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CULTURAL COMPETENCE AND HEALING CULTURALLY BASED TRAUMA WITH EMDR THERAPY

INNOVATIVE STRATEGIES AND PROTOCOLS

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CHAPTER 17

EMDR Therapy and the Recovery Community: Relational Imperatives in Treating Addiction

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Addicts and alcoholics are some of the most misunderstood people in global society. People in active addiction can inflict great harm on others and the wounds caused by addicts can fuel many of the hateful condemnations made by the public. The stigma of being an addict can cast a tremendous barrier—built with the bricks of shame and disgust—that can prevent people from seeking help in the first place. The more that the helping professions learn about the impact of unhealed trauma on addiction progression, the more what we've grown used to simply labeling "addict behavior" can be understood through a more informed, compassionate lens. Creating quality treatment informed by this new understanding does not just require an understanding of trauma and eye movement desensitization and reprocessing (EMDR) therapy. Rather, a comprehensive understanding of what individuals seeking recovery (a term preferred in many circles to the traditional labels of *addict* or *alcoholic*) experience as part of their journey is also required.

In her first article on EMDR in the treatment of chemical dependency, Francine Shapiro (Shapiro, Vogelmann-Sine, & Sine, 1994) recommended the use of EMDR after the initial phase of treatment. Achieving stabilization from the immediate effects of addiction is the primary goal of this initial phase. Shapiro advised that EMDR should never be used in a vacuum but rather as part of a system designed to make the client feel safe and supported. In her landmark book *EMDR: The Breakthrough "Eye Movement" Therapy for Overcoming Stress, Anxiety, and Trauma*, Shapiro proposes that "[EMDR] works best when it is used in conjunction with counseling groups that provide a nurturing atmosphere, such as group therapy, Alcoholics Anonymous (AA), and Narcotics Anonymous (NA)" (Shapiro & Forrest, 1997, p. 178). Shapiro now regards EMDR therapy as a distinct approach to psychotherapy, signifying EMDR's growth and evolution. However, her early writing about integrating EMDR into the treatment of addictive disorders offers sound guidance for introducing EMDR therapy to someone seeking recovery from chemical dependency or other compulsive behaviors often described under the umbrella of addiction (e.g., sex, food, overspending, and gambling).

I guide you through this chapter as a woman in long-term recovery from drug addiction, alcoholism, and codependency, a journey that began in 2002. Being

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public about my recovery as a professional exposes me to constant criticism from many of my peers. Hearing comments like "talking about being an addict so much undermines your credibility" is evidence to me that stigma and misunderstanding about individuals in recovery is alive and well. Much of this criticism has come from other EMDR therapists. I celebrate the inclusion of the recovering community in this collected volume, especially because EMDR therapy has so much to offer us. I credit EMDR therapy, which I experienced in my early recovery, as the healing modality that invigorated my overall sense of wellness. Inspired by my own journey with EMDR therapy, I decided to get trained so that I could carry this healing art to others in recovery. This decade-long journey led me to where I serve today as an EMDRIA Certified Therapist, Approved Consultant, and training provider.

Shapiro's early wisdom about pairing EMDR with other means of support remains the most culturally appropriate course of action when working with individuals on a path of recovery. Using this larger context of her guidance, I use this chapter to offer practical suggestions from my perspective as an openly identified addict in long-term recovery. The chapter examines EMDR therapy as a powerful healing mechanism in the treatment of addiction and provides insights on future directions. Research citations and case studies are integrated throughout the chapter, and I use pseudonyms in discussing case studies.

MODELS OF RECOVERY IN THE MODERN ERA

Disparate opinions exist about the utility of 12-step programs and the disease model on which they are based. Some people are adamant that the 12-step path saved their life. Clinical professionals strongly identifying with the 12 steps may insist that embracing this path completely is the only way to get sober and stay sober. Others condemn the 12 steps as being ineffective, unscientific, and even harmful (Glasser, 2015; Peele, 2015). A neutral middle also exists—people who acknowledge the benefit of 12-step programming, yet also recognize that the program does not have to be followed so rigidly in order to be useful. This third group, with which I identify both clinically and personally, largely embraces the idea that 12-step principles are most successful when used in tandem with other therapeutic supports throughout the healing process.

