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Eye Movement Desensitization and Reprocessing in Addiction Continuing Care: A Phenomenological Study of Women in Recovery

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Traditional models of addiction treatment and relapse prevention fail to consider the role that unresolved trauma plays in an addicted woman's recovery experience. Implementing Eye Movement Desensitization and Reprocessing (EMDR) into the treatment process offers a potential solution to this problem. Ten women (alumnae of an extended-care treatment facility) participated in a semistandardized interview to share their experiences with active addiction, treatment, EMDR therapy, and recovery. With the use of A. P. Giorgi's descriptive phenomenological psychological method for analysis, four major thematic areas emerged from the interview data: the existence of safety as an essential crucible of the EMDR experience, the importance of accessing the emotional core as vital to the recovery experience, the role of perspective shift in lifestyle change, and the use of a combination of factors for successful treatment. All 10 women, to some degree, credited EMDR treatment as a crucial component of their addiction continuing-care processes, especially in helping with emotional core access and perspective shift. Implications emerge from the data on how to best implement EMDR into a comprehensive addiction treatment program.

Keywords: EMDR and addiction, gender-specific treatment, trauma and addiction, phenomenology

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Traditional models of addiction recovery and relapse prevention fail to appropriately consider the role that unresolved trauma plays in an addicted individual's attempt at recovery (Miller & Guidry, 2001; Zweben & Yeary, 2006). Although not discrediting traditional models of addiction recovery such as the 12-Step/Minnesota Model or Cognitive–Behavioral Therapy (CBT), Miller and Guidry (2001) contended that these traditional approaches tend to marginalize addicted, traumatized women more than they do their male counterparts. The literature contains several themes of relapse risk factors: poor self-efficacy and high volumes of negative emotion coupled with poor coping skills (Allsop, Saunders, & Phillips, 2000; Connors & Maisto, 2006; Donovan, 1996; El-Sheikh & Bashir, 2004; Moos & Moos, 2006; Tapert, Ozyurt, Myers, & Brown, 2004; Walitzer & Dearing, 2006; Walton, Blow, Bingham, & Chermack, 2003). Information processing models suggest that the maladaptive effects of trauma can further complicate these already problematic relapse risk factors (Gagne & Medsker, 1996; Shapiro & Solomon, 2008).

Zweben and Yeary (2006) proposed that Eye Movement Desensitization and Reprocessing (EMDR) answers the call for a more holistic approach to the treatment of trauma and addiction due to EMDR's ability to combine cognitive, body-oriented, emotional, and experiential matter into a single treatment protocol. EMDR is a therapy for posttraumatic stress disorder (PTSD) that utilizes eye movements or alternate forms of bilateral stimulation (e.g., audio tones and tactile pulses) to accelerate the body's inherent information processing system and ultimately shift traumatic memories to a neurologically more adaptive state. Developed by psychologist Francine Shapiro, EMDR uses a comprehensive, eight-phase therapeutic approach; desensitization with bilateral stimulation constitutes only one of the phases (Shapiro, 2001). EMDR has received approval as an efficacious, PTSD treatment by several major clinical bodies (American Psychiatric Association, 2004; Bisson & Andrew, 2007; Chambless, 1998; Foa, Keane, & Friedman, 2000; U.S. Department of Veteran Affairs & U.S. Department of Defense, 2004). Since its discovery in 1987, EMDR has been effectively utilized with a variety of clinical presentations related to anxiety and other forms of psychopathology (e.g., social phobias and depression) connected to unresolved, antecedent memories that do not necessarily merit a formal, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM–IV–TR*) diagnosis of PTSD (Maxfield, 2007; Shapiro & Forrest, 1997; Stewart-Grey, 2008).

Shapiro (2001) constructed the adaptive information processing model as the theoretical basis for EMDR, recognizing that an experience does not have to qualify as a *DSM–IV–TR* Criterion A trauma (typically a life-threatening experience) to be traumatic. In her model, surviving war combat (a Criterion A trauma) and growing up in an emotionally abusive home (not a clear Criterion A trauma) can be equally impacting, depending on the person and her ability to make sense of traumatic experiences. The adaptive information processing model includes a formula for moving dysfunctionally stored information to a more adaptive, functional place:

(a) Access the target information (i.e., the dysfunctionally stored memories).

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(b) Stimulate the information-processing system in a dynamic way (i.e., with bilateral stimulation).

(c) Move the information to an adaptive resolution in order to solve the presenting problem.

For instance, if the survivor of a sexual assault learned, "I am damaged goods" as a result of her trauma and has remained stuck in that message, through bilateral reprocessing, the survivor is able to learn more adaptive information about herself. More adaptive beliefs would include material such as, "It wasn't my fault," or "I am alright just as I am." Receiving this new information at various levels of her being (sensory, cognitive, emotional, physical, and perceptual) can facilitate a resolution of the presenting problem, including problems that may be complicating establishment and maintenance of addiction recovery.

The validation of EMDR for the treatment of PTSD has been rich (Bisson & Andrew, 2007; Ironson, Freund, Strauss, & Williams, 2002; Maxfield & Hyer, 2002;Power et al., 2002; Van Etten & Taylor, 1998). Furthermore, the comorbidity between substance use disorders and PTSD has been well-established (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Najavits, Weiss, & Shaw, 1997; Ouimette & Brown, 2002; Peirce, Kindbom, Waesche, Yuscavage, & Brooner, 2008), especially in women (Miller & Guidry, 2001; Najavits et al., 1997). Zweben and Yeary (2006) contended that unaddressed PTSD or trauma is a relapse factor in many clients with substance use disorders. Since the inception of EMDR, the treatment has been used successfully with appropriate clients who have a substance use disorder, justified by the established comorbidity between PTSD and substance use disorders (Brown, 2003; Lipke, 2000; Shapiro & Forrest, 1997; Shapiro, Vogelman-Sine, & Sine, 1994; Zweben & Yeary, 2006).

EMDR and Addiction Treatment

Until recently, most of what investigators published about EMDR and addiction consisted of clinical report and case study research. These reports and case studies, along with reviews analyzing these reports and their implications (Brown, 2003; Lipke, 2000; Shapiro et al., 1994; Zweben & Yeary, 2006) suggested that EMDR, when used properly by trained clinicians, "is a powerful tool for trauma resolution, but it must be carefully integrated into addiction treatment" (Zweben & Yeary, 2006, p. 115).

