Application *of* EMDR *and* Brainspotting *with* Addiction *and* Mental Health

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In writing this article, it is important to understand that once trained in eye movement and desensitization reprocessing (EMDR) and brainspotting, the applications can be limitless. I have had limited trainings in both areas and am not certified in either approach. However, with the different levels of training and the numerous books available to all clinicians, the ability to use these approaches effectively is based on the clinician's experience, willingness to integrate and use the approaches, and coming to an understanding of what EMDR and brainspotting has the potential to do with clients. That said, I intend on completing the trainings in both approaches given there is always something new and exciting to learn in this field. In the meantime, ongoing readings and applications will continue in practice. The books I use most frequently with clients include the following:

- *EMDR Made Simple: Four Approaches to Using EMDR with Every Client* (2011) by Jamie Marich, PhD, LPCC-S, LICDC
- *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy* (2013) by Francine Shapiro, PhD
- *Brainspotting: The Revolutionary New Therapy for Rapid and Effective Change* (2013) by David Grand, PhD

What are EMDR and Brainspotting?

In 1989, Shapiro (2013) introduced eye movement desensitization and reprocessing (EMDR), which is composed of dual attention stimuli in the form of bilateral eye movements, taps or tones that directly address distressing life events. EMDR therapy is guided by the adaptive information processing (AIP) model. Arousal points from distressing life events are stored memory points from original emotions, physical sensations, and beliefs (Shapiro, 2014). Symptoms such as flashbacks, nightmares, and intrusive thoughts are experienced from these stored memories. Processing of these memory points using the EMDR therapy protocol brings adaptive resolution and functioning, reducing PTSD symptoms mentioned earlier (Shapiro, 2014). It alters negative emotions, physical sensations, and beliefs into more adaptive information, whereby, "the disturbing life experience becomes a source of strength and resilience" (Shapiro, 2014, p. 39).

Brainspotting (BSP) was developed by David Grand while using EMDR and recognizing traumatic material was not always easily accessible when Grand observed clients' eye movements wobbled and froze during bilateral movements (Corrigan & Grand, 2013). Corrigan and Grand (2013) further explained that the traumatic episode has a prominent visual focus linked with maximum body activation during recall. It is the activation in the body during remembering and recounting the traumatic event that resonates with the "brainspot" (Corrigan & Grand, 2013). Clients are prompted by therapists to identify arousal points in the four quadrants of the brain where a brainspot can be identified, and bilateral repetitions are applied to reduce the arousal points in the brain. This process is called brainspotting.

Rapport Building and Empowerment of Clients

In working with clients, the first and most important step is to demystify the process and have the clients educate themselves. Francine Shapiro's book, *Getting Past Your Past* (2013), is recommended to clients before the process begins. The book describes a number of cases and applications of EMDR that helps with conceptualizing what to expect. This takes away some of the mystery of what clients will be experiencing. It is also very important to build rapport with clients in order to handle the variety of questions and skepticism about the process that are understandably given to clinicians. One client asked me, "Is this some new age thing?" and laughed when the process of eye movements began. The client was able to trust me enough to move forward and was surprised to see that she moved out of stuck points carried for years in her life so rapidly. The client was so impressed she decided to enroll in a program for mental health counseling, studying to become a psychotherapist after her experience with effective treatment. A lot of times I tell clients that EMDR "looks hokey," but it works. That is why building a strong rapport with your clients is essential. With a strong connection to clients, they are more invested in trying new approaches and willing to engage with techniques that are unfamiliar to them such as moving their eyes back and forth during the session or tapping while processing incredibly traumatic material. Therapists must also be able to be flexible and utilize clients' knowledge combined with their feedback.

David Grand utilizes a feedback process called the "inside window" to better understand the reflexive responses and feelings of his clients. Through this understanding, clinicians can concentrate on areas of the brain that are most effective with relieving clients of their disturbances (Grand, 2013, p. 30–1). Grand also uses the term "activation points" as emotions or body sensations (2013). Therapists must also have the ability to observe and accurately identify clients' reflexive cues while undergoing brainspotting. This observational stance is the key to "outside window brainspotting," according to Grand (2013, p. 31). Grand expresses using both inside and outside window techniques to better find the activation spot in the brain and found that both techniques were equally effective. In addition, he also shares that he asks his clients what they prefer, to guide him or have him guide them in the process. He empowers his clients to have control of their therapy.

