

Using EMDR in the Treatment of Chemical Dependency and Impulse Control Disorders

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Training Objectives

- Phase One--History and case conceptualization concerns unique to Clients with histories of addictions and impulse control disorders.
- Phase Two/Preparation phase of treatment—stabilization techniques.
- Client selection issues for Phases Three through Eight. Desensitizing addiction memory networks. Use of addiction Protocols and Standard Protocol.
- Ego States and Addiction treatment. Brief overview of the use of the “conference room” or “dissociative table” to address addiction issues.

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Impulse-Control Disorders and Addictive and Compulsive Behaviors

- “Impulse-control disorders (ICDs) involve some level of intensity before, positive feeling or relief during and may have regret, remorse of guilt after—kleptomania, pyromania, gambling, trichotillomania, intermittent Explosive Disorder (DMS 4).
- Other Addictive and Compulsive Behaviors (ACB’s)—food issues, perfectionism, porn, video games, work, cleaning, self harm, ect., ect., ect.

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Why Addiction? ACES (Adverse Childhood Experiences Study)

“In our detailed study of over 17,000 middle-class American adults of diverse ethnicity, we found that the *compulsive use of nicotine, alcohol, and injected street drugs* increases proportionally in a strong, graded, dose-response manner that closely *parallels the intensity of adverse life experiences* during childhood.” (Felitti VJ. 2003)

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Why Addiction? ACES (Adverse Childhood Experiences Study)

“Our findings are disturbing to some because they imply that the **basic causes of addiction lie within us and the way we treat each other**, not in drug dealers or dangerous chemicals.” (Felitti VJ. 2003)

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Finding Your ACE Score While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? Yes No If yes enter 1 _____
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you? Yes No If yes enter 1 _____
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? Yes No If yes enter 1 _____

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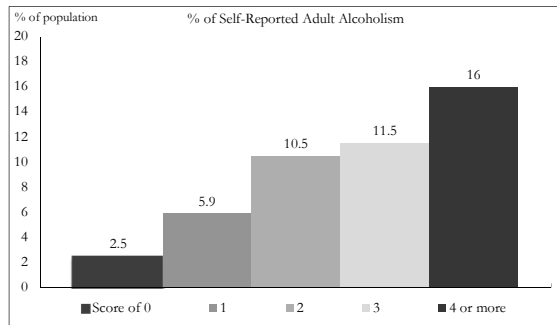
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes No If yes enter 1 _____
6. Were your parents ever separated or divorced? Yes No If yes enter 1 _____
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife? Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? Yes No If yes enter 1 _____
10. Did a household member go to prison? Yes No If yes enter 1 _____

Add up your "Yes" answers: _____ This is your ACE Score.

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ACE Score and Adult Alcoholism

500% increase of alcoholism in graded manner to ACE



Felitti, 2003

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AIP, ACES and Addiction

- EMDR is based on the theory that negative thoughts, feelings and behaviors are the result of unprocessed memories.
- The ACE study links addiction to childhood trauma.
- Unaddressed addiction hinders trauma resolution and perpetuates more trauma.

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Addiction Memory Networks

The repetitive use of maladaptive behaviors to cope, creates emotionally charged memory networks.

- Triggers, urges, compulsions and **both** negative and positive feeling states.
- Trauma created by active addiction.
- Relapses and treatment failures.
- The negative impact addiction has on one's sense of self or identity—"I'm bad" "I'm a loser" "I'm a failure".

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Substance Abuse and Trauma Treatment Dilemmas

- In many substance abuse treatment settings the trauma diagnosis may be overlooked or "put on hold" while the addiction is treated.
- Many treatment programs still require or suggest abstinence prior to addressing past trauma.
- In EMDR treatment, active substance use can stall or interfere with the treatment progress.

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Other dilemmas--"The Doctor said, it's okay"



"You should just feel a tiny prick, and then a lifetime of morphine addiction."
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American Journal of Psychiatry January 2010

- “Do Treatment Improvements in PTSD severity affect substance use outcomes? A Secondary Analysis from a randomized clinical trial in NIDA’s Clinical Trails Network”---Denise A. Hien et al .
- **“PTSD changes were found to impact substance abuse outcomes.** Specifically, PTSD severity reductions were associated with substance abuse disorder improvement, with **minimal evidence of substance abuse reduction improving PTSD symptoms”.**

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EMDR/Addiction Research If you can’t keep them, you can’t treat them.....