Several of the existing sources on using EMDR in the treatment of addictive disorders can be described as clinical proposal based on extant field experience. Rougemont-Buecking (2007) and Brown (2003) presented neurological literature reviews to defend EMDR's role as the potential missing piece in treating addictive disorders. Popky (2005) and Barbieri (2008) published pieces on their creative alterations to the EMDR protocol. Shapiro and Forrest (1997) proposed several guidelines for using EMDR with addicts, and Parnell (1997) included an extensive case of an addicted client in one of her books.

A recent thrust in momentum related to EMDR and addiction research is evident in the literature. Ricci, Clayton, and Shapiro (2006) and Ricci and Clayton (2008) addressed sexual deviation and sexually acting out as phenomena similar to addiction. Ricci et al. noted that, as with addiction, recidivism to problematic behaviors is high among offenders. In their study, 10 incarcerated child molesters (molested themselves as children) were treated with a course of EMDR therapy as an adjunct to standard CBT and relapse prevention therapy. Significant differences existed between the EMDR group's decrease in sexual arousal, increase in motivation for treatment, and increase in empathy for the victim.

Cox and Howard (2007) presented relevant qualitative data on how a 21-year-old sexually addicted client responded favorably to EMDR in 15 sessions; in this study, the resolution of core traumatic memories positively impacted the client's use of relapse prevention skills. Cox and Howard called for further research on using EMDR to enhance the entire addiction and recovery process. Research by Brown and Gilman (2007) demonstrated EMDR's positive impact on treatment completion in a county drug court program in the Pacific Northwest. Clients meeting criteria for PTSD who opted for Gilman and Brown's Integrated Trauma Treatment Program (using a combination of EMDR and L. M. Najavits' *Seeking Safety* program) graduated from the drug court program at a rate of 90%, whereas those who declined EMDR and completed only *Seeking Safety* groups graduated at a rate of 31%.

In a German hospital setting, Hase, Schallmayer, and Sack (2008) found that the group of alcohol-dependent clients receiving treatment as usual along with EMDR showed a statistically significant reduction in addiction craving 1 month posttreatment in comparison with the group receiving only treatment as usual. Hase et al. (2008) also found a statistically significant difference in relapse at 6-month follow-up. Marich's (2009) case study showcased a cross-addicted woman treated in a 12-step facilitation program followed by 15 sessions of EMDR over a 9-month period. Marich's case had never achieved more than 4 months of consecutive sobriety in 12 years of attempting multiple inpatient and outpatient treatment programs. After the episode documented in the Marich article, the case achieved 18 months of sobriety and was finally able to complete the 4th and 5th steps in her Alcoholics Anonymous program, a feat that was insurmountable in previous treatment episodes because of the complications of trauma. The research conducted by Brown and Gilman (2007), Hase et al. (2008), and Marich (2009) are relevant to addiction research in general because they respond to a call made for increased addiction research in usual care settings. Tucker, Donovan, and Marlatt (1999), although acknowledging the relevance of randomized, controlled research, asserted that such research designs are contrived and not optimally reflective of real-world treatment settings. The major studies completed thus far on the use of EMDR in addiction treatment are all representative of "usual care" research, an important domain of addiction studies.

Research Purpose and Foundation

Although the studies cited in this literature review constitute a positive beginning to the research on using EMDR with addicted individuals, even more experience-based data are needed from addicted clients to evaluate implementation and impact. A phenomenological research study is the optimal design to investigate themes of client experience in the usual care setting. Phenomenology, a philosophical approach attributed to Edmund Husserl (1859–1938) that blossomed into phenomenological research methodology, rejects the Galilean idea of seeing the world through mathematical principles (Crotty, 1998). Exploring the subjective, human experience is at the heart of phenomenological inquiry. In addiction studies, White and Kurtz (2006) proposed that professionals in the field must not simply measure sobriety by tallying

days sober, tracking the number of 12-step meetings attended, or calculating the number of clean urine drug screens. Rather, the field needs to embrace an approach to recovery that monitors the whole person and respects their individual experiences; this is especially important in the treatment of women because of their susceptibility to marginalization in traditional treatment, and in larger society. The principles of phenomenological philosophy provide a framework for investigating the whole person in recovery.

The purpose of this study is to explore (a) the lived experiences of women participating in EMDR treatment as part of their addiction continuing care and (b) the impact of the EMDR experience on their lives as individuals recovering from addiction. Addiction is the entire pattern of maladaptive behaviors, cognitions, belief systems, consequences, and their effects on others, not just the specific act such as drinking, using drugs, or sexual compulsivity (Hagedorn & Juhnke, 2005). The term *addiction* is favored in the study because of its emphasis on totality of the problem, as opposed to *chemical dependency*, which refers to any of the *DSM–IV–TR* (American Psychiatric Association, 2000) descriptions of *substance dependence*. Continuing care refers to the professional or informal measures that an addict takes to maintain recovery in the period of time after the initial phase of addiction treatment is completed and initial sobriety is established; continuing care is often referred to as *aftercare* or *relapse prevention* (White, 1998; White & Kurtz, 2006). *Recovery* means the process by which an individual is actively taking measures to keep his or her addiction in remission (White & Kurtz, 2006). Recovery, in the context of this study, is more than abstinence from chemicals or problematic behaviors; rather, it is a process in which an individual takes active measures to repair the life damage caused by addiction (Evans & Sullivan, 1995).

Method

A qualitative, phenomenological design was used, with semistandardized interviewing (also known as *semistructured interviewing*) as the primary modality of data collection. The researcher developed an original, semistandardized interview instrument (see the supplemental Appendix online) to elicit experiential data that would best address the purposes of the research. McCracken's (1988) *The Long Interview* and a qualitative study on the use of EMDR with sex offenders (Ricci & Clayton, 2008) were a guide for structuring the questions. Another major factor influencing the development of the questions was the investigator's induction to phenomenology and phenomenological inquiry. Further refinement of the semistandardized interview instrument occurred after a field-tested interview (Marich, 2009). The field test case is not included in this data set because she was the researcher's former client. For this main study, the investigator decided to obtain a sample of female clients that she did not treat to ensure a greater degree of objectivity.