Dr. Jane Dye, an LMFT trained in EMDR, demonstrated her technique to me during a peer consultation where she allows clients to move her hands fast or slow in the eye movement process of EMDR, again, empowering clients to have some control over how this procedure is administered. This therapist constantly asks for feedback and direction with clients when using both EMDR and brainspotting.

In finding the exact area of the brain to stimulate for brainspotting, a variety of visual positions are given to clients as to where to implement the eye movements. Clients are surprised when they feel the activation points or emotions of their experience intensify when their eyes are moved from one area of the brain to another. They begin to recognize there is a difference in their activation points and become more invested in the process.

Basic Setup and Protocols

While working with EMDR and brainspotting, basic protocols are set up with clients. Marich (2011) refers to Shapiro's EMDR-International-Association-approved training protocols as expansive. They range from collecting client history, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation to how clinicians set up and execute an EMDR session (Marich, 2011).

The protocol for me would be to collect data about clients' overall lives via the biopsychosocial, identifying, disturbing life events they continue to struggle with from the earliest age to the present, and conduct an assessment on any dissociative tendencies. I also prepare clients for the process by setting up in a safe place and having clients practice using the safe place at home the week before they come in for their first EMDR session. Before beginning the actual EMDR or brainspotting session with clients, the following processes must be completed:

- A specific issue is identified to work on
- Activation of clients' disturbances
- Identifying the subjective units of distress (SUD)
- Locating the body sensations that correlate with the event

This allows me to have insight about where clients may take me during the EMDR or brainspotting process.

EMDR protocol has a more structured approach with clients than brainspotting. There is a script clinicians follow with the EMDR sessions and I make a decision with each individual client on which approach to use based on what is presented in the sessions. There is also a mix of approaches that can be utilized based on the intensity of the issue presented or level of rumination on the issue at hand. It has always been productive for me to follow clients in the process. Encouragements and verbal prompts in relation to where clients have moved during the session are also utilized during the EMDR process. Using EMDR and brainspotting for a variety of life disturbances has been rewarding for both my clients and me. Seeing the relief and actual surprise from clients has been a rewarding experience.

Use of Biolateral Sound

During sessions, music from David Grand's (2013) work is played—the album is called *The Best of Biolateral II*. I play the music during the EMDR and brainspotting sessions and call it "the double whammy" for clients, given that their brains are being stimulated from two different modalities: audio and visual. Auditory stimulation was found to be an effective method of activating the left and right hemispheres of the brain. Grand (2013) began using sound boxes that stimulated the left-right hemispheres of his clients that suffered from anxiety and depression and found these sounds reduced their symptoms. He was able to take this process a step further and develop music, with the help of a musician named Evan Seinfeld, that induced deep processing that is hard to notice at the time it takes place. In using only the biolateral music designed by Grand during sessions, clients have been more insightful and engaged with the therapeutic process even without the eye movements used in EMDR.

Use of EMDR and Brainspotting for Addiction and Mental Health

In working with clients dealing with addiction, it is important to understand that addiction "is more than just a behavior gone out of control; there are many other factors fueling it (e.g., cognitions, effects of trauma) and many more factors affected by it (e.g., global functioning of the individual, impact on family and society)," as Marich states (2011, p. 217). Marich further shares that EMDR can play a powerful role in addressing these factors. Underlying issues that contribute to the active addicts' desire to numb their lives can be eliminated with the use of EMDR. In addressing relapse and recovery, poor self-efficacy, negative emotions, and poor coping skills put those in recovery at risk of relapse (Marich, 2011).

Marich (2011) used Miller and Guidry's addiction and trauma recovery integration model that explained how unresolved trauma plays a huge part in addicted individuals' attempts to recover and stay clean. The model further states that traditional approaches tend to marginalize traumatized women more than men. Marich explains that by treating trauma as part of the addiction treatment process, using EMDR integrates cognitive, body-oriented, emotional, and experiential into a single treatment protocol so it can sustain recovery more fully by keeping addicts in remission (2011). EMDR becomes a useful construct with recovering addicts and can be added to the "recovery capital" as a resource that makes recovery successful in the long run (Marich, 2011). The other recognized components of "recovery capital" include a support group, Twelve Step meetings, a sponsor, a church group, a job, hobbies, supportive family, motivation, and a place to live. EMDR helps build on these resources by providing further stabilization during their recovery process.