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

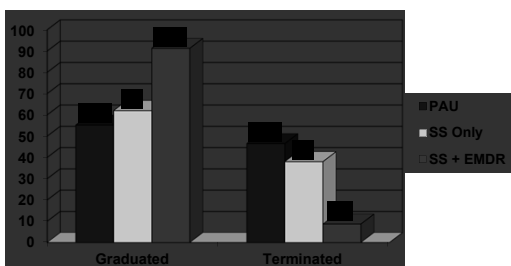
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14²⁴

Post - ITTP Graduated by Group N=219 (Aug. 1, 2004-Dec. 31, 2009)

PAU N=58 SS Only N=50 SS+EMDR N=69



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EMDR/Addiction Research

- Hase, Schallmayer and Sack (2008) Cravex protocol for alcoholism.
- Bae and Kim (2012) DeTUR for internet addiction.
- Miller (2012) FSAP for behavioral addiction.
- Tsoutsas (2013) FSAP for smoking cessation.

Treatment goal—creating a life worth staying abstinent for

Desensitizing addiction memory networks to “deactivate relapse triggers”.

Building a network of accessible, healthy coping skills that can address life stressors when they happen.

Clearing past trauma so one can live, love and pursue goals in the now vs living in reaction to the past.

If this is accomplished, addictive behaviors are no longer necessary or as appealing

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Addictions can be used as...

- A substitute behavior.
- Self-medication.
- A way to “fit in” with others.
- An aspect of a family culture.
- A way to cope with trauma symptoms.
- A favorite coping skill of “protector” parts of dissociative clients.

The relationship your Client has with their drug/behavior of choice helps to determine the treatment plan.

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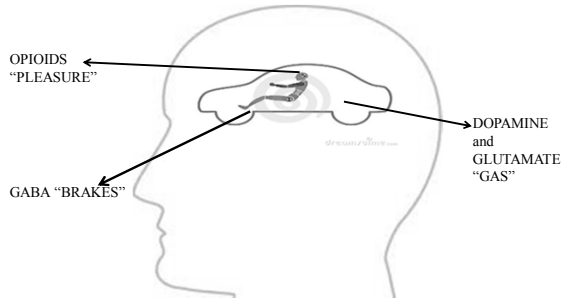
Therapist Assessment Issues

YOUR Personal “buy in” and an assessment of your reservations.

- The *strong belief* that your client can achieve their goal.
- the *willingness to tolerate* the client’s treatment goals when they differ from yours.
- the *ability to hold out hope*--no matter how long you have to hold it or how heavy it may get.

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Jon Grant, M.D., J.D., M.P.H Addicted Brain



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Client History—Phase 1

Full History

- Developmental/ACES
- Medical
- Past treatment
- Substance use/abuse
- Psychiatric diagnoses
- Past/current medications
- Trauma history
- DES

Assess Impulsive behaviors

- Assess for detoxification
- Assess clients’ ability to honestly report impulses and behaviors.
- Client’s patterns of use
- Triggers
- Maladaptive Positive Feelings linked to ACB

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Client History—Phase 1

For clients with histories of dissociation and substance use clarify the difference between “black outs” related to substance use and the “black holes” associated with dissociation.



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Client History—Phase 1

▪ Assess for “Red flags”:

- Suicidal/homicidal thoughts
- Self harm behaviors
- Lethal drug/alcohol use
- Dissociation
- Major psychiatric instability
- Pressing medical concerns or other safety concerns.





