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CHAPTER

EMDR Therapy and Addiction

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Abstract

This chapter provides a summary of methods of treating addiction-related issues with eye movement desensitization and reprocessing (EMDR) therapy. The chapter commences with an overview of the issue of addiction and its complexities, including the issue of comorbidity and common issues in addiction treatment. This is followed by a discussion of how addiction is conceptualized in diagnostic systems and in EMDR therapy. The existing experimental and treatment research base is then discussed, including the empirical evidence for EMDR therapy approaches. The remainder of the chapter outlines the key adaptations and considerations for clinicians in providing treatment. This is discussed in the context of each of Shapiro's eight phases of the standard EMDR protocol.

Keywords: EMDR, addiction, substance use, drugs, alcohol, comorbidity

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Individuals who experience addiction are a heterogenous and complex population. This group experiences high rates of comorbid mental and physical health conditions, along with psychosocial disadvantage (Black et al., 2013; Connery et al., 2020; Evans et al., 2020; Galea & Vlahov, 2002; Kingston et al., 2017; Santo et al., 2022; Valenciano-Mendoza et al., 2021; Wu et al., 2018). The experience of childhood adversity and disturbances and losses in attachment relationships are consistent predictors of addiction-related problems (Dube et al., 2003; Mills et al., 2017; Scherrer et al., 2007; Schimmenti et al., 2017; Schindler, 2019). In addition, those who experience addiction have almost universally experienced multiple traumatic experiences across their lives, with correspondingly high rates of trauma-related disorders present (Kausch et al., 2006; Kingston et al., 2017; Mills et al., 2006; Moore & Grubbs, 2021). Importantly, marginalized groups disproportionately make up this population and often have less access to treatment (Collins, 2016; Oluwoye et al., 2020).

Those who seek treatment for addiction often experience stigma, at times even at the hands of health professionals who can regard addiction-related problems less favorably than other health conditions (Howard et al., 2022; van Boekel et al., 2013, 2014). A significant barrier to treatment is the lack of integrated

treatment—with clients required to engage with parallel or sequential treatment services, clinics, and therapists to address comorbid issues in different treatment episodes. The result of this is that people tend to receive incomplete or inconsistent treatment as they move between different services, as opposed to wholistic care. What is striking is that despite decades of research and development, there is little evidence of improvement in the overall burden of addiction on our society (Ciobanu et al., 2018).

Addiction as a Clinical Construct

This chapter will speak broadly to the concept of "addiction," however it is important to note that there are conceptual differences between what many clinicians label as an addiction and what diagnostic systems classify as a disorder. There remains contention in the literature regarding the classification of some addictions (Petry et al., 2018; Starcevic, 2016). The International Classification of Disease 11th Edition (ICD-11) (World Health Organization, 2022) defines several diagnostic categories in this area including substance-related conditions (e.g., *alcohol dependence*), along with behavioral addictions of *gambling disorder* and *gaming disorder*, and an impulse control disorder—compulsive *sexual behavior disorder*. These diagnoses assist in understanding conditions across different settings and cultures, but there remains variability in diagnostic systems and a wide array of behavioral addictions which are discussed clinically but not in diagnostic systems (e.g., buying-shopping disorder). Research in this area relates primarily to substance use, with behavioral addictions less well defined and studied in general (Kuss & Lopez-Fernandez, 2016; Petry et al., 2018; Rumpf et al., 2019). As such, carefully consider commentary and discussion here when being generalized to behavioral addictions.

Conceptualizing Addiction in EMDR Therapy

Learning and memory processes have been theoretically implicated in the development and maintenance of addiction (Hyman, 2005; Muller, 2013). In line with learning theories, cues in the environment are thought to trigger craving and approach behaviors through reinforcement processes (Carmack et al., 2017). Beyond this, there is an overlap between the neurobiological systems involved in memory and learning and those implicated in addiction (Carmack et al., 2017). Researchers have posited the concept of the "addiction memory"—memory representations associated with the addiction, such as the effects of the addictive behavior and an associated loss of control (Boening, 2001; Hase et al., 2008; Heyne et al., 2000). In this model, activation of the addiction memory results in craving and/or the addictive behavior. It is important to note that this concept has not been extended to behavioral addictions and is largely based on animal models of substance-related addictions. While there remains uncertainty as to whether behavioral addictions operate on the same neurobiological mechanisms as substance-related addictions, there are indications in the literature that this is the case (Chamberlain et al., 2016; Mauer-Vakil & Bahji, 2020). Nonetheless, the *addiction memory* has been proposed as a useful target for disrupting the process of addiction, albeit one which is considered difficult to change (Wolffgramm et al., 2000).