Sampling Design

A purposive sampling design was implemented for this study. Purposive sampling is used largely in exploratory research or field research, and cases are selected on the basis of judgment for the unique qualities that these cases offer in addressing a research problem (Neuman, 2006). On the basis of Neuman's (2006) description, purposive sampling was quite useful in achieving the aims of this research. The sampling design used for this research does not, however, locate all possible cases. Hence, an element of criterion sampling, in which a researcher establishes criteria and then identifies cases to meet the criteria (Mertens, 2006), was incorporated into the sampling design of this research. Both of these sampling designs are characteristic of phenomenological research (Starks & Brown-Trinidad, 2007).

Participant recruiting was a joint effort between the researcher and the women's treatment facility that collaborated in this research study. The researcher believed that to enhance the credibility of this study, it was vital to interview women with whom she had no role in treating. After the researcher's academic institution granted Institutional Review Board (IRB) approval, the facility invited several hundred alumnae of its program by mail, phone, and public announcement (at community events) to participate in the study. All reasonable attempts were made to contact adult (i.e., 18 years old and over) alumnae treated at the facility since their initiation of EMDR programming in the mid-1990s. To meet criteria for participation in the study, at least 6 months needed to have passed between engagement in EMDR treatment and the time of an interview arrangement. Six months is a time frame established by the researcher to allow for some element of perspectival reflection on lifestyle change and recovery experience. Identification as an *alcoholic* or *addict* was not necessary to participate, but an addiction treatment episode had to take place. A formal diagnosis of PTSD was not necessary to participate because the emphasis of the study is on the recovery experience and because preliminary evidence indicates that EMDR can be useful in presentations other than PTSD (Shapiro & Forrest, 1997; Stewart-Grey, 2008).

To allow for the possibility of negative case analysis, the researcher stipulated that all eligible participants be invited to participate, not just those participants who had good experiences with EMDR. Interested participants contacted the liaison from the partnering treatment facility, who secured release of information documents to allow for correspondence with the researcher. A brief telephone screening was then conducted to determine appropriateness (e.g., 6 months since last EMDR session and acknowledgement of informed consent parameters). Participants were given a short orientation to the interview process and were debriefed about what to expect. With the written permission of the participants as part of the informed consent process, all of the interviews were audiorecorded and then transcribed.

To conduct a successful phenomenological study, the researcher set out to obtain at least 7 eligible participants to engage in the semistandardized interviews. Seven is a manageable number, yet it is large enough for qualitative research to make thematic comparisons among the interviews. A maximum of 10 participants was established by the researcher. This number sounds small from a quantitative perspective, but in qualitative, phenomenological research, 10 in-depth interviews carry more value than would a vast sample of general data measures (e.g., pre- and posttests or Likert scales). The sheer volume and immensity of qualitative interview data are often a challenge for a researcher, and for many scholars, this volume presents one of the greatest setbacks of qualitative research (McCracken, 1988). Hence, the researcher found it prudent to set a limit for the sake of time and resource management.

Generalizability, a term that carries quantitative research connotations, is not a primary goal of phenomenological research (Crotty, 1998). A concept that is more appropriate for qualitative research is that of transferability (Morse, Barret, Mayan, Olson, & Spiers, 2000). *Transferability* implies that the results of this research study are not only relevant to the treatment center at which the research was conducted but also to other treatment centers with similar characteristics and population. With the use of thick description presented later in the article, reasonable comparisons can be drawn between the treatment centers used in the study and other treatment centers in the United States.

Data Analysis

A properly selected, systemized data analysis procedure is a crucial component of establishing credibility in a qualitative study. Data analysis procedures for qualitative data offer researchers a step-by-step method to follow for reading, coding, and interpreting the data. Otherwise, a qualitative researcher can be easily accused of reading the data simply to find the passages she is looking for to support her own preconceived notions. Three systems of phenomenological data analysis were considered for this study in the works of Moustakas (1994), Giorgi (1997), and McCracken (1988). The system presented by Moustakas seemed best-suited for conducting heuristic research, which is why his method was eliminated as an option for this study. Although McCracken's work has been an invaluable component of this study in terms of qualitative study design and interview-structuring guidelines, the work of Giorgi was ultimately selected as the primary analytical system for this study because his work is specifically based in phenomenological theory. Moreover, Giorgi's system of data analysis has not yet been used in qualitative studies on EMDR, so incorporating his system will add another level of depth to the qualitative literature on EMDR.

The Giorgi (1997) method was showcased as an optimal method for analyzing phenomenological, qualitative data in the American Psychological Association text *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design* (Camic, Rhodes, & Yardley, 2002). Giorgi's approach emphasizes the importance of what he calls the scientific phenomenological reduction. This attitude references Edmund Husserl's original desire to investigate an organism's motivation. According to Husserl, the father of phenomenology, investigating motivation goes deeper than simply identifying what exists in the world, an attitude concomitant with natural sciences and more quantitative forms of inquiry (Giorgi, 1997). Rather, investigating the experience is critical to understanding the motivation.

The steps of Giorgi's Descriptive Phenomenological Psychological Method are as follows (Giorgi & Giorgi, 2003, p. 254):

1. Within the attitude of the scientific phenomenological reduction, the researcher reads the transcription or description to grasp the basic sense of the whole situation. Nothing more is done at this stage.

2. The researcher, remaining within the scientific phenomenological reduction, then creates parts by delineating psychological meaning units. A meaning unit is determined whenever the researcher, in a psychological perspective and mindful of the phenomenon being researched, experiences a transition in meaning when he or she rereads the description from the beginning. Slashes are placed in the description in appropriate places.

3. The researcher, still within the scientific phenomenological reduction, then transforms the participant's everyday expressions into expressions that highlight the psychological meanings lived by the participant. This requires the use of free imaginative variation as well as rendering implicit factors explicit.

4. On the basis of the transformed meaning units and still within the scientific phenomenological reduction, the researcher uses the transformed meaning unit expressions as the basis for describing the psychological structure of the experience.

Giorgi's analytical system, which was selected before the interviews were even conducted, is compatible with the phenomenological purposes of this study. In his system, four major levels of data analysis are incorporated to foster inductive reasoning by the researcher and extrapolate the essence of the data's meaning. In summary, the researcher reads through all of the transcribed data, then uses hash marks to break the data down into separate meaning units (e.g., if drinking is being discussed, that is one meaning unit; once the expression transitions to sexual assault, a new meaning unit is started). Then, each meaning unit is translated into a psychologically identifiable description or expression (e.g., if the passage on drinking addresses physical illnesses that result, the classification of *addiction consequences* can be made). Giorgi's fourth and final step requires the researcher to present the analytical results in the form of psychologically recognizable themes.

