ARTICLES

The Perceived Effects of Standard and Addiction-Specific EMDR Therapy Protocols

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Existing literature on co-occurring posttraumatic stress disorder (PTSD) and addictive disorders suggests improved outcomes when both diagnoses are treated concurrently. Eye movement desensitization and reprocessing (EMDR) using the 8-phase protocol and standard 11-step targeting sequence has been investigated within integrated treatment models. However, use of newer EMDR addiction-specific protocols (e.g., desensitization of triggers and urge reprocessing [DeTUR], feeling-state addiction protocol [FSAP], craving extinguished [CravEx]) in treatment has been studied less extensively. A qualitative, phenomenological design was employed to investigate the lived experience of 9 participants with co-occurring PTSD and addictive disorders. These participants experienced both standard protocols/targeting sequences and the addiction-specific protocols as part of their treatment. Creswell's system for interpreting meaning units in qualitative data, based largely on the work of Moustakas, was used to analyze the data gleaned from semistandardized interviews. All participants reported positive outcomes from the combined EMDR approaches; 4 major themes emerged. Participants recognized their trauma and addictions as related. As a result of this insight, their thoughts and addictive behaviors changed. All recognized remission of symptoms of both disorders; EMDR therapy was reported to be effective whether the traumatic symptoms were treated before or after the addictive symptoms. All indicated that integrated treatments (including other supportive services) were optimum for their ongoing recovery. The relationship with the therapist was integral to the overall success of treatment.

Keywords: co-occurring disorders; addictive disorders; desensitization of triggers and urge reprocessing (DeTUR); feeling-state addiction protocol (FSAP); craving extinguished (CravEx); protocols

The high comorbidity between posttraumatic stress disorder (PTSD) and addictive disorders is well established (Hendrickson, Schmal, & Ekleberry, 2004; Hruska & Delahanty, 2014; Najavits, Kivlahan, & Kosten, 2011; van Dam, Vedel, Ehring, & Emmelkamp, 2012). In most individuals with addictive disorders, PTSD is presumed to have preceded the onset of substance abuse. Most practices for treating these co-occurring disorders suggest stabilization of the addiction first before treating the PTSD because of the need for better coping when dealing with traumatic memories (National Collaborating Center for Mental Health, 2005; Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). However, the addiction and trauma reexperiencing cycles may not be mutually exclusive but are interacting with each other in the development of PTSD and substance abuse (van Dam et al., 2012). Patients with concurrent disorders may end up in a "vicious circle, where PTSD symptoms trigger substance abuse, substance abuse in turn increases the risk for future traumatic experiences, and withdrawal from substances can trigger PTSD symptoms" (van Dam et al., 2012, p. 203).

Eye movement desensitization and reprocessing (EMDR) therapy came into being as a behavioral

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technique for the treatment of trauma in 1989 after Francine Shapiro made a surprising discovery that bilateral eye movement seemed to reduce the emotional distress of negative memories (F. Shapiro, 2001). The technique evolved into a therapeutic approach to treat PTSD (F. Shapiro, 2001). The standard protocol uses eight phases to address the past events that set the foundation for pathology, present-day stressors or triggers, and future desired thoughts and actions. The eight phases consist of history taking, preparation, assessment, desensitization, installation, body scan, closure, and reassessment. In the desensitization phase, bilateral stimulation (BLS) is applied which facilitates the decrease in arousal, negative emotions, and/or imagery vividness. The Subjective Units of Disturbance (SUD) scale is used to assess client progress during the EMDR session and a Validity of Cognition scale to determine cognitive restructuring of the targeted event. To date, 24 randomized controlled trials support the use of EMDR therapy with a wide range of trauma populations (F. Shapiro, 2014).

Improved outcomes in the treatment of co-occurring PTSD and substance abuse/addictive disorders are evident when the presentations are treated concurrently (Carruth, 2006; van Dam et al., 2012). Recommendations for treatment also suggest that care for co-occurring disorders not be limited to a single correct model or approach (SAMHSA, 2013). EMDR using the 8-phase protocol and standard 11-step targeting sequence has been investigated within integrated treatment models (Abel & O'Brien, 2010, 2015; Brown, Gilman, Goodman, Adler-Tapia, & Freng, 2015; Marich, 2010; Zweben & Yeary, 2006). The problem remains that EMDR has not been widely used in an integrated treatment model combining the use of the standard protocol (hereafter, used to describe the traditional Shapiro 8-phase protocol and 11-step targeting sequence for Phases 3–7) and addiction-specific protocols.

Since the 1990s, there have been three specialized protocols developed by EMDR therapists to facilitate recovery from both chemical and behavioral addictions. Desensitization of triggers and urge reprocessing (DeTUR; Popky, 2005) was the first introduced, followed later by craving extinguished (CravEx; Hase, 2009), and the feeling-state addiction protocol (FSAP; Miller, 2012). The addiction protocols are designed to enhance stabilization and reduce the incidence of relapse, with no direct targeting of traumatic memories required. When combined with standard measures including a support system, 12-step or other mutual support groups, psychoeducation, medication monitoring (if needed), and maintaining a clean and sober environment, these protocols show promise in promoting recovery from addictions according to practice knowledge in the EMDR therapy community and the limited research that exists. Overall, little has been known about how the use of these specialized addiction protocols, in combination with standard protocol EMDR therapy, may enrich the recovery of persons with PTSD and addictive disorders.