This concept fits well with the Adaptive Information Processing model underlying eye movement desensitization and reprocessing (EMDR) therapy and has been the focus of several studies using EMDR to treat addiction, including Hase's CraveEx protocol (2010) and within the *Palette of EMDR Interventions* (Markus & Hornsveld, 2017). Popky's DeTUR protocol (2005) is consistent with the concept of the addiction memory—in this model the urge to perform an addictive behavior is targeted via the memory representation of a trigger situation; while others have instead focused on targeting positive affect states associated with the addiction. This includes two related but different conceptualizations—Knipe's Dysfunctional Positive Affect (2010) and Miller's Feeling-State Addiction Protocol (2010). Miller posits that

addictive behaviors are maintained by positive affect states that become connected to early experiences of the addictive behavior and are therefore pursued through performance of the addictive behavior. Knipe contrastingly offers a conceptualization of positive affect states initially providing a relief from some pre-existing psychopathology, but then becoming increasingly called upon in response to ongoing psychopathology. This is akin to the well-known *self-medication hypothesis* which has been a popular model for understanding substance use for decades (Khantzian, 1985; Schimmenti et al., 2022).

The Evidence for EMDR Therapy in the Treatment of Addiction

Despite the number of EMDR therapy addiction-specific protocols, there is little empirical support for their use at this time. Literature has explored the use of EMDR targeting alcohol (Abel & O'Brien, 2010; Hase et al., 2008; Markus et al., 2015, 2019, 2020), tobacco (Littel et al., 2016; Markus et al., 2016), opiates (Shapiro et al., 1994), GHB (Qurishi et al., 2017), cocaine (Cecero & Carroll, 2000), and mixed substance use issues (Brown et al., 2015; Carletto et al., 2017; Kullack & Laugharne, 2016; Perez-Dandieu & Tapia, 2014; Rougemont-Bucking & Zimmerman, 2012; Tapia et al., 2017), along with behavioral addictions such as gambling (Bae et al., 2015; Henry, 1996; Miller, 2010; van Minnen et al., 2020), Internet use (Bae & Kim, 2012), sex (Cox & Howard, 2007), and various compulsive behaviors (Miller, 2012). Existing reviews have concluded there is potential utility of EMDR in targeting addiction (Tapia, 2019; Valiente-Gomez et al., 2017), however these statements are tempered by other reviews finding inadequate evidence and highlighting significant issues with risk of bias and methodology in the existing literature (Cuijpers et al., 2020; Markus & Hornsveld, 2017). In short, the evidence base in this area remains under-developed, and as such clinicians should not rely on addiction-specific protocols as stand-alone interventions without consideration of each individual case and the overall treatment needs of the client.

There remains no overarching account for addictive behavior in EMDR treatment. As mentioned, addictions co-occur with other mental, physical, and social problems at alarming rates and are almost universally preceded by the experience of adverse childhood experiences and other traumatic events (Kausch et al., 2006; Santo et al., 2022; Santo et al., 2021). As such, and in line with the use of EMDR as a broad, transdiagnostic model of therapy (see Dominguez, this volume), the approach offered here does not adhere to or endorse any specific protocol or technique but rather encourages a comprehensive conceptualization of the client, which includes the addiction in question but also considers the broader network of symptoms and issues in the client's life, and their associated, underlying memory representations. Addiction should not be treated as a standalone issue, rather it should be conceptualized with other presenting symptoms and contextual factors. The application of EMDR in this area can be informed by the broader literature of trauma-informed treatment of addiction and by the implementation of EMDR in complex trauma presentations. It is often useful to consider treating addiction in the same light as treating complex trauma, albeit with a unique cluster of symptoms that can be difficult to conceptualize, and which may interrupt treatment processes or necessitate shifts in focus to risk issues at times. Indeed, for many clinicians working in this area, the more EMDR they provide to treat addiction, the more similar the practical delivery of EMDR therapy appears to any other implementation of EMDR in a complex population with comorbidity.