My clinical assumption is that 12-step programming is one of many paths available to help individuals in the pursuit of lifestyle change required for recovery (Marich, 2009a). In the many models of recovery I've studied throughout my career (e.g., 12 step, faith-based recovery, SMART® Recovery, Rational Recovery, Moderation Management, and Refuge Recovery), the single greatest common denominator in success appears to be the success of that model in teaching and promoting lifestyle change. The culturally sensitive EMDR therapist will not impose their biases about the utility of any one model of recovery on their clients; rather, the therapist will facilitate an experience where the client can discover which path will best serve him or her. Part of this openness is allowing clients to choose how they identify (e.g., addict/alcoholic, person in recovery) and how they conceptualize their struggle (e.g., treatable disease, behavioral compulsivity, a biological manifestation of unhealed trauma, or a combination of explanations).

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In Shapiro's 1997 book referenced at the beginning of this chapter, an excellent framework for where EMDR therapy fits into the comprehensive picture of lifestyle change required for recovery appears. She details:

1. EMDR should never be used in a vacuum but rather as part of a system designed to make the client feel safe and supported. It works best when it is used in conjunction with counseling groups that provide a nurturing atmosphere, such as group therapy, Alcoholics Anonymous (AA), and Narcotics Anonymous (NA) (p. 178).
2. The goal in doing EMDR with a substance abuser is to touch into and process the negative emotions that are perpetuating their addiction (p. 192).
3. Many addicts who repeatedly relapse have had some kind of life-threatening experience in their history or an experience that they had perceived as life-threatening. These experiences set off a tidal wave of intense anxiety and unbearable feelings of powerlessness. To avoid these feelings (and, therefore, in the logic of automatic connections, to avoid dying), the recovering addict would do whatever it took, even go back to drugs after years of sobriety (p. 197).
4. *Working it through* is not only done on an intellectual level. The goal of EMDR is to work things through on all levels so that the person's *knee-jerk responses* are naturally healthy ones—intellectually, emotionally, and physically (p. 200).

These four major points provide invaluable guidelines for integrating EMDR therapy in working with clients on a path of recovery. The guidelines are explored further with the specific purpose of helping EMDR practitioners with clinical decision making.

EMDR SHOULD NEVER BE USED IN A VACUUM

As a person in recovery, I get concerned when I hear EMDR therapists say, "Once we clear up the trauma, your desire to drink (or use drugs, or engage in a problematic behavior) will go away." Research such as the ACE Study (Centers for Disease Control and Prevention, 2013) establishes correlations between early childhood trauma and substance use disorders. However, clearing out antecedent traumas with EMDR or any other modality is not necessarily a magic bullet to healing. Although dealing with core traumas is a critical part of the recovery process, targeting that clearance as a primary goal without stabilization, healthy motivation, and adequate sober support is not wise.

EMDR purists may argue that Phase 2 of the eight-phase protocol covers the stabilization component. Within this assumption, it is important to note that one Calm/Safe Place exercise is not sufficient preparation for most on a path of addiction recovery. In addition to guided visualizations like the Calm Safe Place, other skills like progressive muscle relaxation, breath work, grounding techniques, and use of other senses (e.g., sound, taste, touch, and smell) to regulate affect should be in the EMDR therapist's toolkit of skills. Within EMDR literature, Greenwald (2010), Knipe (2014), and Parnell (2008) offer outstanding suggestions for building this skill set. You are also welcome to visit my trauma resources website at www.traumamadesimple.com for guided videos.

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More time will need to be spent in EMDR preparation (Phase 2) with those whose main coping mechanisms in life can be described as addictive or focused on numbing intense emotion. Accessing healthy sober support can serve as an important part of the preparation; for many individuals in recovery, 12-step meetings or other groups are the most available source of such support in their communities. I have engaged in the trauma reprocessing phases with people claiming as little as 1 month of sobriety if they are actively working to build and to implement affect tolerance skills associated with EMDR preparation. Others require longer; it is truly a case of the quality of stabilization over the quantity. In a qualitative research project that I conducted with recovering women who received EMDR therapy as part of their own continuing care, the time frame in which the reprocessing phases (3–6) commenced varied from 1 month to 2 years of abstinence (Marich, 2010).

When making decisions about whether or not to move into reprocessing with a client, Dr. Shapiro does not offer specific time guidelines regarding how much sobriety a person should have before engaging in the reprocessing phases of EMDR therapy. My position remains that quality of recovery versus quantity must guide our clinical judgments. As EMDR evolves, more practitioners contend that one can begin EMDR reprocessing even if the client is still using drugs or actively engaged in problematic behaviors. The three main specialty addiction protocols published since the inception of EMDR (e.g., the DeTUR protocol, the CravEx protocol, and the Feeling State Addiction protocol) do not require abstinence (Hase, Schallmayer, & Sack, 2008; Miller, 2012; Popky, 2005). Still, appropriateness must be assessed on a case-by-case basis; in some cases, it would be unwise to use these protocols in the absence of sufficient stabilization and a modicum of abstinence from the drinking/drug use or the problematic behavior. Many EMDR colleagues see this position as too conservative. It is a position that is informed by my own personal experiences with addiction and recovery and my clinical experience in using EMDR with many different types of people in recovery over the last decade.