Literature Review

General Findings on EMDR Therapy and Addictive Disorders

In a review of available literature on the concurrent treatment of PTSD and substance use disorders, van Dam et al. (2012) proposed that concurrent treatment for both disorders may be more effective than treatment focusing on one disorder alone. Other findings indicated that exposure therapy combined with addictive disorders treatments was more successful than other types of trauma treatment but that "an apparent gap is the lack of studies investigating the effectiveness of EMDR" (van Dam et al., 2012, p. 212).

The use of EMDR therapy for treating addictions as part of an overall treatment plan has been discussed since 1994 (F. Shapiro, Vogelmann-Sine, & Sine, 1994; Zweben & Yeary, 2006). Although few studies have been conducted specific to addiction and EMDR therapy, there is a growing body of investigation. Existing phenomenological research (Marich, 2009, 2010) offers insight as to how standard protocol EMDR can be best implemented as part of a comprehensive addiction treatment program. Brown et al. (2015), upon analyzing the statistical data collected on treatment completion, concluded that integrating EMDR therapy into comprehensive treatment improved graduation rates and decreased recidivism in a drug court program. In a randomized usual care setting study, Perez-Dandieu and Tapia (2014) found that treatment as usual plus EMDR therapy lead to statistically significant changes in PTSD symptoms by targeting traumatic memories with the standard protocol. However, no reduction was noted in addiction symptoms. In contrast, Kullack and Laugharne (2016), found that use of the standard protocol alone to treat persons with PTSD also resulted in a reduction of addictive symptoms. All of these publications, in addition to other case study articles in the literature on process or behavioral addictions (Cox & Howard, 2007; Henry, 1995), address standard protocol EMDR therapy, albeit as part of integrated treatment models incorporating other supportive interventions (e.g., 12-step facilitation, *Seeking Safety*). Abel and O'Brien (2015) proposed use of EMDR standard and addiction

protocols according to Prochaska and DiClemente's (1982) transtheoretical model of the stages of change.

The Three Addiction-Specific Protocols: DeTUR, CravEx, and FSAP

The addiction-specific EMDR protocols, according to their authors, are all based in the same adaptive information processing (AIP) model that informs standard protocol EMDR therapy. They posit that whether an addiction is chemical or behavioral, the symptoms can be reduced and stabilized concurrently by the use of EMDR along with other ongoing treatment (Popky, 2009). In this literature review, the basic steps of each addiction-specific protocol are reviewed, and the existing research is summarized.

The DeTUR Protocol. The DeTUR protocol (Popky, 2005, 2009) can be summarized in the following steps:

1. Rapport
2. History, assessment, diagnosis
3. Support resources
4. Accessing internal resource state
5. Positive treatment goal
6. Associated positive state
7. Identify urge triggers
8. Desensitize triggers
9. Install positive state and
10. Test and future check

The DeTUR protocol (Popky, 2005) differs from the standard protocol primarily by its focus on the present situations, events, or stimuli that bring up uncomfortable feelings leading to urges to use. Use of a floatback to earlier traumatic memories is not required. After triggers for using are no longer activated, past issues are addressed. The protocol uses the level of urge (LOU) as the unit of measurement instead of the SUD. Clients are empowered by accessing and installing positive resource goals, reducing triggers to use, and developing greater resilience to relapse.

Although very popular in the EMDR community, appearing in casebooks (R. Shapiro, 2005) and scripted protocols series (Leeds, 2009; Luber, 2009), the DeTUR protocol has not been extensively researched as its own entity. Using case study designs, Abel and O'Brien (2010, 2015) described how to integrate standard protocol EMDR therapy and some use of both DeTUR and CravEx into addictive disorder treatment. Halvgaard (2015) presented a similar case study of integrated standard protocol EMDR therapy with her own modifications on DeTUR in the successful treatment of an emotional eater. Dissertation research by Dohrmann (2009) concluded that a combination of standard protocol EMDR and DeTUR with three sexual offenders led to no significant decreases in level of trauma symptoms; yet, a significant difference in deviant arousal level was measured in two of the offenders.

There are two studies from Korea that demonstrate DeTUR's usefulness aside from standard protocol EMDR. Bae and Kim (2012) investigated a single-case study of an adolescent with Internet addiction solely using the DeTUR protocol. A positive treatment goal was identified, and seven triggers for the urge to play Internet games were established. Notable in this work was the need to adjust the amount of BLS: Longer sets of BLS became evocative; shorter sets decreased the LOU. Because the adolescent had a positive goal of a healthier lifestyle, and there were no identified traumas underlying his compulsivity, treatment was successful using only the DeTUR protocol. Park, Kim, Jang, and Bae (2016) also conducted single-case research using solely DeTUR with a 29-year-old man suffering from paruresis (shy bladder syndrome). After eight 60-minute DeTUR sessions, the participant no longer met clinical symptoms or paruresis, and gains were maintained at 1-year follow-up.

The CravEx Protocol. In describing and evaluating the CravEx protocol, first published in 2009, it is important to look at the original study from Hase, Schallmayer, and Sack (2008) serving as the basis of CravEx. In this study, particularly relevant because it was conducted in a usual care setting with a randomized controlled method of investigation, the group receiving *treatment as usual* along with EMDR ($N = 15$) showed a statistically significant reduction in addiction craving 1 month posttreatment compared to the group receiving only *treatment as usual* and a statistically significant difference in relapse at 6-month follow-up. Hase et al. concluded that "EMDR might be a useful approach for the treatment of addiction memory and associated symptoms of craving" (Hase et al., 2008, p. 170).