Thick Demographic Description

The partnering treatment center on this research project is located in a large capital city in the urban Midwest. The program offers long-term addiction, trauma, and mental health treatment on an outpatient basis, integrated with safe and affordable housing. There are more than 100 transitional and permanent housing units underneath the program's umbrella, and every year, approximately 150 women and 100 children are treated. The average length of stay is 29 months (Price, 2008), which means that more rigorous levels of treatment are used at earlier phases of the process, and the women transition to a phase that is concomitant with continuing care after certain behavioral milestones are reached. Continuing care, as conceptualized by this facility, is an ongoing process that commences when the women are still therapeutically monitored and in safe housing situations provided by the facility. According to the facility's Chief Executive Officer (CEO; personal communication, March 9, 2009), their programs receive state and county funding, in addition to federal grants that are obtained on an intermittent basis. Private donations and funding are a crucial part of subsidizing what the facility is able to offer, especially to indigent women.

The CEO and 8 other women conceptualized the facility in the early 1980s when they observed that the needs of women were not sufficiently or respectfully addressed in 12-step meetings and

conventional treatment. Designed to enhance the possibilities of traditional recovery approaches, the program was originally established as a single sober house. The program has since developed into an entire organization encompassing multiple housing units and offering a plethora of services to recovering women and their children (e.g., transportation to 12-step meetings, life skill classes, child care, General Educational Development [GED] preparation, social work services, specialized treatment groups, medical care, and psychoeducation). Even the CEO described the founding of the program using phenomenological language in the community handbook: "As a result of our *lived experiences*, we knew that women needed a safe, drug free, nurturing environment where they could have the time and resources necessary to heal from their addictions and often from physical and sexual abuse" (Price, 2008, p. 2). The program is dedicated to treating women and their families in a holistic manner considering the physical, emotional, mental, and spiritual needs of their clientele (Price, 2008).

The CEO (personal communication, March 9, 2009) shared that one of her former clinical directors introduced EMDR to their facility sometime in the mid-1990s. The CEO stated, "I mean, we just knew it made a difference. They weren't relapsing. They weren't leaving. I think we changed our length of stay; it improved." The CEO shared that the long-term nature of their programs makes EMDR especially feasible because women have time to get into the deep issues that will eventually affect them in an adverse way.

The women in this study ranged in age from 27 from 52 years (M = 41.7, median = 46.5). Four of the participants identified as African American (or Black), 5 identified as Caucasian, and 1 identified as mixed European-Iranian. The time in continuous sobriety reported by each participant ranged from 1 to 6 years (M = 3.75 years; median = 3.625 years), and various primary addictions of choice were represented by the sample. Five of the women in the sample were no longer associated with the facility in any way, and the other 5, although not actively in treatment, still lived in housing arranged by the facility. The participants reported a variety of religious, educational, and parenting/family experiences. Eight of the participants reported prior addiction treatment episodes, 1 participant reported no prior treatment, and 1 participant reported prior treatment at a correctional facility only. According to the Director of Trauma Services at the partnering facility (personal communication, March 9, 2009), EMDR was incorporated into the treatment plans of each respective participant on the basis of her respective treatment team's evaluation of her needs and readiness. Thus, the time of EMDR implementation into the continuing-care process varied (from 1 month of observed sobriety to 2 years among the sample) because of the facility's individualized treatment plan philosophy. The experiences reported in supplemental online Table 1 are all relevant traumas that were addressed using EMDR. Table 2 (see supplemental online materials) chronicles the addiction progression patterns of the participants and their prior attempts at treatment. Each participant is identified in this study by a randomly selected female pseudonym.

Results

The fourth and final level of Giorgi's Descriptive Phenomenological Psychological Method calls for the researcher to take the transformed meaning units from the data and, with the purpose of conveying participant experience, to describe the psychological structure of the data (Giorgi, 1997; Giorgi & Giorgi, 2003). The experience of the sample can be described through four major psychological themes: *safety* as an essential component of the EMDR experience, the importance of accessing the *emotional core* as vital to the recovery experience, the role of perspective shift in *lifestyle change*, and *using a combination of factors for successful treatment*.

Theme 1: Safety

All 10 of the participants shared experiences that referenced the important role that safety played in their treatments, specifically in their respective EMDR experiences. The participants (whose personal senses of safety were threatened at various stages throughout their respective trauma and addiction histories) needed to feel that they were not going to be attacked or belittled in order to open up in the meaningful way that EMDR fosters. Four subthemes present the various ways that safety was established and assured for the participants: the treatment setting, quelling initial skepticisms about EMDR, the role of the EMDR therapist, and features of the EMDR approach.

Seven of the participants directly referenced the treatment facility and its programs as establishing a climate of safety. There are several key elements that made it a safe setting for the participants, notably the milieu of women with similar histories, the progressive nature of the facility (e.g., willing to address trauma), and optimistic reception by facility staff. One of the most significant examples of how the treatment center created safety is from Fadalia's experience. Fadalia, who was treated approximately 25 times prior, shared, "The people that I worked with here communicated to me somehow that they believed that I could really stay clean. I never really experienced that before." Fadalia feels that she would not have gotten well if she was greeted cynically as she had been at other treatment centers; such receptions reinforced her inner sense of shame. She further noted that she would not have felt safe to open up and do EMDR had she been greeted with cynicism and doubt.

Nine of the participants shared that they experienced some level of skepticism when clinical staff first presented EMDR as a treatment option, ranging from mild hesitation, to outright fear that the treatment facility was trying to control them. There were several factors that ultimately allowed the women to feel comfortable with the EMDR approach (e.g., simple education from counselor, mustering internal willingness, hearing positive experiences about EMDR from other members in the therapeutic community, and trusting in a reliable counselor). The therapeutic alliance represents the third subtheme related to safety. In summary, feeling that they were in capable hands with their EMDR therapists facilitated fulfilling EMDR experiences for the women. JoElle and Cindy were 2 participants who needed to switch EMDR therapists before they experienced good results, and they directly attributed these results to feeling more comfortable with their new therapists. Not only did participants recognize the value of the therapists, many credited certain features of the EMDR approach—such as safety preparation, orientation, and session closure—because these strategies facilitated personal safety for them.