Many professionals from the addiction field have moved past the rather antiquated notion that an individual must have 2 years of sobriety to successfully target trauma. However, it is always crucial to practice caution when delving into reprocessing. A critical question that should be asked before targeting trauma is whether or not the person in question can handle what might surface during the trauma work, a concept often referred to as assessing for the affective window of tolerance.

Another critical evaluation point in clinical decision making relates to a person's motivation for targeting past traumas. Like many others working with recovering alcoholics and addicts, I've seen clients and fellow 12-steppers get lost on the quest to find out "why I drink/use . . . " at the expense of overall commitment to a new lifestyle. Addiction psychiatrist David Ohlms, MD, disclosed that when he first entered the profession, he dedicated himself to finding the "root cause" of addiction. As Ohlms (1991) recounted in one of his training videos, he treated one alcoholic with serious trauma for about 5 years using psychoanalysis with the goal of helping him resolve the root causes. After much success in psychotherapy, the man ended up dying after relapsing and subsequently being attacked in a bar. As a result of this experience, Ohlms realized that in rigorously exploring possible root causes, he had furnished the man with more excuses for self-pity and, ultimately, more reasons to relapse. He concluded that the therapeutic time could have been

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better spent helping the man in taking responsibility for his disease, accepting it, and moving forward from there.

Although EMDR therapy can do more than just identify the root causes of addiction, EMDR therapists would be wise to heed Ohlms' caution. In my own EMDR practice, I've seen clients who are not ready to process adverse life experiences get stuck in looping patterns. For a person in recovery who is not committed to a recovery lifestyle, such rumination on the past can be dangerous. Debates between traditional 12-step-oriented addiction counselors and mental health professionals have raged for years about whether the addiction or the mental health symptoms ought to be treated first. In dealing with addiction colleagues I often find myself justifying the need for trauma services. Some of these colleagues are so filled with fear about trauma work potentially leading to destabilization, excuse making, and ultimately relapse. Diving into causality without looking at overall lifestyle change, commitment, support, and motivation is not optimal.

The stages of change—a model developed by Prochaska and DiClemente (1994, with Norcross) and used widely in the mainstream addiction treatment field—provides a useful tool for EMDR therapists in evaluating when to move forward with the reprocessing stages. Intense affect can surface in the use of the specialty addiction protocols (e.g., DeTUR, CravEX, and FSAP) as well. Thus, assessing a client's stage of change is useful in accounting for the larger context no matter how you are using EMDR. The stages of change are *precontemplation* (no desire for change), *contemplation* (beginning to think about change), *preparation* (beginning to take steps toward change), action (proactively working toward goals), and *maintenance* (continuing to engage in wellness to sustain the gains of action). A sixth stage, *termination*, is generally not used by traditional 12-steppers who see their recovery as a state of constant maintenance. From the perspective of sensitivity to the 12-step path, using the stages of change to guide your EMDR case conceptualization is a clinically intelligent way to avoid using EMDR in a vacuum (Marich, 2011; for useful applications also refer to Abel & O'Brien, 2014).

As I discuss in *EMDR Made Simple* (Marich, 2011), EMDR reprocessing work—which includes the specialty protocols—is best pursued when an individual is in the action stage of change. However, in some cases it may be appropriate to pursue in the preparation stage of change. If an individual best fits the description of *precontemplative* or *contemplative*, it is ideal to remain in EMDR Phase 2 preparation strategies and other recovery skill building. Some EMDR targeting may be appropriate in these stages. In such cases I primarily target the motivation issue, using a negative cognition that's blocking the client from accepting wellness (e.g., "I can't handle it," "My addiction is my identity"). Such an approach is safer than immediately targeting their earliest or worst memories.