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Client History—Phase 1

➤ How is your client managing recent distressing issues

- Test the system by asking client to imagine future problem.
- Can the client handle discussing traumatic events?
- Can they stay present and able to tolerate their feelings?
- Does client return the next week without setbacks?
- If the addiction/impulse disorder stops—what coping skill will be used instead?
- Safety of the client’s living situation
- Availability of supports

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<p>Positive Aspects of Impulsive Behaviors -What am I getting out of using? -What are the good feelings I get just before using and during using? -What are the positive things drugs give me?</p>	<p>Negative Aspects of Quitting What am I going to lose if I stop using/engaging in behavior? What will I miss?</p>
	
<p>Negative Consequences of Current and Future Use What are the problems I have with using now, and what will happen if I continue to use (engage in behavior)?</p>	<p>What are the advantages of stopping the behavior/drug use? What do I have to gain if I stop or slow down?</p>
	

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Phase 2 preparation work with non-abstinent clients

- Create a “radically honest” treatment contract with your client, asking for candid reporting of all impulsive behaviors as part of the work.
- Discuss and contract around the possible consequences of this type of reporting, for example: reports for the legal or child welfare system or agency policy.
- Ask client to present substance free for your sessions, schedule sessions at times that make this more likely.

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Phase 2 preparation work with all clients

- Start by teaching the, safe/calm place, stop signal and creating a “container”—practice during and between sessions.
- Install resources related to times when the client felt: resourceful, powerful or in control—Slow short sets of BLS. Ask Client to access resources between sessions.

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Common Resourcing Needs

- Ability to ask for and use help
- Avoidance of responsibility
 - Determination
 - Willingness
- Over-responsibility.
- Avoidance of emotion

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Phase 2— Stabilization Protocols

- HASE—how would you feel if you had accessed your drug/compulsion of choice? Has there been a time moment when you have experienced this feeling in a healthier way? Install/enhance as a resource.
- Using a future template to “practice”/enhance the use of healthier coping skills.
- Robin Shapiro’s “Two Handed Interweave” In one hand--motivated, invested in change, “good” behavior and in the other hand—not motivated, more invested in the “problem behavior”

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Phase 2--Stabilization Protocols

- Adler-Tapia’s Reverse Protocol
- Andrew Leed’s Positive Affect Tolerance (Andrew Leeds 2007) or Resource Development and Installation (RDI)
- Elan Shapiro’s 4 Elements
- Katie O’Shea’s Clearing the Affective Circuits

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Phase 2— AJ Popky’s Positive Treatment Goal

- Create and install a solid and accessible “Positive Treatment Goal”—what Client would be doing if they achieved their recovery goals—Slow, short sets of BLS.
- Ask the client to practice using the “Positive Treatment Goal” between sessions when facing smaller challenges. Do not expect it to be successful in helping them to maintain abstinence. Success means that they practiced and could access this state.

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Stop or Move Forward—Stable enough?

- Can access some calm/safe place, a container and can use a stop sign.
- Can access alternative behaviors to addictions—has some healthy coping skills & has a relapse prevention plan.
- Is “stable enough”—non-lethal addictive use.
- Meets normal EMDR requirements for moving forward or risk is so high or it is a “yellow flag” situation.

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Stop or Move Forward—Stable enough?

- Other considerations: What memory networks can the Client tolerate processing? Addiction specific networks? Underlying trauma?

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Desensitizing Addiction Memory Networks—Phases 3-8

Addiction Focused Protocols

- A.J. Popky's DeTUR Protocol: Desensitization of Triggers and Urge Reprocessing (2005)
- Michael Hase's CraveEX Protocol, addresses urges, cravings and addiction memories (Hase et al., 2008, 2010)
- Jim Knipe's Targeting Positive Affect & Level of Urge to Avoid (2010)
- Feeling-State Addictions Protocol (Miller, 2012)

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Addiction Protocols—Differences (Brown 2014)

- DeTUR (Popky) targets *triggers and urges*, measures LOU (level of urge)
- Positive Affect or Avoidance targeting (Knipe) targets *maladaptive positive (idealized) memory or avoidance*, measures LOPA or LOU-A
- CravEx (Hase) targets *cravings, loss of control, and relapse* (includes positive & negative elements), measures LOU
- FSAP (Miller) targets *maladaptively encoded Positive Feeling-States*, measures Positive Feeling-State (PFS)

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Addiction Protocols: Similarities (Brown 2014)

- All can be used before abstinence is achieved, but with caution....
- All target specific *maladaptively encoded memories* associated with addictive / compulsive behavior or avoidance.
- Once unlinked, reveals disturbing affect underneath
- Therefore, all have the AIP as the underlying theoretical framework for explaining symptoms, case conceptualization, treatment planning, and predicting outcomes

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A “Unified Addiction Approach” (Brown & Payson in preparation)

- Conceptualizes the entire memory network involving associations with addictive or compulsive behaviors as needing reprocessing
- Utilizes any “doorway” into that network as a target: traumas, triggers, urges, positive feeling-states, euphoric recall, idealized relationships or behaviors, cognitions, emotions, sensations, relapses, obsessions or rituals
- Uses the standard 3 pronged protocol (past, present, future) with modifications only as needed

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Where to Start?

