EMDR Therapy in the Treatment of Trauma and Addiction

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Objectives

• Review the role of memory and learning in the development of symptoms of trauma and addiction
• Apply EMDR therapy’s Adaptive Information Processing (AIP) model in case conceptualization and treatment planning
• Describe a phased, integrated treatment of trauma and substance abuse with EMDR therapy

“If you want to treat an illness that has no easy cure, first of all, treat them with hope”

George Vaillant, M.D.

What’s trauma got to do with addiction?

Everything......
Integrated Trauma Treatment Program (ITTP) (Brown et al., in preparation)

- Thurston County Drug Court Program (Olympia, WA)
- Combined “Seeking Safety” (Najavits, 2002) with EMDR
- Treat co-occurring trauma and addiction in a drug court population
- 70% of participants reported a “Criterion A” trauma history (DSM V 2013)
- Hypothesis: Improved treatment retention, graduation, lower recidivism

If you can’t keep them.... You can’t treat them

- “Successful completion (graduation) from drug court program is the variable most consistently associated with low-post-program recidivism” (NIJ, 2006)
- Drug court program completion rates range from 27%-66% nationally (U.S. GAO, 2005)
- EMDR participants (voluntary) graduated at a rate of 91.3%

The Role of Memory & Learning in Trauma & Addiction

Trauma/ACEs

Solutions

PTSD: A Disorder of Memory and Learning (van der Kolk 1996)

- Traumatic or highly distressing experiences can overwhelm the natural information processing system of the brain
- Resulting in symptoms of posttraumatic stress, depression, anxiety, and addictions (a maladaptive ‘solution’)
- Memory is fragmented (sights, sounds, smells, emotions, sensations) resulting in “triggering” the disturbance as it was originally encoded....as if frozen in time
- These unprocessed fragments cannot link up in present orientation with more adaptive networks in the brain
“Adverse Life Experiences” vs. Criterion ‘A’ Trauma...

- A study by Mol et al. (2005) (N = 832) determined that **PTSD scores were higher for more common “disturbing” life experiences** (e.g.: divorce, bullying, unemployment, chronic illness) than for Criterion ‘A' trauma (abuse, accidents, combat)

- Robinson & Larson (2010) reported similar findings

- Implications for “trauma-informed” treatments

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Addiction: A Disorder of Memory and Learning
(Hyman, 2005; Hyman et al., 2006)

- Context + positive experience (or reduction of negative) = desire to “do the drug/behavior” (classical conditioning)

- Involve a **huge** number of pairings of cues & contexts as reinforcers....both predictable and unpredictable, conscious & unconscious

- The combination of *implicit and explicit* memories makes the associative addiction networks highly individualized and complex (infinite permutations)

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The link between Memory, Addiction, and EMDR

- Trauma and addictions are, in part, a function of memory and learning

- EMDR focuses on dysfunctionally linked memory fragments (negative and positive)

- Activates a previously ‘consolidated' memory

- Renders the memory temporarily ‘unstable’

- Introduces “new” information necessary for reconsolidation (Pedreira et al. 2004)

- Reprocesses into more adaptive, stable, present-oriented state....that generalizes

- Reconsolidates memory differently...not a competing memory (Solomon & Shapiro, 2008; Suzuki et al., 2004)

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The brain did not evolve to process information about abused substances.....

Drugs (as well as behaviors) can “hijack” the parts of the brain that reward our *necessities* such as food, sex, and socialization
“Addiction is the only disease that tells us we don’t have a disease”
Source Unknown

EMDR Therapy
Originator: Francine Shapiro (2001)

• A comprehensive treatment approach, theoretically informed by the Adaptive Information Processing model (AIP)
• Standardized 8-phase, 3-pronged protocol (past, present, future)
  1. History
  2. Preparation
  3. Target “assessment”
  4. Desensitization
  5. Installation
  6. Body Scan
  7. Closure
  8. Re-evaluation

Phased Integrated Treatment

Stage 1: History-taking, case conceptualization, and treatment planning (Phase 1 of EMDR)

Stage 2: Safety and stabilization (Phase 2 of EMDR)

Stage 3: Trauma memory reprocessing (past / present triggers) with EMDR integrated with ‘Addiction Memory’ targets (Phases 3-8 of EMDR)

Stage 4: Relapse Prevention (Future Template)
Learning to live addiction-free (All phases)
Trauma & Addiction Through the Lens of Adaptive Information Processing

- EMDR is considered a “memory-based psychotherapy”
- Unprocessed *disturbing* memories contain the specific affects, cognitions, and sensations encoded at the time of that event
- “Euphoric or positively-charged addiction memories” are hypothesized to be held in the same “isolated” manner as unprocessed trauma memories
- These maladaptively stored memories can disrupt the information processing system, leaving them isolated and unable to link up with more adaptive networks

Addiction Through the Lens of the AIP

- Addiction is an “adolescent-onset behavior” strongly correlated with attachment difficulties, trauma, and “lesser” adverse childhood experiences
- Children are particularly susceptible to negative emotions, beliefs, and a misplaced sense of responsibility
- An immature PFC leads to poor: impulse control, judgment, planning, & self-regulation (We need “adult others” to co-regulate us)
- When substances are used to self-medicate, developmental trajectory becomes “frozen in time” (arrested development)

The AIP Operationalized

- Past unprocessed, disturbing experiences are fundamental contributors to addictive and compulsive *symptoms* (“solutions”)
- Negative *beliefs* are a verbalization of the thoughts, emotions, and sensations associated with the original experience (e.g.: shame, guilt)
- Present day *triggers* maintain the cycle of symptoms
- Future *expectations and assumptions* are based on negative self-concepts (“I’m unworthy, shameful”)
- EMDR Therapy targets the *origination* of those beliefs
“Long before we start drinking or drugging, the demons grow inside, whispering their taunts:

‘You’re so stupid, you’re so weird, you’re so lonely, or maybe worst of all, you’ve been born into a long line of substance abusers.....’