Phases 3 and 4 Targeting Sequence Example: Using a Negative Cognition Connected to a Motivational Block

- Image: What image represents the worst part of the incident/issue? ***Seeing my dad come to my rescue after getting arrested for a possession when I was 19—he called me a black sheep.***
- Negative cognition: When you bring up that image, what is the negative belief that goes along with it? ***My addiction is my identity.***

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- Positive cognition: What would you like to believe about yourself now, even when that negative memory/issue comes up? ***I am recovering and restored.***
- Validity of Cognition (VoC): What is your gut-level reading of how true that positive statement is right now (1 = completely false through 7 = completely true)? **2**
- Emotion: What emotions or feelings are coming up for you when you link the negative image/worst part with the negative cognition of *my addiction is my identity*? ***embarrassed, sad, disgusted***
- Subjective Units of Disturbances (SUDs): What is your level of distress as we're bringing up these memories/images, negative beliefs, and emotions (0 = no disturbance/neutral through 10 = worst disturbance imaginable)? **7**
- Location of body sensation: What are you noticing in your body in this moment as we're bringing up these memories/images, negative beliefs, and emotions? ***stomach, throat***
- Desensitize (Phase 4): Hold those body sensations together with the negative belief of *my addiction is my identity* and the image of *seeing your dad come to your rescue after getting arrested for a possession when you were 19. Remember that he called you a black sheep.*
- Begin stimulation.

THE ROLE OF EMDR THERAPY IN WORKING IT THROUGH

After you've accounted for the contextual and other safety factors, the possibilities for using EMDR to target recovery roadblocks are limitless. A major challenge that many in recovery experience is working on the fourth and fifth step. These are often viewed as the steps that cause many people to abandon a 12-step program.

Nancy, one of the first 12-step clients that I guided through the EMDR therapy standard protocol, struggled with Steps 4 and 5 for a long time (Marich, 2009b). These steps require individuals to take a deep look at themselves—the positive and negative traits—and then share what they've found with another person. As a trauma-informed practitioner, it's been evident to me that unhealed trauma can be a significant factor keeping a person from working Steps 4 and 5.

Nancy was a Caucasian female in her mid-40s who was referred to treatment after her third driving under the influence (DUI) charge. She met criteria for alcohol, marijuana, and sedative dependence. Although externally mandated for services, she presented with a high degree of internal motivation, ready to work in an action stage of change. Nancy divulged, "You don't have to convince me I'm an alcoholic. I know what I am. I've just never been able to get past a fourth step . . . and then I always relapse."

History taking revealed that Nancy met the substance dependence criteria since her late teens. As a survivor of multiple childhood sexual traumas, she also met criteria for posttraumatic stress disorder. In the previous decade, she went through five and six treatment episodes (all in a 12-step model) and was not able to achieve any more than 4 months of sobriety. I worked with Nancy during my service at an outpatient rehabilitation center, so I was able to stay with her case from assessment through continuing care. During treatment planning, we decided to directly confront the trauma issues . . . *after* Nancy established enough of a foundation in

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her recovery. The first component of her treatment plan required her to complete an 8-week outpatient 12-step facilitation (Nowinski & Baker, 2003) treatment group, attend three to four AA meetings a week, and begin working the first three steps with a sponsor.

Nancy completed the 12-step facilitation treatment group successfully, during which time she developed relationships with a sponsor and a support group. We worked on coping and relaxation skills during our individual sessions as she completed the group. Nancy responded very well to breath work and guided visualization exercises. Once her support, coping skills, and sobriety skills were in place, I offered her two possible options: cognitive behavioral therapy (CBT) or EMDR therapy. Because she heard good things about EMDR at a previous treatment center, Nancy opted to use EMDR. We revisited some of her developed coping skills in the context of EMDR Phase 2 preparation, commencing with the reprocessing phases (3–6) when Nancy reported about 3 months of sobriety.

In these sessions, we primarily targeted the negative cognition of "I am shameful," floating back to sexual abuse she experienced at the hands of neighborhood kids. Ultimately, this work led to what she identified as the worst of her sexual traumas—being raped by a close family member at the age of 12. She made multiple connections to sexual assaults she experienced within her toxic marriage to another alcoholic. Nancy cleared all of these targets and she was able to successfully install more positive belief states like "I am worthy." After approximately 10 individual EMDR reprocessing sessions, during which time Nancy continued active AA involvement and worked with her sponsor on the first three steps, Nancy began to write a fourth step. Nancy decided that she wanted me to hear her fifth step. For her, it was important to do a fifth step in an arena where she felt optimally safe. Nowhere does it say that the fifth step needs to be heard by a sponsor or a minister, just *another human being* (Alcoholics Anonymous World Services, 2001). Having a fifth step plan that honored her safety gave her some assurance during her fourth-step process, and after resolving a great deal of toxic shame during her EMDR sessions, Nancy was finally able to work a fourth and fifth step.