Phase 1: History-Taking and Treatment Planning

Assessing the Addiction

As with the EMDR standard protocol, treatment should commence with a comprehensive assessment of the presenting issue and client history. The assessment should incorporate a clinical interview along with standardized screening and assessment measures (Barrett et al., 2019). This should include details of the specific behavior/substance in question. Table 1 provides a summary of key areas to be considered in clinical assessment.

Table 1 Factors to Consider in Assessing the Addiction.

Assessing the Addiction
✓ The history of the addiction
✓ Key life events associated with the commencement or exacerbation of the addiction
✓ The pattern of the behavior:
○ Quantity, frequency, and duration of current addiction(s)
○ Manner of performing the behavior
○ Previous addiction problems
○ Circumstances of use/triggers for the behavior
○ Cravings and urges
○ Typical functioning during the behavior
○ Negative and positive outcomes of the behavior
✓ Family history of addiction/early exposure to the addiction
✓ Previous periods of behavior change
✓ Previous experiences of treatment
✓ Current supports (e.g., peer supports, professional, family supports)

Abstinence vs. Reduction vs. Harm Minimization

It has been a commonly held belief among clinicians that addiction treatment should precede treatment of comorbid mental health issues, and that abstinence in particular is required to progress to other areas of treatment. Evidence from the substance use treatment field, however, clearly demonstrates that integrated models of treatment are both safe and effective (see Marel et al., 2016 and Harvey et al., 2022 for discussion). Beyond this, there is evidence that implementing trauma-focused interventions is unlikely to lead to an exacerbation of substance use (Jarnecke et al., 2019). Furthermore, targeting comorbid symptoms can result in reductions in substance use, while reductions in substance use are less likely to lead to reductions in comorbid symptoms (Hien et al., 2010).

A key concern for clinicians is the potential impact of ongoing substance use on the effectiveness of EMDR. There is currently no available research to quantify this impact. Substance use may impact memory and learning processes (Wixted, 2004), but this impact is likely to differ significantly between individuals and based on the quantity and type of substance used. As such, so long as a client is not acutely intoxicated to the

point that they could not participate in therapy or is not in an acute state of physiological withdrawal, then treatment may proceed.

It is important that substance use during therapy is discussed from the outset, and that clients are informed of the *potential* impact of substances on treatment effectiveness. Client and clinician together should decide on whether abstinence is a goal, and if not, how recurrences of the addiction during treatment might be addressed. While a sturdy period of abstinence prior to commencing EMDR would be ideal, this is unrealistic and would pose a significant barrier to treatment for many clients. Clinician and client judgment are required to collaboratively determine the appropriate plan regarding substance use during treatment.

When abstinence is the goal, it is important to consider the impact of sudden cessation of a substance on the client's wellbeing. A medical review is always recommended prior to making sudden changes to substance use. This should be considered particularly in the case of alcohol or benzodiazepines (Fluyau et al., 2018; Jesse et al., 2017), polysubstance use, or in cases of comorbid health conditions. Regardless, clients should be aware that changes to substance use may lead to short-term increases in other symptoms (e.g., anxiety, emotion regulation difficulties), and this might be equally as impactful on treatment as ongoing use.

Phase 2: Preparation

Therapist Readiness and Suitability

Prior to engaging a client with an addiction, it is essential the clinician assess their own knowledge, skills, and confidence to provide treatment in this area. A base understanding of concepts and theories of addiction, along with an understanding of the interaction of co-occurring mental health and addiction-related issues is important; however it is important to not exaggerate this need. Most often, clinicians are well placed to upskill regarding knowledge and skills, but clinician confidence becomes a barrier to treatment. Engaging with suitable consultation will assist in this area, and it is recommended that clinicians also carefully consider biases, knowledge gaps, or counter-transference issues they hold which may impact on treatment.

Client Motivation and Readiness for Change

As with any implementation of EMDR, it is important to consider how ready a client is for treatment, and in turn, what type of preparation may be required before progressing to the later phases of EMDR therapy (Table 2 provides a summary of these issues). Assessment of readiness should incorporate a consideration of the client's motivation for change in the addictive behavior specifically (O'Brien & Abel, 2015). Motivational Interviewing (MI; Miller & Rollnick, 1991, 2012) is a useful integration in EMDR which can assist here.

