PALETTE OF EMDR INTERVENTIONS IN ADDICTION

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1. Introduction

In the spring of 2017 in the *Journal of EMDR Practice and Research* an overview was presented of all, until then, conceivable and already described interventions in the field of EMDR and addictions and interventions (Markus & Hornsveld, 2017). This ‘Palette of EMDR Interventions in Addiction’ (PEIA) included 15 interventions, each focusing on a different aspect of the behavioural or substance addiction. In our opinion this overview is fairly comprehensive; it offers an overview for research purposes but also for clinical practice. In this overview trauma-focused treatments have also been included.

All modules are stand-alone and it’s up to the clinician, together with the patient, to choose which is the most appropriate intervention to apply.

Earlier versions of this collection of modules for EMDR for addictions were published as a Dutch protocol “EMDR en verslaving, een klinisch protocol” (Hornsveld & Markus, 2014), various chapters in Dutch books (Markus & Hornsveld, 2015; Markus & Van Rens, 2014). This current version you have before you is the result of various developments since that time.

The first development is the conclusion of the research into the effectiveness of various modules of this Palette. (The research design has been presented in Markus, De Weert-Van Oene, Becker, & De Jong, 2014). It concerned a randomised study of 109 patients of a mental health institute for addictions and social care with a specialised unit for alcohol abuse disorders. The EMDR treatment consisted of modules 2, 4–8, 10, 14, en 15, taking a total of 7 sessions with 90 minutes per session. In addition the participants received addiction treatment as usual. Preliminary results were disappointing with regard to clinical outcomes, both with regard to the effects of treatment as usual but also in terms of the added value of EMDR. This has been reported during the European EMDR-conference in 2016 (Markus & Hornsveld, 2016b) and during the Dutch National EMDR Conference in 2017 (Markus, 2017). An article presenting the definite research results, including a follow-up of six months will soon be offered for publication.

Other experiences have been noted to be variable, but still often showing a clear positive outcome (for example Qurishi, Markus, Habra, Bressers, & De Jong, 2017)

Colleagues who participated in our workshop ‘EMDR and addictions’ reported frequent succesful treatment outcomes, especially for behavioural addictions and at times with patients with whom ‘everything else had been tried but to no avail’. Experimental research once again showed positive results for the possible influence of eye-movements in reducing craving (Littel, Van den Hout, & Engelhard, 2016; Markus, de Weert-van Oene Woud, Becker, & de Jong, 2016). Different modules are currently being used in a clinical trial with persons with a gambling problems and problems with exhibitionism. In other words, the research into the (im)possibilities of EMDR in addictions is starting to take off and we think that this overview of EMDR interventions can play an important part in this.
In front of you, you have the Palette with the description of 15 interventions. The starting point is the aforementioned article ‘EMDR Interventions in Addiction’ (Markus & Hornsveld, 2017). The modules can be used separately from each other: the choice for each module is based upon the case conceptualisation and the treatment plan. The final choice clearly depends on the severity and nature of the addiction, characteristics of the patient but also the moment when the patient has decided to seek help in the overall ‘addiction career’ of the patient. For example, in an early stage of an addiction perhaps the positively reinforcing aspects of the addiction (e.g. a ‘good feeling’) will be the focus, whereas the focus with chronic addiction is on the negatively reinforcing aspects (e.g. ‘reducing stress’). Each component describes possible considerations for using a particular module in the treatment programme. Qurishi and colleagues (2017) suggest that ‘shared decision’ making leads to a joint treatment plan which in turn increases treatment fidelity.

Popky (2005; 2010) introduced the term LoU (Level of Urge) to be indicated on a scale from 0 ‘no urge at all’ to 10 ‘maximum urge’. We have also used the LoU scale in different modules. Comparably, Knipe (2010) uses the LoPA (Level of Positive Affect) to indicate the level of positivity from 0 ‘not positive at all’ to 10 ‘as positive as can be’. We have also included this scale.