Nancy continued to work closely with her sponsor, and she continued sessions every other week with me while she worked through the rest of the steps. In total, Nancy engaged in the treatment process for an entire year, staying sober the entire time. Nancy publicly shared her story at an AA speaker meeting upon celebrating 18 months of sobriety, a remarkable feat considering that she had not previously been able to stay sober any longer than 4 months. Shortly after this first lead, I interviewed Nancy as part of a follow-up research project, and she offered some perspective about her recovery (Marich, 2009b). Nancy credited the combination of EMDR, 12-step work, opening up to a sponsor, seeing addiction as a life-or-death matter, her willingness to change, and deepening her spirituality as factors that worked *together* to help her get sober and well. She also acknowledged that her trauma history made it difficult for her to work the 12 steps of AA during her prior attempts at recovery:

> You can't put anything in the proper perspective. And you can't really get a heads up on what really happened because you were so traumatized and you had such bad experiences and, like in my case, I had the trauma then I had the—I call it the after-effect of my

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> ex-husband—pounding over and over and over and over it for like fourteen years after that. I took so much responsibility for it. It was almost like I victimized myself all over again in my mind. (p. 103)

Nancy shared that all of these factors in combination helped her achieve a perspective shift that helped her achieve her goals for recovery. EMDR helped her to put responsibility in its proper perspective—she was able to admit the wrong she did in her addiction without beating herself up for all that was done to her. The last time that Nancy contacted me, she reported 5 years of sobriety.

Standard protocol EMDR can be used any time a person encounters a roadblock on their recovery journey. The key is to understand the basic concept of setting up a target sequence with EMDR therapy. Simply asking the question "What's keeping you stuck?" is powerful. Helping a client come up with an answer to that question and identify a corresponding negative cognition can provide a good opportunity to engage in the floatback process, which can lead to an immensely powerful therapeutic experience.

The extensive qualitative research study I conducted with an ethnically diverse group of women in continuing care (Marich, 2010) took the investigation with Nancy a step further. These women were not my clients, so I had the opportunity to be an objective investigator of EMDR therapy implementation within a 12-step friendly facility. The women's (five African American, four Euro American, and one Iranian) lived experiences suggested that EMDR can be safely and effectively integrated into addiction continuing care as long as proper safety precautions were taken. Just 1 of the 10 women studied credited only EMDR therapy with her sobriety—the majority suggested that other factors like support and lifestyle skills learned while they were in treatment served as critical components in what they were able to achieve.

In the context of this safety and support, the collective sample reported that EMDR therapy allowed them to address the core issues that kept them in an addiction cycle. Ultimately, this standard protocol targeting led to perspective shifts serving the larger recovery process (Marich, 2010). Although many amazing stories of transformation are apparent in the phenomenological data, one woman's interview offered formidable insight on how EMDR can bolster the 12-step recovery process.

Sasha, an African American woman, entered treatment in her mid-40s for cocaine addiction. Acting out and violent behaviors were also issues that needed attention, according to her report. During many previous attempts at addiction recovery, her anger was an obstacle. Sasha was sexually molested as a small child and indicated a long-standing history of discord with her mother. "I am bad" was the core negative cognition defining her identity. I interviewed Sasha when she had 3½ years of continuous sobriety, and at that time, she reflected on the role that anger played for her (Marich, 2009a):

> I was a cesspool of badness . . . of dysfunction. I was very promiscuous . . . I was a liar, a thief, and a cheat. And I was very aggressive, real angry, and I had been molested at the age of 5, and me coming here [to treatment] had really helped me identify all those behaviors I had going on and

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> connect the dots on why I did what I did. And in my addiction, I was just angry and I was covering up a lot of feelings, trying to suppress them. So when I came in here, the only feeling I could really identify with was anger. Anger and rage. And by me staying in that addiction as long as I did, I wasn't me, I wasn't my authentic self anymore. I just did what I had to do to survive and did what I did and had to do to get the drugs and alcohol. 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. I really didn't. And it was just surfacy stuff: the things you know to say that you say when you do the treatment thing, the treatment jargon. But for me today, it's just totally different, because I've gotten to my core issues. EMDR helped me get in touch with the things, with the resentments I had towards my mom and me wanting to know why my mom didn't love me or care anything about me. During the EMDR, I saw that it's none of my business of why she didn't love me or any of that. I did a lot of crying, I did a lot of that work.