Table 2 Key Points for Clinicians for EMDR Phase 1 and 2.

History-Taking and Preparation
• Phase 1 of EMDR therapy may need to be extended to carefully assess and understand the nature of comorbidities. • Devise goals for the addiction—cessation, reduction, or harm minimization • Agree on clear therapeutic goals, devise a collaborative plan for treatment, and how the episode of care will close. • Treatment can commence with ongoing substance use—and changes to substance use should be considered carefully in collaboration with other professionals. • Consider both *safety* and *stability—but* be confident that in general trauma focused interventions are appropriate in this population

Safety and Stabilization within Preparation

Clients presenting with addictions may be at risk of specific harms due to the addiction. In addition to standard practices, these specific types of risk will need to be considered. With any addiction, behavioral or substance related, careful consideration should be given to minimizing the harm caused by ongoing action of the addiction. This might include discussions of possible negative impacts of the behavior and possible steps that can be taken to mitigate or minimize these risks (see Table 3 for a summary of key risk areas). Clinicians should ensure they liaise appropriately with other treatment providers (e.g., general practitioners, psychiatrists, addiction medicine physicians) where necessary to fully understand and manage the client's risk profile.

Table 3 Key Risk Considerations for Substance Use and Behavioral Addictions.

Key Risk Considerations for Substance Use

• Severity of substance use
  ○ Use of substances to point of loss of consciousness
  ○ Repeated overdoses
  ○ Polysubstance use
• Withdrawal symptoms
  ○ High-risk profile for alcohol and sedative (e.g., benzodiazepines) substances—incorporate medical assessment prior to changing substance use behavior
  ○ Cannabis, opioids unlikely to have life-threatening withdrawal syndromes but symptoms may require medical intervention
  ○ Withdrawal symptoms during treatment are a barrier and possible reason for early exit—incorporate monitoring and discussion of withdrawal symptoms
• High-risk substance-use behaviors
  ○ Intravenous drug use
  ○ Blood-borne viruses
  ○ Sharing smoking implements
  ○ Vulnerability to harm from others when intoxicated

Key Risk Considerations for Behavioral Addictions
• Risk of transmissible disease • Risk of vulnerability to harm from others • Risk of physical injury from hazardous sexual practices • Risk of financial harm • Risk of social and occupational harm • Risk of legal/forensic issues for criminalized behaviors

Regarding "stability," clinicians should consider practical elements to stability—can the client present to sessions regularly for the duration of the treatment and fund their sessions? Do they have access to food, shelter, and basic needs? Do they have supportive people in their life? Are there any sources of adaptive information (e.g., validation, encouragement, praise from others)? It is then important to consider what adaptive information clients need to assist them to make meaningful change. An important consideration in this area is the ability for the client to develop adaptive beliefs regarding their capacity to influence, manage, or abstain from an addictive behavior. Disentangling the relationship between self-worth and the addictive behavior is crucial (e.g., "Can I be a good enough person, even if I keep doing this?"). Individuals experiencing addiction are likely to have experienced the negative impacts of stigma associated with, and the negative outcomes of, their addiction. As such, issues of self-worth and the core sense of "good enough" will be of significance. Particularly in populations such as this, there can be a tendency towards the overuse of resource-building techniques in EMDR, however in general it is considered helpful to incorporate bolstering positive information or resource networks early in treatment (Knipe, 2018; Leeds, 2009, 2016; Parnell, 2020; Popky, 2005). Beliefs associated with strength, competence, and mastery hold particular sway here and counteract the experiences of feeling helpless or powerless in the face of the addictive behavior.

More broadly, there have been concerns regarding the minimum necessary preparation required for trauma-focused interventions (De Jongh et al., 2016; Hoppen et al., 2022). In the addiction field this is a common concern, specifically that trauma-focused treatment might lead to an exacerbation of the addictive behavior (Brown et al., 2016; Dansiger et al., 2020; Gielen et al., 2014; Shapiro, 2018). Despite these concerns, EMDR therapy can be implemented safely and effectively without an extended preparation phase, even in complex trauma populations (Boterhoven de Haan et al., 2020; van Vliet et al., 2021), and trauma-focused interventions can be safely and effectively implemented in addiction populations (Jarnecke et al., 2019).