- Consider desensitizing positive feeling states and triggers associated with addictions to further stabilize client and prepare them for standard protocol work on the underlying trauma, particularly for clients who are not yet abstinent or are new to recovery. This work can **increase self-confidence, ego strength, safety and therapist/client rapport.**

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Where to Start?

- If the client identifies a direct connection between trauma and addictions—e.g. I drink to sleep at night, because night triggers memories related to sexual abuse, consider targeting underlying trauma first to take the pressure off—IF the client indicates they can tolerate the work and stay abstinent/safe.
- **Your client’s unique relationship with their addiction helps define the treatment plan.**

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Underlying Trauma

AN IMPORTANT CLINICAL DECISION POINT

Working on addiction memory networks, such as triggers, positive feeling states or other addiction material can open access to underlying trauma. If client is stable enough and has contracted for this work, you may need to switch for focus to address the underlying trauma as it arises OR contain the material for the future sessions.

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EMD vs EMDR

TITRATING THE WORK WHEN NECESSARY

If the client is less stable or is unable to tolerate work on underlying trauma, consider using the EMD approach—returning to target more frequently—limiting access to associated networks—containing and/or fractionating underlying traumatic material to address when the client is more stable.

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Common Negative/Positive Cognitions

- I am a failure I am (can be) a success now
- I can't trust others I can (learn to) trust others
- I can't trust myself I can (learn to) trust myself
- I can't ask for help I can (learn to) ask for help
- There is something wrong with me I am okay as I am
- I am weak I am strong
- I am not capable of I can (learn to) do this
getting or staying abstinent
- I am irresponsible I can (learn to) be
responsible

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Common Negative/Positive Cognitions

- I can't handle: I can (learn to) handle:
anger, sadness, happiness,
disappointment,
the anger/disappointment of others

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Maladaptive Cognitions and Addictive Thinking

- Along with cravings, urges, body sensations, and emotions addiction memories can sometimes have their own unique cognitions: "I can have just one", "Screw it", "I deserve this". Clients sometimes refer to these as "parts", "voices" or the "devil on my shoulder".
- They are self-referencing, irrational, and helpful to address/process if they are present as they can fuel the relapse process for some Clients.

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Examples of Maladaptive Addictive Cognitions

- Screw it (I don't matter)
- I deserve this (I don't know any other way to reward myself, I don't deserve good things)
- I can handle it (I am powerless but want control desperately, I can't let go, I want to be like "everyone else")
- It will be different this time (I will be different this time, I can master this, gain control or have what I want, otherwise I am weak)

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“Feeling State” Robert Miller, PhD

DEFINITION OF A “FEELING STATE”
Feeling State = Positive Feeling + Behavior

Creation of a Feeling State
*INTENSE “POSITIVE” FEELING WHEN
ENGAGING IN A BEHAVIOR*

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The Feeling-State Addiction Protocol--Robert Miller PhD RIGID LINK BETWEEN



“FST PROPOSES THAT A COMBO OF SENSATIONS, EMOTIONS, COGNITIONS AND BEHAVIOR COMPOSE THE FEELING-STATE THAT CAUSES THE URGES AND CRAVINGS ASSOCIATED WITH BOTH SUBSTANCE AND BEHAVIORAL ADDICTIONS.”