What impressed me about Sasha's interview, and many others in the research, was their ability to use an emotional vocabulary to describe situations that they once found unspeakable. The implications of this dynamic for helping people really dig deep with their recovery journeys are tremendous. In pursuing recovery with this enhanced understanding of trauma's impact on their lives, people may stand a better chance of thriving in recovery as opposed to "white-knuckling it" or just staying abstinent from alcohol, drugs, or other addictive behaviors without true transformation.

Throughout my almost decade-long journey of offering EMDR therapy to people in addiction recovery, I continue to be amazed by how EMDR therapy can play a powerful role for both those in early sobriety (like Nancy and Sasha) and in long-term recovery. Existential questions, often triggered or elicited by adverse life experiences in sobriety, may also arise. "How do I really know what God's will is for my life?" "What is the line between carrying the message of recovery and helping others and possibly becoming consumed by helping others?" "What if life changes and I'm not sure if I believe in a Higher Power . . . or the 12 steps anymore?" EMDR therapy can help people in long-term recovery address these and other questions.

Such was the case for David, who approached me for services after reading about my work with trauma and 12-step recovery. David had 9 years of sobriety from alcohol when he contacted me. A successful businessman, even during his active alcoholism, David changed professions in recovery and pursued an advanced degree to work as a treatment clinician. At the time he came to me for EMDR therapy, he held a prominent leadership position in a treatment setting. Although David was an active member of a 12-step fellowship for many years, he found himself struggling with the rigidity on certain issues as interpreted by many groups. The "God" language was very difficult for him, and as an agnostic he found it even more challenging as he grew in recovery.

David was actively exploring ways to expand his recovery wellness at the time he met me. In the history taking, David revealed that his biological mother

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relinquished him at the time of his birth. After spending 7 days in a home for unwed mothers, a couple, unable to conceive, adopted him. Five years later they were able to naturally conceive David's younger sister, and then years later they adopted another son from an unwed mother. David explained that, overall, he was well cared for by his adoptive parents and he described his childhood as relatively carefree, yet there were still some unsettling issues that had begun to manifest now that he was in his 50s.

Even though he was sober and successful in his work, he was struggling in many other life domains, namely in connecting with others. He also identified problems with compulsive overeating, even following his sobriety from alcohol. When David presented for EMDR he was unsure if he could describe the relinquishment and experiences connected to being adopted as *trauma*. In our initial history taking session, I explained to David that trauma does not have to meet PTSD criteria for us to name it as trauma, explaining the concept of adverse life experiences as they are described in the adaptive information processing model.

In our initial history taking session I assessed him to be sufficiently stable and capable of handling an extended history. Because David traveled a long distance to see me for services, I asked him to write out as much of a narrative as he was comfortable writing to optimize our time spent in session. Upon reading his presentation, certain statements stood out as trauma-fueled cognitions influencing his presenting maladaptive symptoms. These statements became candidates for EMDR targeting sequences in Phases 3 to 6:

- "I have vague memories of feeling like I was under the microscope whenever I was with people."
- When his friends found out he was adopted (around age 6), they acted in total disbelief and shifted their attitude toward him: "I am guessing I may have felt at the time that something was wrong with that [being adopted]."
- "I felt hugely ashamed and humiliated. I guess more importantly is that it added to my feelings that something was wrong with me. I no longer felt safe around other people or myself."
- "I seemed to become distant or withdrawn. I remember beginning to feel at all times like I didn't belong wherever I went."
- "Some of my fondest childhood memories come from spending time at the lake."
- "I got sober in August 2005, still wondering, as I had my whole life, who I was, where I had come from, and if I had blood family still living."
- At the prospect of meeting his biological half-sister, with whom he was just able to establish contact: "I fear that I'll disappoint them somehow."
- On his general reason for seeking services: "I still feel like a chronic malcontent who is often dissatisfied and rebellious."

In our initial history taking session, I began gathering information about David's existing coping skills, most of which he gained from 12-step exposure. We began discussing a plan for how he could build more body-based coping skills like breathing into his daily regimen. I sent him to some of my online videos that teach

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breathing and mindfulness skills, and he was willing to try these in between our initial history taking session and our second session. When David presented for his second session, we reviewed which breathing strategies worked the best for him, and discussed other visualizations that might work for distress tolerance. I picked up on his statement in the history that some of his fondest childhood memories came from spending time at a lake where his family vacationed, and we transitioned that into a Calm Safe Place exercise with tactile bilateral stimulation. He chose to alter the safe place for the purpose of the exercise and use the serenity of a Caribbean beach. We also "tapped in" a positive experience that he had at a new 12-step meeting the night before our session.