The steps of the CravEx protocol, credited to Hase (2009) can be summarized as follows:

1. History taking
2. Preparation
3. Assessment
4. Desensitization
5. Installation
6. Body scan
7. Closure
8. Reevaluation

As with the standard protocol, CravEx (Hase, 2009) addresses the past, present, and future. However, it focuses on the addiction memories. The targets to reprocess are "memories of intense craving or relapse in abstinence-motivated clients" (Hase, 2009, p. 476). The unit of measurement is the LOU. The addiction memory will be an episodic memory and, in the case of a chemical addiction, consists of the drug-independent memory of the loss of control and a drug-specific memory of the addictive drug (Hase, 2009). Popky and Hase both recommended the importance of the comorbidity of PTSD and addiction and recommended stabilization throughout treatment including the resource development and installation protocol (Korn & Leeds, 2002) as well as other standard support measures such as 12-step groups. Aside from the Abel and O'Brien (2010) case study, which integrated standard protocol EMDR and DeTUR as well, no further direct research has been done to date using CravEx.

Feeling-State Addiction Protocol. The FSAP was first introduced by Robert Miller (2012) in his multiple baseline study of four participants with behavioral addictions. The results of the study indicate that the part of the FSAP targeting the feeling state was effective in reducing the participants' reactions to the visualized stimuli. Self-reports also suggest that the feeling states which were targeted may have affected the corresponding behavioral addictions.

According to Miller (2012), the feeling state is conceived as a memory that has been isolated from the overall memory network. The feeling state connected to addictive behavior consists of any positive feeling that becomes rigidly linked with specific behaviors or objects. When the feeling state is triggered, the entire psychophysiological pattern is activated and triggers out-of-control behavior. By targeting the feeling state, the EMDR can connect the isolated memory with the larger memory network and the brain's more adaptive functioning resulting in changes in behavior.

The FSAP consists of the following steps:

1. History of addictive behavior
2. Evaluation of coping skills
3. Identify aspects of behavior that hold the most intensity
4. Identify the positive feeling linked with the addictive behavior
5. Locate and identify physical sensations
6. Visualization of performing the addictive behavior including the positive feelings
7. Desensitization of the positive feeling state
8. Install future templates
9. Homework to evaluate progress
10. Reevaluation of targeted material
11. Steps 3–9 repeated as necessary
12. Determine negative beliefs underlying the feeling state, choose desired positive beliefs
13. Process negative beliefs and install positive beliefs as in standard protocol
14. Negative belief created as a result of addictive behavior is determined
15. Negative beliefs processed and positive beliefs installed
16. Installation of future templates

Like Hase and Popky, Miller recommends stabilization of the client with resource development (Korn & Leeds, 2002) in the preparation stages of the protocol. In addition to Miller's own original work with behavioral addictions, one outside research team in Greece reported positive treatment in an FSAP study on smoking cessation (Tsoutsa, Fotopoulous, Zakynthios, & Katsaounou, 2014). This study compared two groups of 12 patients each, one group receiving six sessions of FSAP versus the second group receiving six sessions of cognitive behavioral therapy (CBT). The FSAP group self-reported greater rates of cessation overall than the CBT group. Although rudimentary in its design, the study represents the only existing research on FSAP that is not connected to Miller.

Knipe's Contributions. Knipe (2009, 2015) has also made significant contributions to the use of EMDR therapy and addictive disorders. Although Knipe has not developed a separate protocol for addictions, he has added a degree of differentiation among the three protocols and when to use each. In Phase 1 of EMDR therapy, evaluating when the addictive behavior began and what function it served in alleviating disturbance will direct the clinician to the type of protocol needed. In addition, Knipe (2009) identifies a way to address defenses often present in addictive behaviors by using a level of urge to avoid scale.

Purpose of the Study

The purpose of this study was to explore the lived experiences of persons with co-occurring PTSD and addictive disorders who received combined treatment of EMDR therapy standard protocols and addiction-specific protocols. By gaining more understanding of how individuals perceived EMDR as a mechanism of change in their progression of recovery, the knowledge of how to implement combined protocols in treatment could be advanced. Through this inquiry, it may also be possible for clinicians to better understand the necessity of addressing both diagnoses concurrently within the EMDR therapy approach.

Method

The choice of research design must be tied to the research problem and purpose. The purpose of this study was to study subjective experiences of those who had PTSD and addictive disorders and had experienced different protocols of EMDR. Because qualitative research is suited to promoting a deeper understanding of a phenomenon as viewed from the perspective of the research participants, a qualitative design was chosen. Quantitative research, on the other hand, is applicable when discovering relationships between two conditions and to study cause–effect phenomenon. In this study, a quantitative approach could not encompass the breadth of the research questions. McCracken (1988) stated that quantitative research is preferred when questions to be researched can be answered readily and unambiguously. Questions that cause a respondent to be more reflective, are difficult to answer, and are imprecise call for a research method that casts a bigger net. In casting a bigger net, the research obtained a richness of participant experience.

Phenomenological inquiry, a specific approach within qualitative studies, focuses not only on human experiences but also on the meaning that human beings make of those experiences (Seidman, 2013). In seeking to understand the phenomenon of an experience of EMDR therapy, there is much to be learned about the meaning individuals make of their experiences, especially as it occurred within a longer course of treatment. Such meaning cannot be extracted in a quantitative design. Therefore, a phenomenological qualitative design was selected for this particular inquiry.