In practice, this means that clinicians should not assume that clients require a lengthy preparatory phase. However, this does not imply that clinicians should overlook these preparatory issues. In clinical presentations with multiple comorbidities, a longer Phase 1 assessment, followed by careful consideration of which internal and external factors may impede or influence a client's capacity to engage in memory reprocessing, will be necessary. These factors should not be considered from a "Yes/No" standpoint. Rather they should be considered from the standpoint of "What other skills, knowledge, or resources does this client need?" The clinician and client should collaboratively evaluate readiness for EMDR memory reprocessing, considering all these factors in formulating a treatment plan.

Timing and Delivery of Treatment

The at times cyclical nature of addiction means that choosing the right time for treatment can be crucial. It may not be best to commence all phases of EMDR therapy when there are active daily life crises occurring, but similarly for many clients there is rarely a period of quiet between storms. At times EMDR therapy can be integrated into other treatment approaches such as delivering EMDR therapy during residential treatment, following a structured detoxification program, or during engagement with a peer-support program. At other times, there may be opportunistic windows where brief episodes of treatment are possible. For example, clients may present with a window of motivation that can be capitalized on to work through several specific therapeutic goals. Models of intensive treatment (e.g., Bongaerts et al., 2017; Voorendonk et al., 2020) may be of benefit here. It should also be considered that treatment can be delivered across multiple episodes of care in a cumulative manner, particularly in cases of intermittent engagement.

In the complexities of addiction treatment, with comorbidities present, clinicians should consider whether they are providing a discrete, time limited course of therapy, and if so, when, and how therapy would be considered complete. At times, therapy in addiction populations can be intermittent as clients may fluctuate in their engagement and potentially disengage before returning later for further treatment. Clinicians should consider their capacity to offer recurring episodes of treatment and how they might manage a premature end to therapy.

Phase 3: Target Assessment

When using the standard EMDR therapy protocol, clinicians should consider a treatment plan including past, present, and future targets (see Figure 1 for suggested targets). Past targets should include the key past experiences associated with the addiction, including the development of the addiction. Examples of this could be the first instance of the addictive behavior, particularly salient experiences of relapse, or adverse events associated with the addiction. This will also include consideration of key negative life events which generate distress, negative belief systems, or other symptoms comorbid with the addiction. In identifying targets, it is often useful to explore specific beliefs associated with the maintenance of the addiction. This may include beliefs that romanticize or exaggerate the positive effects of the addiction (e.g., false positives), or beliefs that the client cannot cope, isn't strong enough, or isn't "good" enough to overcome their addiction. Identifying early experiences which led to the development of these beliefs will be important in breaking the links between the client's broader memory networks and the current addictive behavior. Current triggers will primarily be incidents which activate the addiction through craving or urges. These may be internal (e.g., thoughts, emotions, memories) or external (e.g., people, places, or events) and may be addiction specific (e.g., walking past a bar, being home alone with a computer) or more general (an argument with a loved one, waking up after a nightmare). Consideration of positive future templates and flashforwards will also be important. This might include a positive future template for navigating experiences of craving or high-risk situations for relapse. For those clients with significant fears regarding their ability to cope in the absence of the addictive behavior, a flashforward (Logie & Jongh, 2014) of the feared experience may be useful.

Figure 1

Suggested EMDR targets when working with addiction.

As previously mentioned, other models of targeting addiction with EMDR Therapy utilize different concepts to identify targets, and different sequencing across Shapiro's (2018) three prongs. Table 4 summarizes targeting via these approaches. Importantly, these approaches are typically integrated into a broader EMDR therapy treatment plan. Clinicians should consider which aspects of the client's addiction may be targeted by these protocols and carefully consider the sequence of targets. For example, Knipe (2018) cautions that not all clients will be able to target past events without experiencing an increase in current symptoms, while others may be overwhelmed by feared or anticipated future events which need to be addressed first. As such, once the range of targets for the client is identified, the therapist and client should collaboratively sequence these in a treatment plan—with regular review and adjustment based on treatment response.

Table 4 Summary of Addiction Protocols and Associated Targets.