Marich used EMDR with those in recovery who had been sober as early as one month. She found that EMDR could work well for the "sober but stuck" clients (i.e., clients who achieved initial sobriety but hit a stalemate in their emotional growth after the pink cloud of initial sobriety lifted). She found EMDR was helpful with clients working on Steps Four and Five of the AA program due to the difficulties of taking moral inventory. She also shared that coupling the use of EMDR with past-life traumas are highly successful for recovery only with the understanding that ongoing sober lifestyle changes must continue after clients feel "cured" from their past demons (Marich, 2011). If ongoing sobriety plans were not reinforced to clients, the likelihood of relapse would be high, given clients' misconceptions that they are cured after having successful outcomes from EMDR with addressing the effects of past traumas.

I use EMDR with the addiction population as early as two to three weeks clean to address life disturbances that keep them from wanting to numb themselves. These disturbances or traumas keep clients in their addiction if gone untreated. One client, currently in recovery, shared with me an experience when he was young. He had volunteered as a fireman, and the trauma took place when he was in a blazing

fire looking for a child and could not find her in time to save both her life and his. He shared that he woke up every morning for thirty years feeling a sense of failure and sadness over failing to save that child. He also shared that the incident was most likely a factor in his alcohol dependence over the years. After three sets of EMDR regarding this disturbance, he came in and shared that he was not even thinking about the incident anymore. He was very surprised and grateful to have fully processed this event. He was able to let go of the guilt and sadness from the traumatic event where he had to choose to save his life over another. His final outcome was the thought that he did the best he could in the situation, and that provided peace for him.

Other countries such as Australia report successful outcomes with the use of EMDR protocol with alcohol and substance dependence comorbid with posttraumatic stress disorder (PTSD). Kullack and Laugharne (2016) described research where PTSD increased the rates of SUDs where men with PTSD were twice as likely as those without PTSD to have alcohol abuse or dependence, and three times more likely to have a drug use disorder. Women with PTSD were 2.5 times more likely than those without PTSD to have alcohol disorder and four times more likely to experience a drug use disorder (Kullack & Laugharne, 2016). Use of self-medication for those dealing with PTSD led to the dual diagnosis where clients suffering from avoidance symptoms may have used stimulants to boost socialization and motivation while others suffering from hyper arousal symptoms may have used sedatives to alleviate their discomfort. In using EMDR to treat PTSD, the traumatic memory is processed through bilateral stimulation where there is a reduction or cessation of the PTSD symptoms whereby the unpleasant emotional charge and negative somatic sensations are removed, recalibrating the brain and body (Kullack & Laugharne, 2016).

Other EMDR protocols that were modified and utilized for addiction recovery include the concept of addiction memory (AM), where an obsessive-compulsive craving and episodic memory creates a maladaptive memory. Use of level of urge scales in place of SUD scales and Shapiro's (2013) adaptive information processing (AIP) model that suggests all human beings possess the innate ability to naturally integrate and assimilate many aspects of an experience to address the memories of intense craving or drug consumption incorporates EMDR with reduction of such cravings (Kullack & Laugharne, 2016). Kullack and Laugharne (2016) shared outcomes of studies using this treatment modality that showed results of significant reduction in craving posttreatment and one month after treatment.

In addition to craving reduction, research by Kullack and Laugharne (2016) also discussed a desensitization of triggers and urge reprocessing (DeTUR) protocol developed by Popky that uncovers and processes base traumas or core issues that are viewed as the underlying cause of addiction. DeTUR is known as a trauma-based protocol that combines clients' internal resources with external supports such as the Twelve Step program and cognitive behavioral therapy (Kullack & Laugharne, 2016).

Another treatment protocol for chemical dependency that "employs a Gestalt dialogue technique to identify object relation deficits that can be used to create targets for EMDR Processing" is identified as "chemotion" (Kullack & Laugharne, 2016, p. 35). This approach does not have published studies to date, however, it is identified as a modified protocol for treatment of PTSD and SUD.