Sampling Design

Purposeful sampling was used to recruit participants by contacting EMDR therapists who have treated clients for PTSD and addictive disorders using both standard and addiction-specific protocols. Criterion sampling was also used to assure that all participants met specific criteria to qualify as experiencing the phenomenon addressed in the research questions. Other criteria established to participate in the interviews included the following:

1. All genders welcome to participate
2. Age 18 years or older
3. Addiction free or not at the time of the interview
4. EMDR therapy received in the last 5 years

Participant recruiting began as part of the first author's (AW) dissertation research after IRB approval was obtained from her academic institution of study. Recruiting began by identifying licensed clinicians fully trained in EMDR therapy through networking in the EMDR community, primarily in California, where the first author (AW) is based. It was necessary to contact the clinicians initially for two reasons: (a) the prospective participants were clients of other therapists, so the first author (AW) had no access to them unless their therapist made the contact and releases of information were agreed on and (b) the treating clinicians made the criterion evaluation of possible participants. Because clients are often not aware of the designations of different EMDR therapy protocols, ascertaining what protocols were used in treatment was necessarily a function of the referring clinician. Once clinicians identified clients as prospective participants, they made the initial contact with the client, explaining the rationale for the research and gave them the first author's (AW) contact information. The first author (AW), in personal communication with the referring clinician, reiterated the intention to achieve a sample of respondents who had varying experiences with EMDR, whether negative or positive.

Data Collection

Demographic information was obtained prior to the interview. A semistructured interview was developed and used to gather the data. Although some qualitative designs favor a more open questionnaire format (McCracken, 1988), a completely nondirective interview style would not allow for the specific information needed about the experience of EMDR therapy. The interview structure was based, in part, on a model set forth by Smith, Flowers, and Larkin (2009). According to the authors, a solid interview should include 6–10 open questions, along with prompts. Other guidelines for the interview included having a range of topic areas to cover, putting the topics in a sequence, creating open questions, and discussing the questions with someone else before starting the formal interview process.

The selection of interview questions was also informed by phenomenological research conducted by Marich (2009, 2010). Marich used this qualitative method in both a case study (Marich, 2009) and a larger addictive disorders treatment center investigation (Marich, 2010) in which 10 women participated. Marich (2010) formulated a semistructured interview, which the first author (AW) used as a guide for the interview in this study because of the similarity in subject matter. The interview is listed in Table 1.

TABLE 1. Semistructured Interview

Participants are asked to answer a set of basic demographic questions at the beginning of the interview:

1. Name
2. Age
3. Gender
4. Parenting/family status
5. Employment status
6. Summary of treatment currently for PTSD and of SUD or other addictive disorder
7. Summary of other treatments in the past for trauma, addictive disorder, or other disorders
8. Length of time in treatment with the EMDR therapist
9. What EMDR addiction-specific protocols were used to address the addictive disorder? (This information may be requested from the treating clinician.)

The next set of semistandardized questions will be asked which address the research questions:

1. At what point in your therapy did you and your therapist decide to do EMDR?
2. Did you work on past traumas with EMDR before you worked on the substance abuse disorder, addiction problems, or vice versa? (This information may be requested from the treating clinician.)
3. What was your experience with EMDR in regards to helping you with addictive symptoms?
4. What was your experience with EMDR in regards to traumatic memories?
5. What have you noticed about the interrelatedness of trauma memories and addictive symptoms?
6. What changes have you seen in your life as a result of EMDR treatment?
7. How would you describe your overall participation EMDR therapy?

Note. PTSD = posttraumatic stress disorder; SUD = substance use disorder; EMDR = eye movement desensitization and reprocessing.

The number of participants desired was 8–10. The number of participants in qualitative research needs to be enough that differing experiences can be explored while keeping the amount of information manageable (McCracken, 1988; Smith et al., 2009). Each 60- to 90-minute interview was tape recorded with permission of the participant. A pilot interview was conducted prior to interviews with the research participants. A client from the first author's (AW) own practice treated for both PTSD and an addictive disorder agreed to participate. The pilot interview was used to inform and refine the interview questions used in the main study.

Data Analysis

Selecting a credible, established data analysis procedure is important within qualitative research. Such procedures offer a step-by-step method to follow for reading, coding, and interpreting the data. Creswell (2013) offers a practical approach to data analysis based on the qualitative methods work of Moustakas (1994). The Creswell approach was followed to read, code, organize, and later interpret the data:

1. Describe personal experiences with the phenomenon in question
2. Develop a list of statements about how participants experienced the topic
3. Take significant statements and group them into meaning units or themes
4. Write a description of "what" the participants experienced with the phenomenon (textual description)
5. Write a description of "how" the experience happened (structural description)
6. Write a composite description of the phenomenon using both textural and structural descriptions. This is the essence of the experience. (Cresswell, 2013, pp. 193–194)

In this research, the aggregated themes were the essence of the participants' experience. Along with the Themes 1 and 2, subthemes emerged which were interconnected to the main idea. Because these were conceptually interesting to the main theme, they were also noted. As Creswell notes, subthemes emerge as the "children" to the family of themes (Creswell, 2013, p. 186).

Step 1 in the Creswell approach describes a universal practice in qualitative research: A researcher and reader of data must be transparent and honest about her experience with the phenomenon before reading the data. By engaging in this honest examination, the researcher can have a system in place (bracketing) to account for any biases that might influence reading of the data. The first author (AW) is a certified EMDR therapist and approved consultant, with many years of experience practicing EMDR therapy and working with addiction. In the letter of inquiry to interested clinicians, the first researcher stipulated that the result of the EMDR therapy was not important to the criteria. In this way, the first author (AW) attempted to obtain and present discrepant findings, acknowledging the potential challenges to her expectations that participants would consider their EMDR successful to their recovery. In the interviews, the first author (AW) disclosed to participants that she is an EMDR therapist and assured participants that there was not a particular outcome for which she was hoping.