Protocol	Overview	Treatment Sequence and Targets
CravEx: Craving Extinguished Protocol (Hase et al., 2008)	• Focuses on the concept of Addiction Memory (AM). Reprocessing the AM results in cravings being extinguished. • Subjective units of distress scale (SUDS) are replaced with Level of Urge (LOU)	**Past:** Memories of relapse, memories of intense craving. **Present:** Cues for craving, current stressors triggering the addictive behavior **Future:** Future fears concerning addiction and addictive behaviors
DeTUR: Desensitization of Triggers and Urge Reprocessing Protocol (Popky, 2005)	• Focuses on the desensitization of triggers and urges to reduce cravings. Establishes a positive treatment goal for the client to work towards. • SUDS are replaced with Level of Urge (LOU)	**Future:** A positive future goal state **Present:** Triggers for cravings or urges **Future:** Using the future goal-state as a future template in addressing possible future triggers.
FSAP: Feeling-State Addiction Protocol (Miller, 2010)	• FSAP targets the pleasure dynamic of addiction and aims to break the link between a *positive feeling state* (PFS) and the corresponding behaviors related to the addiction. • SUDS are replaced by Level of PFS	**Past or Present:** Target salient experiences of the PFS in relation to the addiction **Past:** Target early experiences associated with a negative cognition thought to underly the PFS via the standard protocol. **Past:** Using standard protocol, identify a negative cognition resulting from the addiction and process. **Future:** Process memories and images that may cause anxiety about relapsing in future
Dysfunctional Positive Affect (Knipe, 2005, 2018)	• A series of related approaches, primarily used to target ambivalence about making changes to a behavior. Can target the in-session urge to avoid an issue, or dysfunctional positive affect associated with a dysfunctional behavior. • SUDS scale is replaced by Level of Urge to Avoid (LoUA) or Level of Positive Affect (LoPA) scales.	**Past or Present:** Target a recent or past event that strongly activates the positive affect in question. (Knipe strongly encourages integrating this with the EMDR standard protocol.)

Phases 4–6: Memory Reprocessing

During memory reprocessing sessions the clinician should be prepared to contend with strong affect states including cravings, the occurrence of the addiction itself, fluctuations in motivation, and importantly be prepared to adjust treatment as changes to symptoms trigger changes across a client's life that require therapeutic attention. Table 5 summarizes these issues.

Table 5 Factors to Consider in Phases 4–7.

During Memory Processing
• Normalize cravings or strong affect in treatment—"stay out of the way" in processing. • Ensure regular check-ins regarding craving and addictive behavior. • Check in regarding, and normalize changes to, motivation. • Consider the use of interweaves should cravings or urges emerge during processing. • Consider changes to the client's broader life with changes in the addiction. • Reiterate plans or processes for between sessions—skills, strategies, supports. • Encourage minimal substance use immediately after processing sessions.

As with the usual process in EMDR therapy, clients may experience strong affect states, which can result in the occurrence of cravings during reprocessing itself, or between sessions. It is important for clinicians to respond to the emergence of a craving as per the standard protocol; that is, to trust the process, and continue reprocessing unless there appears to be blocked processing. If a client appears to be blocked around a craving, the careful deployment of an appropriate interweave may be necessary to specifically target the assumptions associated with a craving (e.g., "If I have a craving, I lose control" or "I won't be able to handle this craving; it will keep getting worse"). Clinicians may similarly respond with standard strategies for addressing blocked processing related to strong affect in these instances. The clinician should routinely check in regarding cravings and the occurrence of the addictive behavior as subtle increases in the behavior can be difficult to recognize. Similarly, with the sudden cessation of the behavior an individual may experience a surge of cravings, withdrawal symptoms, or an increase in comorbid symptoms (e.g., anxiety).

Should a sudden lapse or relapse occur, the situation should be discussed and factors leading to the lapse examined. This should be done in a curious and collaborative manner. If the circumstances of the relapse align with the existing formulation—treatment can continue. Any new or different manifestations of the addiction should be discussed and incorporated into the formulation and treatment plan.

It is common that motivation to change may fluctuate across treatment. Clinicians should be willing to accommodate fluctuations in motivation and be empathic to the positive intent (e.g., to relieve distress) behind the addiction. For the client, relinquishing the addiction can mean bidding farewell to a reliable source of comfort, distraction, or regulation. Hence, it is important that the clinician is compassionate and can adapt treatment focus in response to fluctuations in client motivation. The clinician should regularly discuss motivation with clients and address changes in motivation as needed. Marich and Dansiger (2022) offer the helpful suggestion of utilizing motivational interviewing statements/questions as interweaves during treatment. Additionally, it may be of benefit to incorporate Knipe's approach to targeting avoidance and ambivalence in these moments (Knipe, 2010, 2018), and to consider the "two-handed interweave" proposed by Robin Shapiro, which allows a client to consider opposing or competing ideas, motivations, and parts of themselves (Shapiro, 2005). Clinicians should ensure they understand any reluctance to change, or changes in motivation in the context of their broader formulation—and not make assumptions regarding this.