Theme 2: Accessing the Emotional Core

Throughout her interview, Sasha steadily referred to the existence of core issues that plagued her throughout her years in addiction. She believes that EMDR was the approach that finally helped her to resolve these core issues and live a meaningful life in sobriety. Sasha shared, "I was a chronic relapser. And I think that was because, now that I have some awareness of a lot of that, I think it was because I didn't get to none of my core issues." Although Sasha was the only participant to use the term *core* directly and steadily, her descriptor most accurately targets an essential experience shared by all of the participants: suppressing the expression of feelings related to their most central, critical life experiences while in active addiction. All 10 of the participants indicated that EMDR played a critical role in addressing the emotional core, which ultimately impacted their recoveries. This thematic category can best be understood through three subthemes: recovery roadblocks, the role of EMDR in addressing core emotions, and impact on recovery.

For every participant, some barrier stifled successful recovery during previous attempts to get clean, either in treatment or on her own. Several of the women specifically identified external barriers, whereas other women directly identified their negative thinking, or cognitive schema, as roadblocks. As Table 1 suggests, negative cognitions can be acquired through traumatic experiences. The most prevalent recovery roadblock experienced among the women was the inability to show emotions or feel what they needed to feel about distressing life experiences. As the adaptive information processing model proposes (Shapiro, 2001), these blocked emotional expressions inhibited adaptive processing of the distressing experiences, leading to negative beliefs about the core self and resultant maladaptive behavior.

For all 10 of the participants, EMDR played a role in addressing emotional issues that affected their core selves and ultimately impacted their addictive processes. Mae revealed that the material she addressed in EMDR sessions was not only embedded within her, it was "tattooed" on her heart. Mae credits the EMDR component of her treatment as the technique that finally got her to feel the feelings that she had stifled for so many years. Fadalia explained that, for her, EMDR was like having a car window defogged. The EMDR brought up clarifying images that reprieved her of self-imposed shame.

All participants identified some level of connection between EMDR's ability to access their emotional core and its resultant impact on their lives as recovering women. Some women were very direct in highlighting this impact. Sasha asserted that she likely would have relapsed had she not dealt with her core issues through EMDR. Cindy believes that treating her trauma through EMDR eliminated the majority of her mental health symptoms, even the traits of her borderline personality. JoElle believes that EMDR helped relieve her of the pain that she would have used over in the past. She no longer experiences a desire to cover up cognitive or emotional triggers because they do not affect her with the same level of intensity. Similarly, Terri feels that past work with EMDR has been crucial to her recovery because her addictive tendencies started in the past. Nya revealed that EMDR directly impacted her sobriety because disturbing or distressful stimuli no longer seem as paralyzing as they used to; she feels that one of the reasons she overreacted in the past was that she carried so much suppressed emotional material.

Thematic Category 3: Lifestyle Change

All of the participants experienced major changes in their lives as a result of their addiction recovery. However, to achieve these major benefits of recovery, the participants also had to change certain aspects of their lifestyles. For the participants, many of the positive lifestyle changes resulted from perspective shifts that occurred as a result of EMDR. The theme of lifestyle change was apparent throughout the interview data, and it can be further described through three subthemes: characteristics of active addiction, the perspective shift, and behavioral/attitudinal change.

All 10 of the participants recognized clear negative traits about themselves, their behaviors, their attitudes, and their actions in addiction. Even the 2 participants who were self-described "high-functioning addicts" (because of their ability to keep a job and live certain aspects of a regular life while using) admitted that their addictions changed who they really were as women. Within the sample, the following nouns surfaced to describe the self in active addiction: *cheater*, *liar*, *monster*, and *thief*. The participants used the following adjectives to describe themselves and their behavior in active addiction: *angry, crazy, deceitful, dishonest, easily offended, entitled, exploitive, fearful, hopeless, insane, rationalizing, manipulative, miserable, promiscuous, rageful, sad, selfish, secretive,* and *unpredictable*.

Nine of the participants reported some type of perspective shift that happened during their treatment either as a result of the EMDR or as a result of the EMDR combined with another aspect of their treatment. These shifts were critical in changing their beliefs about self and their attitudes towards their pasts, their lives, and their recoveries. For many of the participants, the perspective shift about a past issue brought on by EMDR proved to be tremendously healing. Becky's mother died of breast cancer when she was 6 years old, and shortly after her mother's death, her father married her maternal aunt. Becky shared that she was resistant to talk about her mother's death when she entered treatment; she had been in denial about her mother's death for many years, despite being haunted by it. Through EMDR, a perspective shift took place in which she realized that her mother's death was not the end of the world and that she did not have to drink or use because of her mother's death. Becky further recognized that her mother is now "in a better place" and did not choose to abandon her. Additionally, Becky was able to transition from being angry and bitter about her mother's death to being grateful that she at least got to know her mother for 6 years.

Several major changes in behavior and attitude towards self, life, and recovery resulted from the perspective shifts experienced during EMDR. These behavioral and attitudinal changes have been critical factors in empowering the participants and increasing their overall self-esteem. Within the sample, this increase in self-esteem corresponded with improved life functioning in several critical areas. Eight participants reported that they are content to be alone with themselves today, a concept that would have scared them in active addiction. Becky, Mae, Cindy, and Sasha are all making active choices to live as single women while they continue to work on themselves. Linda and other participants highlighted the im-

portance of restored priorities in their lives today. Many of the women in the sample indicated that they struggled with the concept of God or a Higher Power because of being raised in rigid or otherwise intolerant church traditions. For 5 women in the sample, experiencing perspective shifts allowed them to feel more comfortable with their spirituality.

Thematic Category 4: Using a Combination of Factors for Successful Treatment

The experiences of the women in the sample indicate that EMDR should not be used in isolation as a treatment intervention for addiction. In this thematic category, four subthemes explain the combination of factors that were needed, in addition to EMDR, to ensure successful treatment and continued recovery processes for the women in the sample: (a) the treatment program's groups, classes, and services, (b) 12-step recovery meetings, (c) self-care measures, and (d) motivational factors.