TABLE 2. Demographic and Clinical Information for Study Participants

Pseudonym	Age	Self-Diagnosis Trauma/Addiction	Length of Time in EMDR Treatment
Kayla	36	PTSD/alcohol abuse	3 years
Laura	48	PTSD/alcoholic	1–1/2 years
Lynn	34	PTSD/shopping addiction	1 year
Diane	28	PTSD/smoking	2 years
Judy	60	PTSD/food addiction	2 years
Madeline	53	PTSD/shopping/alcohol/cocaine	7 years
Dan	53	PTSD/smoking	2 years
Jack	46	PTSD/alcohol	13 years
Ned	33	PTSD/methamphetamine/alcohol/sex addiction	1–1/2 years

Note. Mean length of time in treatment with EMDR clinician = 3.6 years. EMDR = eye movement desensitization and reprocessing; PTSD = posttraumatic stress disorder.

Results

Thick Demographic Description

All of the participants reported having treatment for trauma prior to their treatment with the EMDR clinician. Time in prior treatments for trauma (before EMDR therapy) ranged from brief, court-ordered therapy of a few sessions to "off-and-on" therapy for 20 years. All of the participants received EMDR therapy with EMDR-trained clinicians in a private practice setting. Five different referring clinicians provided the arrived at sample of nine participants; the mean length of engagement with the clinician was 3.6 years. The types of addiction experienced for which the participants received EMDR therapy included alcohol, smoking, food, methamphetamines, sex addiction, and shopping.

Participants' ages ranged from 28 years to 60 years. Four of the participants had treatment prior to seeing the referring clinician for the specific addiction discussed in the interview, but the treatment had not included EMDR therapy. Two of the participants had received prior treatment for a different addiction, one for prescription drug abuse and one for cocaine and alcohol, but EMDR therapy was not used in the prior treatments. The other five participants received no prior treatment for the addictive disorder.

Table 2 gives the pseudonym for each participant along with the age, self-description of their addiction, and time in treatment with the referring clinician. Table 3 gives the pseudonym and the addiction-specific protocol used: DeTUR, CravEx, FSAP, or a combination of the protocols. Three clinicians not

TABLE 3. Addiction Protocols and Comorbidity Theme of Participants

Pseudonym	Addiction Protocol Used	SUD/PTSD Comorbidity Theme
Kayla	FSAP	Self-medicating
Laura	FSAP/Knipe	Shared vulnerability
Lynn	FSAP	Self-medicating
Diane	FSAP	Shared vulnerability and self-medicating
Judy	FSAP	Self-medicating
Madeline	FSAP	Shared vulnerability and self-medicating
Dan	DeTUR	Self-medicating/shared vulnerability
Jack	FSAP/Knipe	Substance-induced anxiety
Ned	CravEx/Knipe	Shared vulnerability/substance-induced anxiety

Note. SUD = substance use disorder; PTSD = posttraumatic stress disorder; FSAP = feeling-state addiction protocol; DeTUR = desensitization of triggers and urge reprocessing; CravEx = craving extinguished.

only identified the addiction-specific protocol as FSAP or CravEx but also disclosed being influenced by Knipe's recent recommendations on targeting addictive disorders (e.g., specifically on when to use each protocol).

Participants' Lived Experiences

All of the participants noted that their interest in being interviewed was to let others know how much they had been helped by the EMDR therapy. As a collective, the participants expressed positive experiences with EMDR therapy and with their EMDR therapist. How and when EMDR therapy protocols were used within the therapy differed from person to person. All participants were referred to the treating therapist because others specifically recommended EMDR therapy to them, and all were engaged in other therapy prior to the EMDR therapy. Some began the EMDR reprocessing phases as soon as the client history, rapport, and resourcing was accomplished (i.e., Lynn, Kayla, Laura, Dan, and Ned). Others needed a longer period of stabilization before reprocessing commenced (i.e., Diane and Judy).

Theme 1: As a Result of EMDR Therapy, All Participants Recognized Their Addictive Disorder as Related to Their Trauma. Three of the participants (who identified alcohol as the primary problem) noticed a direct link between the use of substances and a desire to alleviate psychological pain. As examples, Kayla reported coming home from work, drinking for 4 hours, and going to bed every night after the suicide of her fiancé. Ned recognized the origins of his use of alcohol and meth when in the throes of keeping traumatic family secrets. He also recognized as his use of both substances continued, that his anxiety created more use, which resulted in further traumatic incidents.

Four others described the addiction-traumatic memories link somewhat differently. For both Madeline and Lynn, shopping was a way to bond with their respective mothers. For Lynn, whose mother was in a violent relationship, taking the kids to shop was a way she could escape, and the children could safely spend time with her. Lynn used shopping compulsively into adulthood to escape her own dysfunctional relationship. Madeline associated shopping with her mother as a means of connection. As a result of the EMDR therapy, she came to realize the tenuousness of her relationship with her mother. Overspending by shopping continued to be triggered whenever she felt unsure of her relationship with others. For Judy, food was linked to her mother's attempts to soothe her as a child after she was abused. Judy continued to use food to self-soothe when difficult memories arose, even to the detriment of her health. For Diane, smoking had links to trauma and continued whenever she had traumatic recall. The origins of her smoking also related back to a time as a teenager when she found an "out" from family dysfunction by smoking with friends. For Dan, smoking was an attempt at passive suicide; he consciously realized this insight through the EMDR therapy. After an accident in which a friend was killed, he had decided he did not deserve to live and thought smoking would be a certain way to end his life.

