmanageable internal states and/or external conditions due to unprocessed trauma and/or developmental deficits, which impact the ability to self-regulate (Schore, 1994). "pushing" use.

- Over time, develops into a rigid, maladaptive pattern of response; emotionally charged memories of the *initial* relief and euphoric recall "pull" the individual toward their chosen solution in the form of cravings – a hallmark symptom of addiction and a target within an AIP-informed treatment plan.

- EMDR therapy focuses on desensitizing and reprocessing dysfunctional memory networks (both disturbing and rewarding) associated with the use of substances and/or behaviors.

- Outcome of successful reprocessing is predicted to lead to loss of interest in engaging in the behavior.

PHASE 1 - HISTORY / CLINICAL ASSESSMENT

- Establish strong therapeutic relationship.
  - Acceptance of client wherever they are in their addiction cycle.

- Enlist the client in a collaborative process.

- Assess for:
  - Dissociative Disorder (DDNOS, DID): if left unidentified can increase risk of destabilization, endanger client, and derail treatment.
  - Suicidal/homicidal thoughts, gestures, previous actions.
  - Lethal alcohol/drug use.
  - Major psychiatric instability (e.g. untreated bipolar disorder).

- Other critical medical concerns (e.g. seizure risk with alcohol; need for detox?).

- Motivation and readiness:
  a. Does your client *want* to stop or cut down (stage of change/motivation)?
  b. Existence of secondary gains.
  c. Can the client approach their history of trauma?
  d. What alternative coping skills do they have, if any?
  e. If they have alternatives, are they willing to utilize them?
  f. Is the client able to shift from a state of distress to a state of calm?
  g. How safe is the client's living situation? Support system?

- Identify and record:
  a. Frequency, duration, amounts, and routes of administration (drugs).
  b. Specific negative consequences of drug use or behaviors (food, pornography, gambling, shopping, Internet use, "love" addiction, etc.
  c. Specific positive or rewarding associations for <u>each</u> drug or behavior (how did each one help?).
     - What was happening in the client's life at the time they started using? (Touchstone linkage between disturbance/distress and a perceived "solution").
     - Previous attempts at reducing use or abstinence?
     - What was good about those times? Bad?
     - When use increased, what was happening at the time? When was control lost?

PHASE 2 - PREPARATION/READINESS FOR REPROCESSING: RESOURCES

- Safety is key for deeper work. What "safe" support system is the client willing to engage in? Clients in recovery need external resources in addition to individual therapy.

- Group support systems: 12-step, SMART Recovery, Buddhist Recovery, Women for Sobriety, church, temple, process groups, etc. offer the critical support, social engagement, attachment to health-oriented others, acceptance, and accountability.

- Identify and strengthen positive qualities/strengths needed for recovery:
  - Empowerment.
  - Motivation/Determination.
  - Honesty.
  - Worthiness.
  - Acceptance of leaving an "old friend."
  - Courage to "feel."

- Utilize containment strategies (e.g., a "container") that can hold all the memories that need to be processed until client is ready and able to address them. Use client's choice of container and RDI to develop and strengthen stabilization. Do not proceed into reprocessing work unless containment skill is established to assist affect regulation.

- **Positive Goal / Sober State Resource** (Popky, 2005): Assess whether a client is able to imagine a time in the future when life is good, feels desirable and compelling, without addiction. If a client cannot imagine anything positive in the future, do not proceed into trauma work. Help the client develop this "sober state" and other needed resources. Hope is an antidote to addiction.

TRAUMA PROCESSING AND THE EMDR PROTOCOL OF PAST, PRESENT, FUTURE

- The AIP model posits that the entire memory network of associations involving addictive and compulsive behaviors needs to be targeted. Clinical choice points include:
  - Specific traumatic events.
  - Triggers and urges.
  - Reward/positive feeling states, euphoric recall.

- Addiction Memory: Images, cognitions, emotions, and sensations associated with relapse, obsessions or rituals (Hase et al., 2008).

- Modifications to the standard three-pronged protocol (e.g., targeting adult-onset trauma first) may be indicated as determined by client stability, time constraints, or other variables (e.g., legal).