**Therapists**

Therapists who want to use the various modules, are preferably experienced in treating (behavioural) addictions. The assumed level of competence in EMDR is practitioner level (level II), as well as being a member of the national EMDR Association.

The protocol presumes knowledge of the Dutch Two Method Approach (De Jongh, Ten Broeke & Meijer, 2010; Beer, in press), RDI, cognitive interweaves and a high level of familiarity with the Standard Protocol.

It is recommended to have all the up to date protocols within reach.

We cannot but emphasize that the described interventions are only to be implemented when the patient fails to benefit from the standard treatment, or as an adjunct to treatment. Don’t use EMDR if you don’t know how to treat without using EMDR.

**Suitable for which patients?**

For legibility sake this protocol has been described for patients with an alcohol abuse disorder. With a few simple alterations it can also be used for patients addicted to other substances or behaviours and for those with impulse control problems. For example shopping, eating, sex, work, sports, gaming, internet, and social media ‘addiction’ and for problematic behaviours such as exhibitionism, kleptomania or stalking. The protocol does not replace standard, regular addiction treatments (e.g. programmes including self management techniques, social skills training, medical treatment and so on). It is meant as an adjunct to these programmes; to increase abstinence and to reduce relapse. Possible exceptions pertain to behavioural and substance related addictions whereby patients function well and have no co-morbid disorders. In practice this could include nicotine dependency.
For patients with poly substance use (when several substances are being used simultaneously) we advise you to choose the substance that is commonly used prior to other substances, (some cocaine users use cocaine only once they have had a substantial amount of alcohol). It seems obvious to focus on the first or primary substance in the escalating chain of substances.

**Practical issues**
Whenever three dots appear (…), wait for the reaction of your patient first.
Everything that can be said literally is marked (in a green tekst box): “In italics with inverted commas”.

A few components can be given as homework. Make sure you leave some time for preparation and discussion of homework.

**Feedback**
This protocol is still undergoing revision. We would like to hear your experiences, preferable using the questions below. Please send your remarks, answers and suggestions to
EMDR.verslaving@gmail.com

- Which substance or problematic behaviour did you use this protocol for?
- Which effects did you report during or following treatment? Do you have questionnaire results to support this?
- Are you satisfied with this treatment? If so, or not, please explain.
- Which components worked best, which least, and why do you think so?
- Which patient related factors (e.g. age, IQ, severity of addiction, multi substance use, co-morbidity etc.) have positively or negatively influenced the results?
- Anything else you have noticed that is worth mentioning, or any suggestions for improvement?
2. Preparation

Coming to agreements and limit setting

Patients do not need to be fully and long term abstinent before you can start with the protocol. Consider as a general rule of thumb that whenever an outpatient addictions treatment is possible, the basic requirements for this protocol have been fulfilled. In other words, patients get to their appointments on time, can have meaningful conversations, are not in crises, and show no harmful symptoms which require treatment first (e.g. severe suicidal behaviours, aggression, or self-harm). In a clinical setting treatment is possible at an earlier stage.

Temporary ‘lapses’ (short periods of (escalated) substance use whereby the patient autonomously manages to return to abstinence) or ‘relapses’ (longer lasting loss of control in substance) use can be used as part of the treatment itself.

Make sure you emphasise that it is important that the patient discusses their cravings openly and honestly, both in the sessions as in between the sessions. Make clear agreements beforehand when you will have to (temporarily) interrupt treatment. Following on from the above guideline an interruption of treatment could be an issue when the criteria for a meaningful treatment are no longer met and a different intervention, such as clinical detoxification, crises hospital admission or medical intervention is required. For example:

- Crises situations and/or actual, potentially harmful symptoms which require immediate treatment;
- Excessive substances abuse which interfere with meaningful treatment and require detoxification first;
- Repeated no-show;
- Repeatedly showing up under influence.

Ensure that reducing or ceasing alcohol always takes place under medical supervision. Immediate cessation of severe and long-term alcohol use can be dangerous.

In case the patient is able to do so, they could write their life, or abuse history. Important aspects in this are the significant experiences before and during the course of the addiction, typical trigger situations as well as ideas about the future. In this way relevant targets can be identified.