Subtheme 1: The Thoughts and Behaviors Related to the Addictive Process Changed as a Result of Making That Connection in EMDR Therapy. After processing the alcohol addiction and the trauma, Kayla reported, "My whole thought process changed. Now, I can think about it, recognize the link, and get a grasp on it." Dan said that once he processed the trauma of the accident and realized there was nothing he could have done to prevent it, he realized he wanted to live and be healthy. Like Dan, after Laura processed relationship traumas with EMDR, she realized she wanted to "get healthy." Madeline expressed that the EMDR helped her "know where this stuff came from and what's underneath all that. It's so gratifying to have understanding—it keeps me out of that emotional hole when I'm triggered to overspend." For Judy, emotional regulation has improved as a result of the EMDR around food as a perceived resource for trauma. Diane thinks differently about attachment subsequent to EMDR, which changed her ability to regulate emotions, "I don't get flooded and dissociate. Since EMDR, I almost never have that problem." For Lynn, her recognition of boundaries and when to use them was a positive change resulting from her EMDR treatment and the link between her traumatic childhood and her addictive disorder.

Theme 2: Participants Identified Remission of Addictive and Trauma-Related Symptoms through EMDR Therapy. Both Lynn and Madeline reported now being aware of when and why they wanted to shop or overspend and an ability to satisfy that need in other more appropriate ways. Madeline admitted to recognizing current, potentially triggering stressors (at the time of the interview) and recognized her need to obtain support. Dan reported to have stopped smoking altogether with no relapses indicated at the time of the interview. Diane, who was also treated for smoking, reported not smoking at the time of the interview but "wasn't sure why" and thought it

might be because of moving out of state where there were no triggers to smoke. She also surmised that the EMDR therapy might have been a factor. Treated for food addiction, Judy felt less triggered to eat in an unhealthy way and better able to "self-regulate" around food. Jack reported being sober from alcohol for 5 years. Ned stated he was clean and sober for 1 1/2 years from alcohol and methamphetamine but continued to work on sexually compulsive behavior with his EMDR therapist. Laura reported continuous sobriety from alcohol for 1 year. In her case, initial work with the EMDR therapist led her to a 3-month inpatient program to stabilize before returning to do more EMDR therapy. Kayla defined herself as an alcohol abuser rather than an alcoholic. As a result of the EMDR therapy, she reported that she had control over her drinking and no longer abused it.

All participants reported dramatic reductions in PTSD symptoms as a result of processing traumas. These included early childhood traumas (i.e., Lynn, Diane, Judy, Madeline, Jack, Ned, and Dan) as well as single-incident traumas such as the accident experienced by Dan, and adult relationship-related traumas (i.e., Kayla and Laura).

Subtheme 2: The EMDR Treatment Was Perceived to Be Effective Whether the Trauma Was Treated First or the Addiction. In the case of Ned, use of methamphetamines had escalated to such a point that he could not stay clean for more than a few months. The EMDR addiction-specific protocols initially helped him to stay clean for a time, "get out of the vicious cycle," and then enter a sober living residence on the recommendation of his therapist, which helped him continue progressing in recovery. His therapist described this initial EMDR therapy work to the first author (AW) in a separate communication as "toggling back and forth between the use of the feeling-state protocol, the reduction of urges, and relapse desensitization." Once stabilized and in a clean and sober environment, he was able to work on early childhood traumas. Laura also had EMDR addressing the drinking, which then led her to a more intensive program and subsequently trauma processing. For the others, trauma processing preceded work on an addictive disorder and resulted in the addictive disorder coming to light. For instance, it was during the trauma processing with EMDR that Lynn recognized her compulsive shopping was a problem and was related to the memory of her mother and shopping.

Theme 3: Integrated Treatment (EMDR and Other Supportive Modalities) Were Recognized as Optimal for Ongoing Recovery From Addiction and Traumatic Disorders. Six of the participants recognized having other supportive therapeutic components as key to their ongoing recovery from addictions and trauma. For Ned, Madeline, and Laura, working an Alcoholics Anonymous (AA) program, including sponsorship and meetings, was very important. Dan continued to go to groups at an outpatient center recommended by his therapist for help with depressive symptoms, which were identified as trauma triggers. He also had a therapy dog and used the dog for mood regulation. Judy found sensorimotor psychotherapy helpful in conjunction with the EMDR therapy. In addition to AA, Laura also participated in an ongoing yoga practice. Once EMDR therapy was completed, Lynn found volunteering at a domestic violence shelter helped her "give back" what she had gained in therapy.

To several participants, having a psychiatrist whom they trusted for medication management was also an integral part of treatment. Because the study did not specify that the participants' diagnoses were exclusive to PTSD and addiction, several persons talked freely about other mental health issues. Jack, for instance, had a difficult time with attention deficit hyperactivity disorder (ADHD) and severe anxiety. Along with addressing the drinking and trauma, proper medication had helped to stabilize those issues. Ned expressed having paranoia, which careful medication and collaborative work with his therapist had helped.

Theme 4: The Relationship With the Therapist Was Integral to Successful EMDR Therapy. All of the participants expressed respect and gratitude for their EMDR therapist. Rapport and trust established with the clinicians was a key part of successful treatment, and the participants described experience suggested that each treating clinician took great care in the preparation phase of EMDR therapy.