As treatment progresses it is important for clinicians to begin to identify any changes to the addictive behavior or other life issues, and to begin to set tasks, challenges, or experiments for the client. Importantly, early therapeutic changes may require corresponding changes to the client's social network or activities. Clinicians should not assume this is a positive experience—often this can be isolating and result in a short-term reduction in perceived quality of life. Pre-planned, out-of-session tasks provide a chance

for the client to recognize the impact of treatment on their broader environment and help identify additional treatment needs. Spontaneous incidents of behavioral change reported by clients should be strongly validated, and efforts at behavioral change no matter how small should be encouraged. Implementing new adaptive behaviors immediately after old negative belief systems are reconfigured can consolidate changes and bolster future efforts against relapse.

Phase 7: Closure and between Session Planning

Clinicians should ensure that they close a session in a safe and supportive manner, particularly in the case of an incomplete reprocessing session. Along with standard components of a closure and debrief, clinicians should also check in regarding the presence of cravings or urges, and reiterate strategies, skills, plans, and supports that may be required between sessions. Clinicians should ideally develop a written plan or summary the client can utilize between sessions should they experience distress or strong cravings and urges. Clients should be encouraged to minimize substance use after a reprocessing session as much as possible, and structured and clear planning can aide this. Considering what activities or obligations the client will be pursuing in the next 24 to 48 hours and specifically planning for any high-risk situations or triggers will support this goal.

Phase 8: Monitoring Change and Finalizing Treatment

In the latter stages of EMDR therapy, the clinician should be carefully monitoring changes in the client's symptoms and broader life in considering whether treatment is complete. Table 6 summarizes these issues.

The client and clinician should consider broadly whether treatment goals have been achieved. This will include consideration of whether specific memory targets are sufficiently processed, along with consideration of improvements in quality of life, reductions in comorbid symptoms and issues, and evidence of sustained adaptive behavioral change. Consider carefully whether the client is demonstrating increased confidence to manage their addiction, or an increased awareness of how their addiction functions. An important part of increasing confidence to finish therapy is normalizing lapse/relapse and ensuring that clients do not associate these events with failure. Similarly, a lapse after treatment does not necessitate a return to treatment. Establishing new habits, hobbies, interests, and connections should be considered and discussed (and ideally commenced) with clients before finalizing treatment. Devise a clear plan for how skills, strategies, and supports can be used in future and ensure clients have a summary of these plans. Be sure to identify all changes, progress, and positive steps the client has taken. At times, this will mean emphasizing comorbid changes in the face of minor addiction specific changes. This is crucial in ensuring a positive treatment experience and fostering confidence in future treatment. Clients' strengths, resilience, and efforts in therapy should always be acknowledged and praised. Discuss future treatment (e.g., outstanding goals), and how or when the client might engage again for further treatment.

Table 6 Factors to Consider when Finalizing Treatment.

Finalizing Treatment
• Assess a broad range of factors to consider whether treatment has been sufficient—not just the frequency/quantity/intensity of the addictive behavior. • Consider whether further treatment is required—and by whom. • Discuss how relapses/lapses after treatment should be managed. • Remind the client that with further behavioral change they will continue to notice new changes/insights/improvements. • Plan for future supports—what will the client need to be successful in future

Conclusion

Individuals with addiction often experience inadequate treatment. Given the high levels of comorbidity and the prevalence of trauma exposure in this population, EMDR therapy provides a useful tool for overcoming addiction, with an emerging evidence base. Importantly, most EMDR therapists already possess most of the skills required to work with addiction and only require updated knowledge (and confidence!) to work effectively with this population. The EMDR standard protocol can address most issues, but supplementing addiction-specific protocols and techniques can provide increased options to support clients. Future research using robust methodologies is required to better understand how adaptations to the standard protocol might improve outcomes in this population.

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