(Chris Beckman)

With the AIP in Mind.....

• Disturbing life experiences contribute to the allure of addictive substances & behaviors

• The more intense the “need” (to feel a certain way) the greater the desire to get the need met

• Therefore the greater the “drive and fixation” on the addictive “solution,” which is perceived to be positive

• AIP predicts both negative and maladaptive positive experiences need to be reprocessed for full restoration of health

“Jane”
Phase 1: History

• Attachment: Given up by birth parents and not really wanted by adoptive parents

• Genetic vulnerability: Birth parents both alcoholic

• Abuse and neglect: Adoptive parents = affect dysregulation

• Collective traumas = shame, depression, anxiety

• Tries to fill the “hole in her heart” with alcohol & sex

• Easy access to all....badly supervised

“Jane” (continued)

Diagnoses: Comorbidity

• PTSD, Generalized Anxiety Disorder, Poly-drug and behavioral addictions (alcohol, cocaine, shopping, sex)

Comprehensive Treatment Plan

• Affect regulation skills (EMDR Phase 2)

• 12-step recovery and family therapy

• Phased trauma reprocessing (EMDR Phases 3-8)

• Relapse prevention (Future template: 3rd prong)
**History AIP Style**

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Event: DV at home  
NC: “I don’t matter”

Drug: Alcohol  
“Positive” FS: “Relief, euphoria”

**Phase 2: Preparation**
(Safety and Affect Regulation)

- Sober social engagement* (AA, NA, Church, etc)
- CONTAINERS / CONTAINMENT
- Heart Math
- Meditation
- Exercise
- Music
- Pleasant scents

**Trauma “Reprocessing”**
(Phases 3-6 of EMDR)

**To treat or not to treat?**

- Traditional belief in addiction treatment was “No trauma treatment prior to long-term sobriety,” but...
- What happens when the untreated trauma is fueling the substance abuse or other behaviors?
- Repeated relapses traumatize and induce hopelessness

**Phase 3: Target “Assessment”**

- Disturbing target (earliest, worst, or present trigger)
- Image (or other salient ‘frozen’ point)
- Self-referencing negative cognition (irrational) (NC)
- Preferred positive cognition (PC)
- Validity of PC: “*How true does that feel on a gut level*” (VOC: 1-7)
- Emotions
- Subjective units of disturbance (SUD: 0-10) “*How distressing now?*”
- Body sensations
Phase 3: Assessment
The “John” Target

- Image: Father pounding on the door / his death
- NC: “I am a murderer”
- PC: “I was just a child”
- VOC: 1/7
- Emotions: Anger, sadness, fear
- SUD 10 / 0
- Body: Gut & chest

Phases 4-6:
Desensitization, Installation of PC, Body Scan

Phases 7-8:
Closure and Re-evaluation

Relapse is the Nemesis of Addiction

The goal of all addiction treatment is to reduce “interest” in drugs or other addictive behaviors.....

This week I visited one of my patients hospitalized with abscesses throughout his body and bacterial invasion of his bloodstream. This man once lay down on a railway track, in a drug haze, and woke up with a shattered hip and an amputated arm. I asked him why all this wasn’t enough to make him give up drugs.....

“I spend my whole day begging, scrimping, and lying for 40 bucks to get a hit...and that gives me relief from pain for maybe 5 or 10 minutes and it gives me a freedom I can’t describe...and that 5 minutes is worth it.”

Gabor Mate
Examples of Addiction Memory

- Euphoric recall & other positively charged feeling-states associated with maladaptive behaviors
- Craving
- Relapse
- Loss of control
- Rituals
- People, places, things

Targeting the Addiction Memory

(Hase et al., 2008)

- 30 alcohol dependent patients
- Compared ‘treatment as usual’ to 2 sessions of ‘modified’ EMDR focused on the “Addiction Memory”
- Targeted memories of intense cravings, drug consumption, and relapse
- Post-tx and 1-month followup: EMDR showed significant declines in craving and fewer relapses

EMDR: 8-Phase, 3-Pronged Protocol: “Organic Relapse Prevention”

- EMDR Therapy reprocesses painful memories to a neutral or positive adaptive state (Past)
- Current triggers associated with past trauma as well as cue-driven addiction memories are targeted until they become neutral and adaptive (Present)
- After reprocessing, neither “past” nor “present” act as “triggers” or “cues” to use substances or do the maladaptive behavior

Future Template

- Generate desired adaptive patterns of response to current life demands
- Project future movie of expected high-risk situation (people, places, things) with more adaptive responses
- Target cravings, triggers, urges (Popky, 2005)
- Recent research: “Flash-forwards” and eye movements (Engelhard et al. 2010)
- Abstinence Self-Efficacy (Ilgen et al., 2005)
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