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Feeling-State, Robert Miller PhD, 2011 DESENSITIZE RIGID LINK BETWEEN



“With client’s full permission, the positive element can be held in mind and combined with DAS. The likely outcome in these situations is a weakening of the positive affect...that are self-defeating or antagonistic to the person’s preferred, realistic life goals” Knipe, 2005

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“Feeling State Protocol” Robert Miller, PhD

Miller's belief about the development of compulsive behavior:

1. Trauma
2. Negative Cognition
3. Deficit in wanted feeling
4. Increased need for wanted feeling
5. The positive feeling state is created when doing certain behaviors
6. Compulsive behavior starts

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“Feeling State Protocol” Robert Miller, PhD

Five phase of treatment

1. History and evaluation
2. Preparation
3. Process the FS “I’m in control”
4. Process the NC underlying the FS “I’m out of control”
5. Process the NC caused by the FS “I’m a loser for doing drugs”

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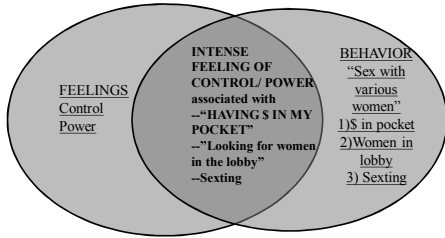
Finding Feeling States/Triggers/Cognitions

BEFORE BEHAVIOR	DURING BEHAVIOR	AFTER BEHAVIOR
Benefits outweigh consequences What are the benefits of using?		
Triggers, Cravings, Urges at this juncture help identify maladaptive feeling states *Feeling States Sensations Emotions Cognitions	Shift in cost vs. benefit	Consequences → Despair → More Trauma

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Client Example—Sex Addiction

RIGID LINK BETWEEN

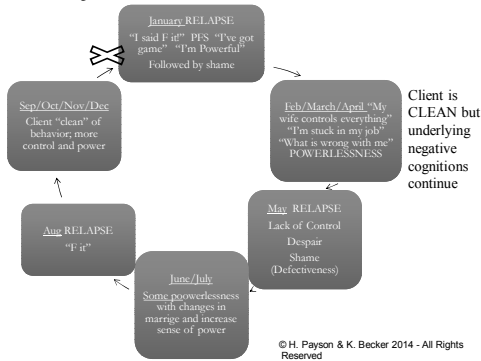


P.C. "I've got game" (power), "I'm doing what I want to do" (control)
 Behavior: Client said that "having sex with various women"
 HAVING PER-DIUM TO SPEND; ANTICIPATION OF "DOING WHAT I WANT TO DO"--FEELING OF LOOKING FOR WOMEN IN THE LOBBY; GF
 SEXTING;

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Cycle of Addiction—Case Example

"Joe" Sex Addiction



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Desensitizing Positive Feeling States—"It's all good"

Why address Positive Feeling States?

- They keep an addiction "alive", prompting continual relapse and instability.
- The connection between addiction/trauma becomes clearer—and "buy in" for working on underlying trauma increases.
- Client's compassion for self grows.
- Therapeutic relationship strengthens.

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Tips for Processing Positive Feeling States

- Be prepared to see underlying material surface as you focus on the “Feeling State”—assess with your client if they have the coping skills/resources to manage this.
- There is often more than one “Feeling State” attached to an addictive behavior.
- If possible, desensitize the “Feeling State” first before addressing NC’s that surface.
- Process the NC caused by the “Feeling State”.
- Carefully close down/contain unfinished sessions.

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Script for Desensitizing PFS

Target: Memory of most intense experience with Positive Feeling State or if no memory can be identified, have the client imagine engaging in the behavior that prompts the PFS. Consider starting with the excitement/anticipation PFS first.

Image: *What picture captures the most intense part of it? (e.g. driving to get substance or to do the behavior, preparing the heroin).* *may not be a picture but rather a physical sensation of excitement or anticipation.

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Script for Desensitizing PFS

Maladaptive Cognition: (associated with maladaptive behavior, therefore not “adaptively positive”)

What words go best with that picture that expresses your belief about yourself when you are in your addictive/obsessive mode? (I am the life of the party, I am powerful, I’m successful, I’m lovable) If no cognition can be identified, move on and access other aspects of the memory network.

Positive (Adaptive) Cognition: *When you bring up that picture what would you prefer to believe about yourself now? (I can learn to be fun without drinking, I can make good choices, I am lovable the way I am) Ask for the positive even if a maladaptive (negative) could not be identified.*

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Script for Desensitizing PFS

Validity of Cognition:

When you think of that picture how true do those words (repeat the adaptive positive cognition above) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?