Participants found their way to the EMDR therapist on the recommendation of a family member (i.e., Madeline, Ned, and Laura), a colleague (i.e., Lynn), or another treatment professional (i.e., Kayla, Diane, Judy, Dan, and Jack). Thus, each of them had some reference to the expertise of the clinician before starting EMDR therapy. Each person stated that EMDR was well explained before processing began. Laura stated, "I felt very safe, once we formed a trust and once she explained about it [EMDR]. And there was relaxation prior. It couldn't be a better experience." Lynn remarked about her therapist, "I felt I had an amazing connection with him, I trusted him a lot, I felt open and comfortable and very safe."

Diane had a somewhat different experience, although positive. She described having a "really hard

time at first. It was necessary to do more talk therapy and resourcing until I felt comfortable. Also, I thought I wasn't doing it right." With the encouragement of her therapist, she was able to begin the EMDR reprocessing phases about 6 months into therapy. Most participants described doing resourcing exercises with their therapist prior to doing trauma or addiction protocols. This provided a sense of safety and trust, both with the therapist and with the EMDR process. Laura completed breathing exercises "before and after, every time." Several participants made reference to a container exercise used by many EMDR clinicians, which helps clients imagine putting disturbing emotional material in a visualized container for safekeeping between sessions. Two clients who had trouble with dissociation reported their therapist used grounding exercises in EMDR sessions, which helped them feel emotionally safe.

Discussion

Four themes and two subthemes were identified from the research data. The essence of each theme further supports ideas already presented in the literature on both EMDR therapy and the concurrent treatment of PTSD/trauma and addictive disorders. All participants recognized how their unresolved traumas and addictive disorders were interrelated as a result of EMDR therapy (Theme 1). Thoughts and behaviors changed as a result of making that connection (subtheme). Although some participants realized their use of substances was a way to self-medicate painful memories prior to EMDR therapy, their thoughts and behaviors had not changed as a result. Others did not know, prior to EMDR, that their particular addictive behavior was connected to the traumatic material. The use of the two separate protocols targeting trauma and addiction seemed to help them achieve that insight and progress in recovery from both, a hope for recovery expressed in some way by each of the addiction-specific protocol authors (Hase, 2009; Miller, 2012; Popky, 2005;). Although hypotheses surrounding the exact interplay between trauma-related symptoms and addictive disorders vary (Hruska & Delahanty, 2014; Kullack & Laugharne, 2016; van Dam et al., 2012), there is consensus that treating both conditions in an integrated way is vital (Carruth, 2006; SAMHSA, 2013; van Dam et al., 2012). For the participants in this study, cognizance of the described interplay was an important aspect of receiving treatment in an integrated manner.

All participants recognized remission of trauma-related and addictive disorder symptoms through EMDR therapy (Theme 2). Existing empirical evidence has well-established EMDR therapy's efficacy in the treatment of PTSD. Although such potent evidence is still inconclusive in the treatment of addictive disorders symptoms, there is a growing body of such evidence (Brown et al., 2015; Hase et al., 2008; Marich, 2010). The findings of this study show promise in combining standard protocol EMDR therapy and addiction-specific protocols for men and women with both disorders.

Subtheme 2 reveals that EMDR therapy was effective whether the trauma was treated first or the addiction. Participants reported that the addiction-specific protocols did not lead to further activation of trauma symptoms. This supports Hase and colleagues' (2008) findings that the addiction memory may be independent of the traumatic memory and that processing it can be done with positive results without increasing reactivity to traumatic triggers. It also challenges an assumption held by many EMDR therapists that the trauma should not be processed with EMDR until an addictive disorder is stabilized or full abstinence is achieved. This assumption is further challenged by Kullack and Laugharne (2016) who found a reduction of addictive symptoms once trauma symptoms were treated with the standard protocol alone. In addition, a widely disseminated research review by de Jongh et al. (2016) challenged long-held recommendations by the 2012 International Society for Traumatic Stress Studies expert task force for the implementation of an extensive stabilization phase with complex PTSD survivors. This research review concluded that there is no substantive research base for these recommendations and that complex PTSD survivors are better served by more trauma-focused treatments, even though there is some risk. Although the studies examined in the de Jongh et al. review did not directly speak to substance use or addictive disorder components, the findings could begin to challenge long-held assumptions that a client must be stabilized and abstinent for EMDR to commence.

Participants in this study reported that working on traumatic memories did not increase their desire to use substances or practice an addictive behavior. It is worth noting that the participants were in therapy with skilled EMDR clinicians who (a) have extensive experience in treating addiction and (b) made careful and judicious decisions about how and when to use the protocols. For most participants, other supportive services were in place, offering a degree of protection that Shapiro herself endorsed in her early writing on EMDR and addiction (F. Shapiro et al., 1994).

All clinicians seemed to practice guidelines recommended by F. Shapiro (2001) for doing a careful client history, assessment, establishment of safety and rapport before proceeding with EMDR therapy.

Participants recognized integrated treatment (EMDR therapy alongside other supportive modalities) as optimum for sustainable recovery from addiction and traumatic disorders (Theme 3). Concurrent treatment for both PTSD and addictive disorders is generally advocated to be more effective than treatment focusing on one disorder alone (Carruth, 2006; SAMHSA, 2013; van Dam et al., 2012). EMDR therapy as a trauma-focused treatment along with other supportive services such as group support, medication management, and lifestyle tools showed positive outcomes for all participants, a finding also reported in the other existing phenomenological studies on EMDR therapy and addiction (Marich, 2009, 2010).