All 10 of the participants spoke very highly about the quality of services offered in the treatment program. JoElle commented, "They saved my life. They do a whole lot for you." The experiences of the other 9 participants support JoElle's sentiments. All of the participants were required to attend 12-step meetings as part of their treatment programs. At the time of the interviews, 7 participants described themselves as actively involved with 12-step groups, 2 described themselves as marginally involved, and 1 participant noted that she no longer attended 12-step meetings. The majority of the women in the sample worked through all 12 steps at least once, and 9 of the 10 participants indicated that they were able to work fourth and fifth steps. The participants utilized 12-step recovery in various ways, and some were even able to see the connection between their 12-step work and EMDR.

Six of the participants identified self-care measures outside of 12-step recovery that they learned while in treatment or that they continue to maintain in their recovery following treatment. For Cindy, the participant who is not currently active in 12-step recovery, work with a counselor twice a month is the most important part of her maintenance. Several participants view some very basic lifestyle choices as self-care measures. For instance, Mae is actively choosing to stay out of romantic relationships so that she can spend some prolonged time getting to know herself better. Linda improved her eating habits and lost a great deal of weight over a two-year period to assist with her overall health. Fadalia maintains daily spiritual contact with her Higher Power, often in the form of small prayers "on the run, while in the car" due to her hectic schedule. Nya still uses the art therapy techniques that she learned in treatment, taking time to draw at home when her inner child needs attention.

For all 10 of the women in the study, motivational factors existed that helped them acquire recovery during their respective treatment episodes. Some of these motivational factors were external, while others were internal. Becky, Denise, and Linda all entered treatment for seemingly external reasons; however, all of them experienced change while in treatment and eventually tapped into their internal motivations for staying clean and sober. Several of the participants described major turning point experiences. Fadalia called hers a "moment of clarity," and JoElle labeled hers a "spiritual awakening." Terri was motivated to get help for her addiction after a suicide attempt. JoElle, Mae, and Sasha reported a general sense of tiredness with the addiction lifestyle, and both Mae and Becky believed that their own aging processes helped motivate them to change. Many of the participants were able to tap into characteristics deep within themselves that they had been unable to access previously. Five of the participants credited their spirituality as a motivating factor in remaining clean and sober.

Discussion

As a whole, the participants had a positive experience with EMDR as part of their addiction continuing care. All 10 of the women who came forward through the established recruitment process expressed positive sentiments about their EMDR experiences, and in various degrees, they credited their EMDR treatment with being a crucial component of their addiction continuing-care processes. The EMDR that participants received at the partnering treatment facility was conducted in a manner that protected their individual safety (Thematic Category 1). The structure of the treatment program itself and the sense of encouragement that staff conveyed were important to the establishment of safety. Additionally, the program's commitment to quelling doubts about EMDR, securing healthy therapeutic alliances between therapist and participant, and adhering to the EMDR process, which includes features for safety as formulated by Shapiro (2001), all contributed to participant safety.

The participants saw the value of EMDR in helping them access their core emotional issues (Thematic Category 2). It was meaningful because this access helped them to address emotional issues that they had suppressed for a long period of time. The majority of participants acknowledged that this suppressed material contained many of the issues and negative self-beliefs that had prompted them to use drugs or alcohol or engage in other addictive behaviors. Addressing these issues was part of an extensive cathartic process that the participants were able to identify as valuable and meaningful.

Participants also identified elements of their treatment experiences other than EMDR that were meaningful to them (Thematic Category 4). These other elements produced a positive synergistic effect when engaged in or accessed alongside of EMDR. These other elements included groups and services offered by the treatment facility, 12-step recovery programs, self- care measures, and motivational factors (both external and internal). Some of the participants in the sample directly credited EMDR as the reason that they are sober today. However, most of the participants shared experiences about how their perspectives on self, others, and situations were altered by EMDR. These perspective shifts resulted in meaningful lifestyle changes (Thematic Area 3) that were critical to developing healthy, enduring recoveries.

The women in the study reported experiences with EMDR that differed from other treatment approaches that they previously tried. In articles published 12 years apart, Shapiro et al. (1994) and Zweben and Yeary (2006) proposed that EMDR be used after the initial phase of treatment when an individual achieves stabilization from the immediate effects of the addiction (i.e., in the continuing-care process), and when an individual shows an ability to affectively regulate themselves to a reasonable degree. This study provides qualitative evidence to support the proposals made by both sets of authors.

Zweben and Yeary (2006) called for the optimal setting for incorporating EMDR treatment to be further evaluated (e.g., inpatient vs. outpatient). This study suggests that there are merits in using it in both settings as long as safety needs are addressed (Thematic Area 1) and other services and supports are in place within a larger system (Thematic Area 4). Zweben and Yeary (2006) also contended that further study would elucidate the conditions that maximize a client's chance of success. The lengths of continuous sobriety in this study ranged from 1 to 6 years (M = 3.75 years; median = 3.625 years), and by most standards these figures indicate that the participants are experiencing a successful recovery. Two of the thematic categories that emerged from the data, Safety and Using a Combination of Factors for Successful Treatment, offer guidelines for maximizing success with EMDR in female clients.

This study is the only known research to specifically examine the use of EMDR with recovering female addicts. Comorbidity between addiction and PTSD is higher in women than in men, yet the unique treatment needs of women have often gone unaddressed (Miller & Guidry, 2001; Price, 2008). Women are much more likely to enter addiction treatment with concerns about child care, feeling unsafe in a coeducational environment, and presenting with a history of sexual trauma (Evans & Sullivan, 1995; Miller & Guidry, 2001; Price, 2008). This study emphasizes what a critical role safety plays for women in addiction recovery, and this is a point that needs to be more widely respected by treatment programs. This study also shows that it is possible and often favorable to integrate EMDR services into a gender-specific program that honors safety and provides a holistic range of services.

Limitations

The greatest limitation of the study is that only women who had a positive experience with EMDR came forward to contribute their stories, leaving information about neutral or negative experiences unexplored. However, as is specified by the original methodology, invitations to participate were extended to all alumnae who received EMDR, which totaled several hundred invitations. Hence, the researcher was open to the possibility of negative case analysis.

Another limitation is that the participants in the study were interviewed at different intervals following their EMDR treatment (ranging from 6 months to 2 years). Because of the qualitative, phenomenological nature of this study, the time interval is not considered to be a major limitation. However, some readers, especially those reading this study from a quantitative perspective, may view the inconsistent intervals as a limitation. The study's reliance on client self-report as a primary component of data collection is another potential inconsistency that some readers may view as a threat to credibility (the term used in qualitative research as opposed to *reliability*, the term used in quantitative research; for a review, see Morse et al., 2000; Winter, 2000). Self-report is seen as an unreliable measure by many in the addiction field, but if the Husserlian, phenomenological ideal of examining a client's experience and motivation is kept at the forefront (which it was in a study of this nature), then self-report is not a limitation; it is a necessity.