Emotions:

When you bring up that picture and those words (maladaptive cognition above) what emotion(s) do you feel now?

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Script for Desensitizing PFS

Level of Intensity:

On a scale of 0 to 10, where 0 is no **positive charge** and 10 is the highest **positive charge** you can imagine, how positive or good does the memory of doing the behavior feel to you right now?

Location of Body sensation: Where you feel it in your body?

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Script for Desensitizing PFS

- Process as with the Standard Protocol. For clients able to tolerate channels of association related to underlying trauma, desensitize this material as it emerges or, if not tolerable, consider containing and reprocessing separately. For less stable or non-abstinent clients, return to target more frequently when underlying trauma emerges (EMD). Contain this material to desensitize after client has gained more stability

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Alternative Treatment Options



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Desensitizing Triggers, Urges and Cravings

Why address triggers/urges?

- To increase overall stability.
- Enhance the client's confidence in both themselves and the therapeutic process.
- Allow you the opportunity to assess the client's readiness for trauma processing
- Deepen your alliance with your client.

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Client Selection Factors for Trigger/Urge work

- Clients who report triggers attached to their impulsive behaviors.
- Non-abstinent clients.
- Clients who are not currently stable enough to tolerate processing traumatic memories, but could tolerate and benefit from desensitizing triggers related to their impulses.
- Clients with minimal dissociative symptoms or other "red flag" issues.

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Client Selection Factors for Trigger/Urge Work

- Clients who display “good enough” reporting skills—they can report what is happening when desensitizing triggers/urges, will tell you if they don’t feel safe/stable enough to leave at the end of the session, and generally report impulsive behaviors to you.
- Your assessment points to a “yellow flag” situation indicating that the risk of staying with the current treatment plan outweighs the risk of trying a new intervention, the “we’ve got nothing to lose” factor.

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Tips for Desensitizing Triggers/Urges

- Start with the less difficult triggers to build confidence and acquaint your client with how the process feels/works. External triggers vs Internal.
- Be prepared to plow through strong cravings and the possibility that the intensity of the cravings may take both you and the client by surprise. *Stay the course*, unless the client or your clinical judgment, tells you to stop. If the intensity gets too strong for the client to tolerate, titrate by cycling between the craving and the “Positive Treatment Goal”. Be prepared to use interweaves.
- Make sure you leave enough time in your session to work through or decrease a strong craving.

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Tips for Desensitizing Triggers/Urges

- End all sessions by containing any negative material and accessing the positive treatment goal or “calm place”. Leave enough time to discuss the client’s safety plan before they leave.
- Desensitizing current urges may result in unearthing early trauma—be prepared to shift into standard protocol work or contain the information that emerges, depending upon clinical judgment and the time you have left in that session.

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Desensitizing Urges=the need to build new coping skills

- Impulsive behaviors are an attempt to self-soothe or “numb out”, as you desensitize the old, less useful coping skills you must replace them with new, healthier coping skills.
- Build up the new skills before or during the process of desensitizing the old. Check on the ability to practice and the usefulness of the new skills each session.

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Script for Triggers/Urges

Target: Have client imagine experiencing the trigger as if it is occurring in the office or identify a recent intense memory of experiencing this trigger and the craving/urges associated with it.

Image: *What picture captures the most disturbing or intense part of it? (e.g. picking up that first drink, smelling the alcohol, driving by the package store).*

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Script for Triggers/Urges

Maladaptive Cognitions: *What words go best with that picture that expresses your belief about yourself as you experience the most intense part? (“I can’t handle it”, “I’m weak”, it can also be an irrational addictive thought such as “I deserve this”, “I can handle having one drink” or “I don’t care about me”)*

Or *“When you are in your addictive/obsessive mode what words go best with that picture?”*

If no cognition can be identified, move on and access other aspects of the memory network.