Conclusion

In looking at all the possibilities of how EMDR and Shapiro's AIP model can be modified and utilized to address mental health and addiction, it is evident that as therapists we are at the cutting edge of further utilizing the neuroscience information currently available to our profession. Marich (2011) encourages further understanding of the biological phenomenon of processing through MacLean's model of the triune brain, where the model explains that the human brain really operates as three separate brains:

1. The reptilian brain (which includes the brainstem and cerebellum that controls reflex behaviors, muscle control, balance, breathing, and heartbeat, which is reactive to direct stimulation)
2. The limbic brain (which contains the amygdala, hypothalamus, and hippocampus and is the source of emotions and instincts within the brain where survival is based on the avoidance of pain and the reoccurrence of pleasure)
3. The neocortex, otherwise known as the cerebral cortex (which contains the frontal lobe and is unique to primates, which regulates our executive function and higher-order thinking skills, reason, speech, meaning, and experience)

Marich (2011) explains that cognitive therapies are designed to activate and work with the frontal lobe. However, for clients who have unprocessed trauma symptoms, the three brains are not fully communicating. During intense emotional disturbance, the frontal lobe is unable to function due to the limbic brain taking over and clients being in a position of flight, fight or freeze. One of the quickest methods of alleviating the pain involved with this level of distress is to use alcohol or drugs, food, sex, gambling, shopping or other reinforcing activities to produce pleasure to offset the distress (Marich, 2011). EMDR can address the limbic level blockage (where traumas stay stuck and unprocessed) and link processing of the trauma to the frontal lobe, where resolution of the trauma can occur.

Presenting clinical issues, I have utilized EMDR and brainspotting to effectively treat phobias such as flying; eating disorders; use of nicotine and cravings for addiction purposes; and trauma events. In using EMDR and brainspotting, therapists must be aware of their propensity for secondary trauma given the amount of trauma information shared in the sessions. Therapists must prepare themselves to purge the information from their own minds after the sessions. It is important to recognize that if therapists are not confident and fully comfortable with their

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bored. Again, I helped her into a trance and used hypnosis to reframe her feelings that were emerging in the form of an addiction, its association with her husband, and also its connection with being "bored." I planted suggestions (based on our discussion) of other activities she could consider if she became bored. Once complete I woke her, then discussed her experience. The next week CC again reported feeling less of a "pull" to go to the casino. During this week she reported going to the casino once as opposed to several times. She also reported staying there less time. CC even admitted that she hadn't realized she was near the casino until she had passed it and was pulling into her driveway.

In the next session, after discussing other techniques and agreeing on the goals of this session, I placed CC in a trance, then created a negative trigger for her addiction. A negative trigger is exactly what it seems like; when activated, clients will experience a negative emotion, forcing them to leave the scene to feel better. Note that this part of protocol cannot be utilized without clients fully understanding and agreeing to the treatment. With this particular trigger, if CC were to enter a casino for any reason, she would feel very nauseated and have to leave. In the next session CC was very excited and told me she had not gone to the casino at all and hadn't thought about it much. That session (and the next couple) was a talk session to bring everything together and check the work. We also worked on some of her negative and positive cognitions associated with gambling and the casino.

Then CC reported that she went to the casino. I was surprised she had gone, but also intrigued about what happened. She said she didn't go there to gamble. Instead, she went there to have dinner, but became very ill with a strong migraine and had to leave the area where the gambling was taking place. Once upstairs in the restaurant, the pain subsided until she left and had to once again go through the casino. Then she felt it again. Needless to say, that was the negative trigger I installed. I had not anticipated this and had to take her back into a trance to alter the suggestion so she could comfortably go into the casino for dinner or a show. As addiction counselors I'm sure you recognize this as being a gamble (pardon the pun), but I worked with her goals and interests and not mine. After discussing the risk of going back into the casino for any reason, I reset the negative trigger. As a result, if CC entered a casino and her intention was to gamble, the negative trigger would take place. If she entered for any other reason, such as watching a show, she would be fine.

These sessions took place several months ago and appear to be helping her tremendously. I have discharged CC since then. We have spoken a few times over the phone and she has reported doing very well. She admitted having one relapse, but was able to handle it. I have reminded her to return if this becomes a problem again, to which she has agreed.

Conclusion

As mentioned previously, I believe hypnotherapy to be one of the most powerful tools available to us as therapists and addiction counselors. It offers a quick resolution while at the same time being the most gentle of all the therapeutic tools combined. For more information about clinical hypnosis training, contact the Milton H. Erickson Foundation. C

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clinical work, EMDR and brainspotting will be difficult to execute. In recognizing that they must follow their clients and trust the process of the therapeutic approach with EMDR and brainspotting, positive clinical outcomes become less and less surprising. Further, confidence in the process continues to build where clients are given hope of living full and productive lives. Addiction treatment can also be enhanced to provide long-term recovery results desired by those who want to live without fear of underlying issues bringing addiction back into their lives. C

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