The final limitation is that the researcher, who is a Certified EMDR Therapist and a proponent of using EMDR in addiction continuing care, conducted the interviews herself (which was a requirement because this research was originally completed as a dissertation). The credibility of the study could have been bolstered if someone with a neutral opinion about EMDR conducted the interviews. However, the researcher conducted this study under the guidance of an academic dissertation committee, the members of which were diligent about flagging any overt bias in her coding or interpretation. The dissertation committee chairwoman listened to all of the interviews as an accountability check to ensure that the researcher was not finding what she wanted as she coded the data using Giorgi's system.

Recommendations for Future Research

A similar qualitative study that examines negative cases is warranted so that clinicians obtain an even greater scope of information about when use of EMDR may be inappropriate with a recovering addict. A focus group may also be appropriate for investigative research to allow for collaborative exchange of experiences. Even though this study contained a sizeable African American sample, one identified lesbian, and several disabled women, it would also be advisable to include cases representing even more racial, ethnic, and other minority backgrounds.

Several other designs can be implemented to further research the use of EMDR with addicted female populations. Designing a quantitative study that allows for inference is a way to test the generalizability of the themes that emerged from this study. A quantitative survey design would make questioning a larger sample more pragmatic and feasible. One suggestion for future research is to use EMDR with addicted clients who have not had a history of trauma that meets criteria for a *DSM–IV–TR* diagnosis of PTSD and compare them with a group who have had a Criterion A trauma (by the *DSM* standards) to see whether there are quantitative and or qualitative differences in sobriety attainment based on trauma. Longitudinal studies are also warranted to determine what effect EMDR treatment may have on long-term recovery in women. It would be interesting to contact the women sampled in this study at a later time (e.g., 5 years from now) to determine whether they have sustained the positive changes brought about by their EMDR and recovery experiences.

One of the subthemes in the study addresses the importance of motivational factors, both internal and external, to the overall EMDR and recovery experience. Although Shapiro (2001) mentioned the importance of assessing for secondary gains in her text, motivational factors are not addressed in any significant way in the current EMDR literature. Another subtheme that opens up an area for further research is the role of the EMDR therapist. This study shows the critical role that the therapeutic relationship plays in the establishment of client safety with women, yet the issue of the therapeutic relationship was not directly considered in the EMDR literature until Dworkin (2005) published on the topic several years ago. The EMDR community needs to investigate whether these characteristics are the result of EMDR training or other factors. At present, there is no known research investigating whether or not formal training standards have an impact on producing effective EMDR therapists.

References

Allsop, S., Saunders, B., & Phillips, M. (2000). The process of relapse in severely dependent male problem drinkers. *Addiction, 95*(1), 95–106.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2004). *Practice guidelines for the treatment of patients with acute stress disorder and posttraumatic stress disorder.* Arlington, VA: Author.

Barbieri, J. (2008). The URGES approach: Urge reduction by growing ego strength (URGES) for trauma/addiction treatment using alternate bilateral stimulation, hypnotherapy, ego state therapy and energy psychology. *Sexual Addiction & Compulsivity, 15,* 116–138.

Bisson, J., & Andrew, M. (2007). Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews 2007, 3,* 1–82. doi:10.1002/14651858

Brown, S. (2003). The missing piece: The case for EMDR-based treatment for posttraumatic stress disorder and co-occurring substance use disorder. *LifeForce Trauma Solutions.* Retrieved June 4, 2008, from http://www.lifeforceservices.com/ article_detail.php?recordid=5

Brown, S., & Gilman, S. (2007). *Utilizing an integrated trauma treatment program (ITTP) in the Thurston County Drug Court program: Enhancing outcomes by integrating an evidence-based, phase trauma treatment program for posttraumatic stress disorder, trauma, and substance abuse.* La Mesa, CA: Lifeforce Trauma Solutions.

Camic, P. M., Rhodes, J. E., & Yardley, L. (2002). *Qualitative research in psychology: Expanding perspectives in methodology and design.* Washington, DC: American Psychological Association.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., et al. (1998). Update of empirically validated therapies, II. *The Clinical Psychologist, 51,* 3–16.

Connors, G., & Maisto, S. (2006). Relapse in the addictive behaviors. *Clinical Psychology Review, 26,* 107–108.

Cox, R. P., & Howard, M. D. (2007). Utilization of EMDR in the treatment of sexual addiction: A case study. *Sexual Addiction & Compulsivity, 14,* 1–20.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* London, England: Sage.

Donovan, D. (1996). Assessment issues and domains in the prediction of relapse. *Addiction, 91,* S29–S36.

Dworkin, M. (2005). *EMDR and the relational imperative: The therapeutic relationship in EMDR treatment.* New York, NY: Brunner-Routledge.

El-Sheikh, S., & Bashir, T. (2004). High-risk relapse situations and self-efficacy: Comparison between alcoholics and heroin addicts. *Addictive Behaviors, 29,* 753–758.

Evans, K., & Sullivan, J. M. (1995). *Treating addicted survivors of trauma.* New York, NY: Guilford Press.

Foa, E. B., Keane, T. M., & Friedman, M. J. (2000). *Effective treatments for PTSD: Practice Guidelines of the International Society for Traumatic Stress Studies.* New York: Guilford Press.

Gagne, R. M., and Medsker, K. L. (1996). *The conditions of learning training applications.* Orlando, FL: Harcourt Brace.

Giorgi, A. (1997). The theory, practice, and evaluation of phenomenological methods as a qualitative research procedure. *Journal of Phenomenological Psychology, 28*(2), 235–281.

Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 243–273). Washington, DC: American Psychological Association.

Hagedorn, W., & Juhnke, G. (2005). Treating the sexually addicted client: Establishing a need for increased counselor awareness. *Journal of Addictions & Offender Counseling, 25,* 66–86.

Hase, M., Schallmayer, S., & Sack, M. (2008). EMDR reprocessing of the addiction memory: Pretreatment, posttreatment, and 1-month follow-up. *Journal of EMDR Practice and Research, 2*(3), 170–179.