David responded well to these preparation exercises, and by the third session he expressed readiness to begin reprocessing. I read back the negative self-beliefs that I noted in his narrative, and I asked him to notice which one(s) seemed to most resonate in his body as distressing. For him it was clear: something is wrong with me. He floated that negative cognition back to a memory of two of his childhood friends making a big deal about him being adopted. After attending to other components of the targeting sequence, we begin "going with that."

Within the first two to three sets of bilateral stimulation, David was able to very deeply connect with what was occurring in his body. For David, a self-confessed intellectual with the tendency to overanalyze, being able to sit with body level experience and simply be mindful was vital. At the end of the session when I checked in with him about the initial issue/belief we took through the targeting sequence, he reported a clear body scan and a near zero SUDs. More significantly, his initial goal statement/positive cognition of "I can work through it" was not only completely true, he was able to name two other positive cognitions to claim as completely true: "I am a human being," and "I can trust myself." We ended our session by installing both of those completely true positive cognitions together with the clear body scan.

In the second reprocessing session we revisited the initial memory that we took through the targeting sequence previously to see if anything else may have come up. David reported: "I now have the power to observe it—I was just a kid. I should forgive myself for putting myself through all of that crap." In the spirit of the three-pronged protocol, we commenced this second reprocessing session by having him simply notice how he *presently* views the memory. David spontaneously began articulating new positive beliefs about himself that he was able to integrate and believe were completely true: "I have the power," "I've got this," "I am safe," and "I don't have to protect myself anymore." Additionally, the two positive beliefs that he reported in the previous session held as completely true statements. In our final check-in during that second reprocessing session, David articulated two new positive beliefs of "I am whole" and "I don't feel judged anymore," together with a clear body scan. Said David: "I'm anchored; attached to the present."

In the next session, after checking in with the positive beliefs to make sure that they held their truth, we transitioned into future template work. For his future template, David wanted to work on issues of intimacy and problems connecting with others. David believed that he was *somewhat* confident that he could connect with others. I asked him what kept him from *complete* confidence, and he immediately identified the message that he received in 12-step meetings that *ego is bad*. So I had

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him consider that notion along with any body experiences that came up as he held it in mind. After applying a few sets of bilateral stimulation, David recognized that he seemed kinder and gentler—and that he could extend that to himself and others. He then made a connection to a famous story in 12-step recovery about the founder Bill Wilson's "bright light experience," and he realized that he finally had something to "give away" to others. Previously, his self-identified "imposter complex" of feeling like a fraud, both personally and professionally, stood in the way. In the next few sets of bilateral stimulation (BLS), he made connections to his family and work life. He ended the session by expressing: "I am more than a victim, a survivor, or a 'rescue,' . . . I am whole." We installed that profound realization as a completely true positive belief.

The final two in-person sessions that I conducted with David focused on reevaluation. The positive beliefs achieved in previous sessions held as completely true statements with a clear body scan. Our natural conversation progressed into discussing what potential pitfalls David might see in moving forward. He stated, "I can find fault like there's a reward for it, at least that's been my pattern." He identified that this tendency began around the time of the target memory we began with at age six, and I had him hold the present experience of that memory together with his insight about finding fault. After a couple of sets of stimulation, he expressed: "That's my head talking, not my heart and my soul." In the next set: "That's a useless energy drain." I also made the decision, in testing out the potency of the generalization effect, to inquire about one of his other negative beliefs identified at the time of history taking: "I am disconnected." I asked him how valid that belief seemed in the moment, and he responded, "It was a delusion—I'm finding the connection within." I had him "go with that" for a few sets, and he ultimately expressed, "I am home." I asked him what, to him, the opposite of "I am disconnected" would be (i.e., his positive cognition) and he said, "I have the capacity to be connected." He reported that was a completely true statement, as it was installed with a clear body scan. David then held that positive belief as he pictured future life scenarios and no distress or concern registered.

David and I followed up via phone call 3 weeks after that last session (part of the reevaluation process) and he noted overall positive progress and maintenance of goals in the weeks since the final in-person session. He said that he was no longer "obsessing" over how he feels, and that he was "over" his feelings of being a fraud. He reported 20 pounds of weight loss in the weeks after his EMDR work, and an increase in faith that everything in his life was going to turn out okay. A final phone call a month later confirmed the maintenance of those achievements. He checked in with me at 3- and 6-month intervals continuing to report maintenance of his EMDR gains. He also indicated further progress in his desire to speak out on adoption issues in the addiction treatment field, working with another collaborator to bring a curriculum to life. In 2015, the book *Do Tell: Stories by Atheists and Agnostics in AA* published David's recovery story; he shared openly and honestly about the adoption component of his story in this venue (see "References" section).