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Script for Triggers/Urges

- **Positive (Adaptive) Cognition:** *When you bring up that picture what would you prefer (or like) to believe about yourself now? (I can handle it—or I can learn to handle it, I am strong, “I deserve a good life”, “I can handle this sober” or “I matter”). Ask for the positive even if a maladaptive (negative) could not be identified.*

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Script for Triggers/Urges

Validity of Cognition:

When you think of that picture how true do those words (repeat the positive cognition above) feel to you now on a scale of 1 to 7, where 1 feels completely false and 7 feels completely true?

Emotions:

When you bring up that picture and those words (maladaptive cognition above) what emotion(s) do you feel now?

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Script for Triggers/Urge

SUD: *On a scale of 0 to 10, where 0 is no disturbance/intensity or neutral and 10 is the highest disturbance you can imagine, how disturbing or intense does the memory feel to you now?*

Location of Body sensation: *Where you feel it in your body?*

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Script for Triggers/Urges

- Process as with the Standard Protocol. For clients able to tolerate channels of association related to underlying trauma, desensitize this material as it emerges or, if not tolerable, consider containing and reprocessing separately.
- For less stable or non-abstinent clients, return to target more frequently when underlying trauma emerges (EMD). Contain this material to desensitize after client has gained more stability

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Standard EMDR Protocol Client Selection Factors

Clients who meet the normal EMDR standards for stability

- Report that they are in solid recovery from their addiction/impulses and do not report triggers/urges/positive feeling states.
- Have supports in place, but find themselves “stuck” in their ability to find a life worth staying abstinent for.
- Clients who reports episodic, non-lethal, impulsive behaviors triggered by underlying trauma.

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Standard EMDR Protocol Client Selection Factors

- Clients who have completed work on triggers, urges, PFS's.
- Clients with “yellow flags: **who understand the risk involved in doing trauma work**, but believe (with you on-board) that the **benefits outweigh the risk**. These clients may have already tried processing triggers, urges or PFSs and noticed during the process that desensitizing triggers/urges always resulted in the need for standard protocol work.

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Targets to Consider First

- Behaviors, cognitions, situations that negatively impact, reinforce or provoke impulsivity.
- Underlying trauma that came up when processing triggers, urges and PFSs.
- Barriers to abstinence or acquiring new coping skills.
- Memories related to relapse or failure in regards to the impulsive behaviors.
- ACES—the adverse childhood experiences that push the addiction.

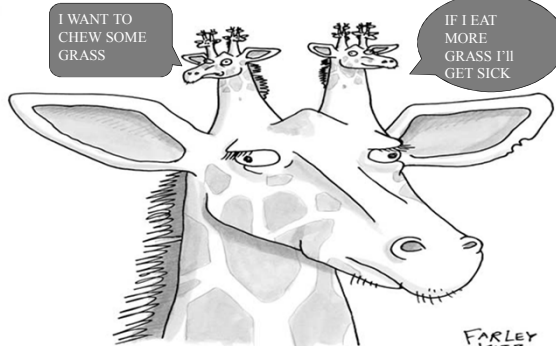
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Other Targets

- Negative sense of self related to being an addict.
“What does it mean about you that you need _____ (Addictive/Compulsive Behavior of choice) to feel _____ (the sought after feeling state(s) related to the ACB)?”

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Working with Ego States



Addicted Clients and Ego States

- “There is a part of me that wants to get sober and a part that doesn’t”.
- “The angel on one shoulder, the devil on the other”.
- “I walked myself through it”.
- Many addicted Clients, have a history of complex trauma and have a more rigid ego state structure.

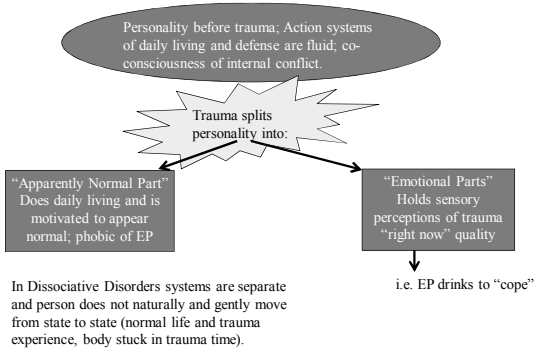
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Ego States-We all have them

- Ego-States Theory (P. Janet, 1907) is based on the view that the personality is not a monolith, but is instead composed of separate parts (referred to as ego states).
- An ego state belongs to a group of similar states, our “internal family”.
- Each ego state is distinguished by a particular role, mood, and mental function, which, when conscious, assumes first person identity.