Ironson, G. I., Freund, B., Strauss, J. L., & Williams, J. (2002). Comparison of two treatments for traumatic stress: A community-based study of EMDR and prolonged exposure. *Journal of Clinical Psychology, 58,* 1071–1089.

Kessler, R. C.., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttramatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry, 52,* 1048–1060.

Lipke, H. (2000). *EMDR and psychotherapy integration: Theoretical and clinical suggestions with focus on traumatic stress.* Boca Raton, FL: CRC Press.

Marich, J. (2009). EMDR in addiction continuing care: Case study of a cross-addicted female's treatment and recovery. *Journal of EMDR Practice and Research, 3*(2), 98–106.

Maxfield, L. (2007). Current status and future directions for EMDR research. *Journal of EMDR Practice and Research, 1*(1), 6–14.

Maxfield, L., & Hyer, L. (2002). The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. *Journal of Clinical Psychology, 58,* 23–41.

McCracken, G. (1988). *The long interview: Qualitative research methods* (Vol. 13). Newbury Park, CA: Sage.

Mertens, D. (2006). *Research and evaluation in education and psychology* (2nd ed.). Thousand Oaks, CA: Sage.

Miller, D., & Guidry, L. (2001). *Addictions and trauma recovery: Healing the body, mind, and spirit.* New York, NY: W. W. Norton.

Moos, R., & Moos, B. (2006). Rates and predictors of relapse after natural and treated remission from alcohol use disorders. *Addiction, 101,* 212–222.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2000). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 1–19.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Najavits, L. M. (2001). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York: The Guilford Press.

Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addictions, 6,* 273–283.

Neuman, W. L. (2006). *Social research methods: Qualitative and quantitative approaches* (6th ed.). Boston, MA: Pearson.

Ouimette, P., & Brown, P. J. (2002). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders.* Washington, DC: American Psychological Association.

Parnell, L. (1997). *Transforming trauma: EMDR—The revolutionary new therapy for freeing the mind, clearing the body, and opening the heart.* New York, NY: W. W. Norton.

Peirce, J. M., Kindbom, K. A., Waesche, M. C., Yuscavage, A. S., & Brooner, R. K. (2008). Post-traumatic stress disorder, gender and problem profiles in substance dependent patients. *Substance Use and Misuse, 43,* 596–611.

Popky, A. J. (2005). DeTUR, an urge reduction protocol for addictions and dysfunctional behaviors. In R. Shapiro (Ed.), *EMDR solutions: Pathways to healing* (pp. 167–188). New York, NY: Norton.

Power, K., McGoldrick, T., Brown, K., Buchanan, R., Sharp, D., Swanson, V., & Karatzias, A. (2002). A controlled comparison of eye movement desensitization and reprocessing versus exposure plus cognitive restructuring versus waiting list in the treatment of post-traumatic stress disorder. *Clinical Psychology and Psychotherapy, 9,* 299–318.

Price, A. (2008). *Community handbook: Staff version.* [Undisclosed city/publisher owing to IRB confidentiality agreement.]

Ricci, R. J., & Clayton, C. A. (2008). Trauma resolution treatment as an adjunct to standard treatment for child molesters. *Journal of EMDR Practice and Research, 2*(1), 41–50.

Ricci, R. J., Clayton, C. A., & Shapiro, F. (2006). Some effects of EMDR treatment with previously abused child molesters: Theoretical reviews

and preliminary findings. *Journal of Forensic Psychiatry and Psychology, 17,* 538–562.

Rougemont-Buecking, A. (2007, May). *Addiction-memory: Current concepts for treatment and research.* Paper presented at Swiss Addiction Research Day II, Lausanne, Switzerland.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). New York, NY: Guilford Press.

Shapiro, F., & Forrest, M. (1997). *EMDR: The breakthrough "eye movement" therapy for overcoming stress, anxiety, and trauma.* New York, NY: Basic Books.

Shapiro, F., & Solomon, R. (2008). EMDR and the adaptive information processing model: Potential mechanisms of change. *Journal of EMDR Practice and Research, 2*(4), 315–325.

Shapiro, F., Vogelmann-Sine, S., & Sine, L. (1994). Eye movement desensitization and reprocessing: Treating trauma and substance abuse. *Journal of Psychoactive Drugs, 26*(4), 379–391.

Starks, H., & Brown-Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372–1380.

Stewart-Grey, E. (2008). De-stress: A qualitative investigation of EMDR treatment. *ProQuest Dissertations & Theses: Full Text.* (UMI No. 3329984)

Tapert, S., Ozyurt, S., Myers, M., & Brown, S. (2004). Neurocognitive ability in adults coping with alcohol and drug relapse temptations. *American Journal of Drug and Alcohol Abuse, 30*(2), 445–460.

Tucker, J. A., Donovan, D. M., & Marlatt, G. A. (1999). *Changing addictive behavior: Bridging clinical and public health strategies.* New York, NY: Guilford Press.

U.S. Department of Veteran Affairs and U.S. Department of Defense. (2004). *VA/DoD clinical practice guidelines for the management of post-traumatic stress.* Washington, DC: Author.

Van Etten, M., & Taylor, S. (1998). Comparative efficacy of treatment for post-traumatic stress disorder: A meta-analysis. *Clinical Psychology and Psychotherapy, 5,* 126–144.

Walitzer, K., & Dearing, R. (2006). Gender differences in alcohol and substance use relapse. *Clinical Psychology Review, 26,* 128–148.

Walton, M., Blow, F., Bingham, R., & Chermack, S. (2003). Individual and social/environmental predictors of alcohol and drug use 2 years following substance abuse treatment. *Addictive Behaviors, 28,* 627–642.

White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America.* Bloomington, IL: Chestnut Health Systems.

White, W., & Kurtz, E. (2006). *Linking addiction treatment & communities of recovery: A primer for addiction counselors and recovery coaches.* Pittsburgh, PA: Addiction Technology Transfer Center Network.

Winter, G. (2000). A comparative discussion of the notion of 'validity' in qualitative and quantitative research. *Qualitative Report, 4*(3 & 4). Retrieved February 18, 2008, from http://www.nova.edu/ssss/QR/QR4-3/winter.html

Zweben, J., & Yeary, J. (2006). EMDR in the treatment of addiction. *Journal of Chemical Dependency Treatment, 8*(2), 115–127.

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