David's case offers an example of EMDR therapy's value as a recovery enhancement measure. Although clinically not meeting the criteria for PTSD upon presentation, it is clear how trauma, especially attachment-related or developmental trauma, continued to cause symptoms of depression and overall disconnection with his life. David's story is a strong example of how EMDR can work very quickly. In

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many ways, his case allowed for that because he presented for treatment already reasonably stabilized. David had a job, 9 years of sobriety, strong family support, and a willingness to work on himself. Moreover, he came to me already in an action stage of change. For clients at earlier points on the recovery path, EMDR may not progress as smoothly. It may be necessary to practice more patience and utilize more advanced EMDR skills like interweaves. Entering the treatment engagement with this realistic view is critical. Combine this view with the precautions offered on how to work with preparation and the larger context, knowing that you can still make a difference with EMDR therapy.

SUMMARY: EMDR THERAPY AS "THE MISSING PIECE"

EMDR and addiction specialist Susan Brown (2003) called EMDR the "missing piece" in addiction treatment care. She demonstrated a great respect for traditional addiction approaches in the article that invoked this phrase, yet recognized that there are gaps that need filling. Well-known addiction researchers Zweben and Yeary (2006) made a similar assertion in their landmark article, and I've carried this message of *EMDR as the missing piece* in the various arenas of my work. When fellow 12-steppers or traditional addiction counselors ask me "*Why EMDR?*," I typically answer: Traditional 12-step work gives us a spiritual and lifestyle path for recovery. Treatment centers have customarily added the cognitive-behavioral component to the mix, helping us work with the mind. Yet, little has been done until recent years to work with the body in addiction recovery, especially the legacy of somatic distress left by trauma. This distress is what leads many people to abuse substances in the first place, or it can exacerbate an existing predisposition for addiction.

EMDR therapy, by design, can address all of these issues: the spiritual, the lifestyle, the cognitive, the somatic, and the historical facets of addiction. Targeting adverse life experiences with this approach can help people move beyond simply surviving in life as a person in recovery. Addressing the wounds of these adverse life experiences can help recovering individuals thrive in all areas of their life, just as the adaptive information processing model inspires. The idea of engaging in this full healing process can come with some fear. I often field concerns like, "What if I get so upset that I end up using again?" or "What will it mean for my life if I actually deal with all of this old stuff?" My general response is to first validate the concern. I then explain how the EMDR therapy approach contains an extensive preparation phase that allows us to build the skills one may need to handle addressing these potentially emotional targets. Emphasizing that the client is in control the entire time and always has the power to stop the processing and come back to a stabilizing resource is critical.

We as EMDR therapists tend to get excited about the radical results that EMDR is known to produce regarding trauma resolution. However, I remain most impressed by the safeguards in the EMDR approach (e.g., therapeutic relationship building, the preparation phases, and highlighting client control) that allow clients who identify as being in recovery to feel safe in enhancing their recovery with EMDR. This emphasis on relationship and safety may seem obvious. However, as a member of the community that I covered in this chapter, I attest to the primacy of safety and

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building the relationship. As individuals in recovery we've been told things like we're lazy, selfish, a waste of a life, and don't want to live in the real world. We've been labeled as the sickest of the sick and told that we can never really change. We've been made to feel weak by those in our families and in the public who proclaim that all we need is a little willpower. Perhaps worst of all, we've been told that we've chosen this life for ourselves. Society and even clinical professionals have referred to us pejoratively as *those people*. Any person in recovery presenting for EMDR will be assessing you, as their treatment provider, to determine if you believe all of these harmful ideas of division and occlusion.

Fadalia is a young woman in recovery from long-term opiate addiction who, with 26 treatment episodes prior to receiving EMDR, was labeled a chronic relapser. When she presented for treatment services at some of the same facilities, it was common for clinicians and medical professionals to roll their eyes at her and chide, "You again?" Fadalia shared that being treated with dignity at the treatment center was a key factor is making her receptive to EMDR therapy (Marich, 2009a, 2010). She noted that everyone at the facility being researched—the clinicians, the medical team, the support staff, the cooks, even the janitors—treated her with respect and made her believe she could get sober. There is a lesson in this simple sharing of lived experience for all of us practicing EMDR therapy. EMDR therapy is more than just a technique or a protocol that can "fix" people, and I am saddened when people view it this way. EMDR therapy is truly an approach that allows for transformation, and getting to know the people we serve before simply reprocessing traumatic memories is paramount.

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