The relationship with the therapist was integral to successful EMDR therapy (Theme 4). Other studies and practice knowledge within the field of EMDR therapy also emphasizes the client–therapist relationship as integral to the success of EMDR therapy (Dworkin, 2003, 2005; Korn, 2009; Marich, 2010, 2012; F. Shapiro, 2012). Participants in this study echoed the lived experiences of participants in the only other phenomenological inquiry on EMDR therapy and addiction (Marich, 2010): The participants' rapport with their EMDR therapist provided the foundation of trust needed to do intensive EMDR work. This theme corroborates earlier recommendations for the use of EMDR therapy for treating addictions as part of an overall treatment regimen (F. Shapiro et al., 1994; Zweben & Yeary, 2006). These early recommendations referenced use of the standard protocol to alleviate traumatic symptoms of PTSD as helpful to addictive disorder recovery in comorbid cases. The addition of the newer addiction-specific protocols for this population offers clinicians even more options for case conceptualization in the treatment of such individuals.

Limitations

Within qualitative research, the sample size used in this study is generally considered sufficient, although a greater sample size might have elicited more varied results. Given the time involved in contacting referring clinicians, finding criterion-specific participants, establishing time for interviews with each person, and transcribing and analyzing data, a greater number of participants was not possible given the time frame allotted for the research.

Because the length of time in treatment of the participants varied considerably, it would be difficult to generalize from this sample an optimum length of time needed to use both protocols in a treatment setting. It is also possible that the recall of treatment effects was less than accurate because of the passage of time since EMDR was administered.

A potential limitation that is often a factor in qualitative research is researcher bias. The first author (AW) and primary investigator is an EMDR therapy advocate (directly trained by Francine Shapiro) in addition to being EMDRIA-approved consultant and training facilitator. As part of the Creswell system for data analysis used in this study, the first author (AW) honestly evaluated her role as investigator and reader of the data. She recognized that there are many instances in her own practice of over 20 years where EMDR therapy did not necessarily achieve the results desired or that reduction of symptoms was not so quickly accomplished. The second author (JM) was also present, in the role of consultant, as the research was completed. Although the second author (JM) is also an EMDRIA-approved consultant and trainer, she has publicly expressed concern about overuse or misuse of the addiction-specific protocols. The first author (AW) willingly maintained objectivity as she gathered and analyzed the data, an important safeguard for credibility within qualitative research.

Although both authors retained a healthy skepticism about the experiences reported, a second limitation, referring clinician bias, must also be identified. The recruiting inquiry letter sent to clinicians specified that the first author (AW) was not looking for a particular result and that there was no requirement for participants to be clean or sober. However, there is a chance that clinicians who did not see favorable results from their work might have been reluctant to refer their clients for the research. Both authors recognize, from the experience as EMDR therapy consultants, that clinicians are slower to report less-than-positive results with EMDR because of the perceived potential negative reflection on their clinical skills. A possible future study might consider a way to have anonymous reports directly from clients who have experienced EMDR to reduce this possible bias.

Lastly, both authors acknowledge the lack of diversity in the sample size. Although both male and female genders are represented, all participants in the study received treatment in private practice settings. Identifiers about race or ethnicity were not specifically asked for in the demographic questionnaire. Both authors fully recognize that conducting similar research in public practice settings (where issues

surrounding diversity and recovery were discussed in the interviews) would have offered more varied lived experiences in the reading and interpretation of the qualitative data.

Future Directions

A high level of enthusiasm exists in the EMDR therapy community about the addiction-specific protocols and their possibilities for enriching case conceptualization and treatment. Research on the EMDR addiction-specific protocols is currently limited, and more studies using various designs must be conducted before these protocols are universally accepted as a treatment standard. How and when to use the addiction-specific protocols may continue to be refined in future studies. As Knipe (2015) indicated, the addiction-specific protocols differ not only in method but also in conceptualizing how addictive behaviors begin. Although Knipe's new work gives EMDR therapists some insight into these questions of implementation, corroboration of his practice knowledge with more specific, empirical research is needed.

Two limitations presented in this study offer pathways for specific future inquiry. First, the referring clinicians used in this study were all experienced at working with addiction, and this experience seemed to positively impact their clinical judgment and decision making. Many EMDR therapists currently receiving training in the addiction-specific protocols are doing so absent training in general addictive disorder counseling. There is concern that lacking knowledge about the larger context could prove problematic (Marich, 2016). Future studies on the addiction-specific protocols may consider examining whether or not an EMDR therapist's overall understanding of addiction is a relevant factor in treatment, or if generalist EMDR therapists can work with the protocols absent training in addiction. Second, the lack of diversity in the sample is a call to action for studies similar to this one to be conducted in public practice settings. In such settings, most clients do not have access to the amount of sessions afforded to the participants in this study. Other issues such as oppression/discrimination and lack of funding for both treatment and basic needs of living might reveal themselves as relevant to the treatment and recovery experience.

In the addiction treatment field at large, further study is needed to explore possible differences in the genesis, development, and treatment needed for different types of addictions in co-occurring disorders, including PTSD (Hruska & Delahanty, 2014). Further investigating the use of EMDR therapy and the addiction-specific protocols within EMDR therapy may continue to provide clarity on how individuals perceive the differences in manifestations of addictive disorders. Any research completed from an EMDR therapy perspective on addictive disorders or addictive disorders co-occurring with PTSD will likely contribute to the general addiction field's understanding of treating comorbid addictive disorders and trauma-related disorders.

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