- **Trauma work in early recovery or without full abstinence:**
  - Clinical choice point to proceed with trauma processing when there is enough stability versus a required period of sobriety due to the notion that untreated trauma is fueling the addiction, relapse and hopelessness.
  - In treating non-abstinent clients, a "radically honest" treatment contract should be established requesting conscientious log keeping and candid reporting of all impulsive behaviors with agreed-upon consequences. May need to address fears or blocking beliefs if unsuccessful. Total abstinence on session days required.
  - Risks: Further destabilization such as relapse (if sober), psychological decompensation, suicidal ideation or intent.
  - Benefits:
    - Increased stabilization by reducing the level of "gasoline in the engine."
    - Reduced risk of relapse.
    - Sense of hope for the future, even if only a little bit of trauma is desensitized and reprocessed; the client now knows what is possible with continued work.
    - Clients learn to "feel" (alexithymia is common in this population) and manage their emotions more effectively and with "mindfulness" in the early stages of sobriety; intense, negative emotional overload (or numbness) are triggers to use.
    - Triggers and urges reduced.

- Start with Past (Standard Protocol for EMDR therapy):
  - Rationale:
    a. A specific trauma or memory network is identified as containing the foundational memories for addictive behavior *Example: Client felt responsible for father's death at age 12 (knowing it was irrational); each time she tried to get sober, this specific memory would intrude causing yet another relapse; reprocessing this "event" gave the client hope. This helped the client experience long-term sobriety for the first time and kept her in treatment.*

b. Client demonstrates sufficient internal and external resources to handle trauma work.
c. Client is engaged in a recovery treatment plan with significant support.
d. Strong therapeutic bond exists between clinician and client.

- Start with the Present: (EMD or EMDR)
  - Rationale: Reduce current distress and/or urges for clients unable to deal with past events or facing imminent challenges that might trigger the desire to use.
    a. Present triggers and urges drive addictive behavior (See Popky, 2005).
    b. Intrusive symptoms due to a recent crisis in need of desensitization (EMD may be most appropriate) to increase stability.
    c. Client is unable to tolerate exploration of past but is able to report current distress, maintain dual attention, able to "contain" past (in a container created in assess), and is responsive to EMD protocol; if able, full EMDR procedure on present disturbance, moving into past as tolerated.

- Start with the Future: (Adler-Tapia, 2012; Hoffman, 2009)
  - Rationale:
    - Client is hopeless and unable to imagine a future without their addiction.
    - Unable to tolerate exploration of the past; present triggers too distressing.
    - Minimal resources available.
  - Suggested Procedures:
    - Identify blocking belief about the future.
    - Identify needed quality to address blocking belie.f
    - Apply RDI to include future rehearsal, identifying anticipatory anxieties that may arise as potential targets for processing.

- **Targeting reward states associated with addiction**
  - Euphoric recall, positive affect and rewarding experiences associated with maladaptive behaviors are an important. element of memory to be accessed, activated, and reprocessed.
  - Example: A socially phobic young person experiences social ease and confidence when drinking alcohol or ingesting other substances.
  - These positively charged episodic memories can become linked together with the behavior and are as important to target as the underlying trauma (See Müller, 2013).

- Identify and target *avoidance* (Knipe, 2005; 2015) that reinforces the positive state (e.g., relief from the social anxiety that gets triggered at the thought of going to an AA meeting).

EMDR THERAPY: ORGANIC RELAPSE PREVENTION

- EMDR therapy may be viewed as "organic relapse prevention" in that it addresses:
  - Negative emotional states (intrapersonal) which often drive addiction such as anger, anxiety, depression, frustration, boredom, etc. that can be traced back to earlier experiences that can be processed.
  - Interpersonal problems such as conflict, maladaptive patterns of behavior with family and others, social anxiety/phobia.
  - Social pressures such as being around others who are using; target present triggers and urges (cravings) to use.
  - Positive cognitive, emotional and/or somatic states that activate urges to use.

  Future Template:
  - Generate desired adaptive patterns of response to current life demands.
  - Future movies of expected high-risk situations (people, places, things, emotional states, etc.).
  - Cravings, triggers, urges.

EMDR therapy has shown promise in a common setting for addicted individuals: Drug Court (Brown et al. 2015). Addicted individuals often resort to criminal activity (stealing, drug dealing, etc.) in order to support their habit. In addition, the mere possession of drugs (other than alcohol, cigarettes, and in some states, marijuana) leaves many addicted individuals in the hands of the criminal justice system rather than the treatment system. It is hoped that future research utilizing EMDR therapy for the direct treatment of addictive disorders co-occurring with PTSD and trauma, will expand the availability of treatment to a growing population of addicted individuals, steeped in shame and hopelessness in the revolving door of trauma and addiction.

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