Lastly, it is important to realise that some patients do not experience cravings, or they tend to describe this in a more or less diffuse way. Sometimes they will experience craving when a specific memory is activated (during phase 3, assessment) In other cases the more general
word ‘distress’ or ‘charge’ suits better. When patients use medications which reduce craving (in particular Campral, Naltrexon or Baclofen) it does not automatically imply exclusion for treatment. Also, craving is usually elicited during the assessment phase of the targets. Do make sure you are in alignment with the other clinicians involved so that possible side effects will be interpreted correctly.

**Explanation EMDR**

“Eye Movement Desensitization and Reprocessing, in short EMDR, is a proven effective therapy for people who continue to have problems following the effects of a traumatic experience. There are growing indications that vivid memories and images also play an important role in addictions.

In this treatment we assess memories and images which possibly maintain your addiction. An important part of this treatment is looking for experiences and images which have caused you to drink more, or have made it more difficult to stop. Because of these experiences you have, for example, learned that alcohol is pleasant and attractive, or that it lessens negative feelings. We believe that these experiences are stored as memories and continue to influence you on a day to day basis. With EMDR we can make these memories harmless by taking away the emotional charge or the craving they elicit. In this way these memories become more or less neutral and so it becomes easier to stop using alcohol or remain abstinent and thereby increasing your self-image.

In order to find out what are the most important memories linked to your alcohol abuse, I will ask you about: pleasant memories, negative memories, how you feel about yourself in relation to alcohol, and about situations that frequently increase craving or using alcohol, or those which you expect will lead to drinking.

Do you have any questions about this?”

**Explanation of the EMDR procedure**

“During EMDR I will ask you to think about specific events, including images, thoughts and feelings. This will be combined with a distraction task: you will be asked to follow my fingers with your eyes (show how).

We will use several sets of these eye movements. After each set of eye movements we will take a very brief break. In this break I will ask you what thoughts or feelings come up. EMDR often brings about images and thoughts, but just as often physical sensations or emotions and feelings. After each set you will be asked what comes up and you can take a moment to focus on this and then a new set will follow.

Whatever comes up is absolutely fine, it’s impossible for you to do it wrong.”
Explain how EMDR works

“We know EMDR works, but how it works exactly is still not quite clear. In any case it seems that the natural processing system gets activated during the stimulation of EMDR. There have been many scientific studies which show that eye movements reduce the negativity of negative memories, and positive memories become less positive. Eye movements can also reduce cravings or desire for certain things. This is exactly what we use in EMDR. Also, EMDR leads to a feeling of physical relaxation and a changed viewpoint on memory images.”

Explanation of the results which can be expected

“So, what can you expect from the treatment? The sets of eye movements will slowly but surely lead to the memory losing its’ vividness and emotional charge. It will become easier to bring the memory or image to mind without for example a sense of craving. In many cases the actual images in the memory change, for example they become more vague, or smaller. Another possibility is that new insights or thoughts come up which give a more helpful interpretation to the event and to your addiction.

Following an EMDR session the effects may continue, and this is fine. However, it can leave you feeling a little out of control as for example new images or feelings come up, or when you experience an increase in craving. It is reassuring to know this effect lasts for no more than a day or three, after which a new balance has been created. In between sessions you can keep a brief diary in which you write down anything that comes up which will be discussed in the next therapy session.”

The aim of treatment

Even though for many patients complete and long-term abstinence would be preferable compared to controlled use (because of the increased chance of relapse or loss of control), it is not of much use to go against the patients’ wishes if they are adamant they wish to aim for controlled use. It is more helpful to agree than disagree. The treatment will then focus on reducing the craving and experiencing more autonomy in the choice of using a substance or not. In our experience patients often realise during the protocol that they make it more difficult for themselves by wanting to continue to use the substance. Eventually they often decide for (a period of) complete abstinence. Because of these shift in ideas about the desired outcome of the behaviours it makes sense to repeat some of these questions during the course of treatment.