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Structural Dissociation Theory



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Structural Dissociation Theory— ANP's and EP's

- A person may have one (or with DID clients more than one) Apparently Normal Personality (ANP), which is a part that “does life,” is oriented to present and is primarily concerned with maintaining high level of functioning.
- With addicted Clients the ANP is often the “part” that initiates therapy and the “part” of the Client that wants abstinence.

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Ego States and Dissociation: ANPs and EPs

- Emotional Parts (EPs) – ego-states, which contain emotions, cognitions, body sensations and behaviors, experienced at the time of traumatic experience. They often perceive danger as currently present, lack awareness of the time passed since the traumatic event and may appear to be the same age as client was at the time of trauma.
- EP's often play a large part in the addiction process. The use of substances or impulsive behaviors may be a specific EP's “job”.

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Conference Room or Dissociative Table

- Helps client identify and understand different parts of themselves (ego-states) and their functions.
- Helps client to better conceptualize, understand and empathize with the “parts” of themselves involved in the addiction cycle.
- Helps improve co-consciousness and cooperation between parts, which can lead to integration of parts in dissociative clients and increased stability/abstinence/harm reduction.

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Conference Room or Dissociative Table

- A powerful tool that can be used with all clients, particularly addicted clients.
- An essential tool to use with dissociative clients, but should be used with caution and requires further training in dissociation and ego state work to use safely.

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Kathy Martin's Dissociative Table

- Psychoeducation and Introduction—normalize , explain “trauma time”
- Establish that client can visualize—Safe/Calm place
- Get client in calm state—reduces ANP's resistance to EP's, increase EP willingness
- Develop the table/meeting place imagery—new to client (uncontaminated)
- Vivify the imagery—safe place where no one gets hurt
- Instruct Adult Self to enter the imagery and take his or her place
- Invite the emotional parts to enter the imagery- all various aspects or parts of yourself
- Gather the clinical information—Who is there? Names, ages, alliances and phobias among them; degree of time orientation, degree of consciousness; take notes; use family therapy skills

Martin, K., Journal of EMDR Practice and Research, Vol 6, Number 42012
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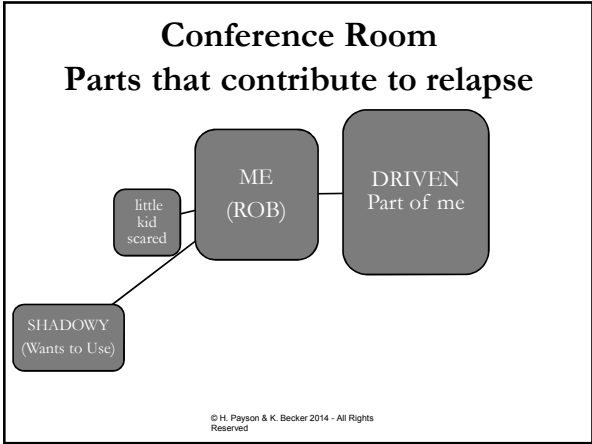
Kathy Martin's Dissociative Table

Use DAS (BLS) after table is established to install resources and treatment gains

- more compassions toward parts
- correct time orientation
- a reduction in arousal
- an understanding that a despised part was created by entire personality to help manage traumatic material
- adaptive information linking in

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Conference Room—contracting with “parts”

A clinical balancing act

- The addictions serve a purpose and may “belong” to a part or parts—understanding the unique structure of your client’s internal system will help you negotiate for harm reduction or abstinence, and the uploading of new skills.

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Addiction is Oppression Recovery Bill of Rights

- The ability to live free of a painful past.
- To define ones own, unique recovery.
- To have a full, meaningful and BIG life.
- To be treated as valued individual.
- To have access to a support system that holds out hope and believes recovery is possible for anyone.

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**THANK YOU—for doing what
you do**

Your PC's as we see them:

- You are strong
- You are brave
- You are compassionate
- You are appreciated
- You are doing your part, to change the world

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