“What are you aiming for in your use of alcohol? Do you aim for total abstinence or controlled drinking /use of the substance?”

Treatment aim __________________________
“On a scale of 0-100% to what extent are you convinced that you can achieve and maintain your aim of complete abstinence / controlled drinking?”

Level of conviction___________________________________________________________

Repeat this question at the end of treatment, or even following each module in order to get a feel for what works best and in what way the original aim has already been achieved.

**Craving during and following sessions**

“Whenever we work on a memory which evokes feelings of craving it is logical that you may wish to use alcohol. This is not a problem as it will reduce during the course of treatment. Ask for support during the sessions whenever you experience cravings. During the session itself you may also experience a similar reaction as you would when drinking alcohol, such as a light feeling of tipsiness, drowsiness, a relaxed feeling or a more excited feeling.

Of course we are aiming for you using the substance less and less and increasing your confidence that you will succeed. Don’t test yourself; avoid typical risk situations as much as you can until you really feel up to it to face them.”

**Ending the session: discuss cravings and homework.**

If at the end of the session the craving has not lessened, discuss which options they have to deal with this (e.g. waiting in the waiting room until the craving has decreased, planning distractions, mobilising support and so forth). Ask at the end of each session:

“Before you leave I’d like to know how much craving you experience right now on a scale of 0 ‘not at all’ to 10 ‘as much as possible’”.

End of session craving (not related to targets!): __________

If >0

“Is this quite normal for you or is it more than usual?”

The craving does not necessarily need to be triggered by the session itself, but could also be related to a planned activity which normally induces craving, such as going to a birthday party. Discuss with your patient how to best deal with this. Preferably use the so called implementing intentions (specifically worked out as ‘if - than’ action plans), for example:

“What will you do once you leave here?”

“What will you do when you keep on craving?”
“How can you prevent yourself from drinking tonight?” “What does that look like?” and so on.

Discuss if additional measures need to be put into place and help the patient in thinking this through. Also bear in mind additional skills such as ‘riding the wave of your emotions’, RDI, recognising and avoiding high risk situations and creating distractions.

You may also wish to consider – if you have reached this point in the protocol and you have some time left – to desensitise an anticipated risk situation (positive or negative flashforward). Discuss at the start and at the end of each session the homework.
## 3. Overview of the modules and target areas

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<th>Intervention</th>
<th>Main indication(s)</th>
<th>Source, further reading</th>
<th>Key instructions and questions</th>
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| RESOURCING | 1 | Safe place and Resource Development Installation | Need for preparation, enhancing skills and resources to handle forthcoming difficult situations | Shapiro, 2001<br>Leeds & Shapiro, 2000<br>Korn & Leeds, 2002 | Please bring up an image of a place that feels safe and calm.<br>When you think about this [challenging] situation, what qualities, resources or strengths are you missing? Think of a time when you felt [i.e. strong, confident, soothed, able to tolerate your feelings]’.

2 | Installation of positive treatment goal | Insufficient availability of a motivating, achievable, personal goal | Popky, 2010 | What really motivates you to reduce/stop using/doing [name substance or behavior]?
What is your dot on the horizon? |
| TF-EMDR | 3 | EMDR on memory representations associated with PTSD (T-trauma’s) | PTSD symptoms | Shapiro, 2001 | Which images are the most intrusive? |
| | 4 | EMDR on memory representations fueling negative affect and affect intolerance (ACE’s, t-trauma’s) | Addiction conceptualized as self-medication strategy | Shapiro, 2001<br>Brown et al., 2015<br>De Jongh, Ten Brooke & Meijer, 2010 (two-method approach, approach 1) | What is the most difficult situation for you when it comes to resisting using/doing [name substance or behavior]?
Further questioning by either affectbridging or method 1 of ‘two-method approach’ |
| | 5 | EMDR on memories fueling negative core beliefs (ACE’s, t-trauma’s) | Addiction conceptualized as maintained by low self-efficacy / low self-esteem | De Jongh, Ten Brooke & Meijer, 2010; Beer, in press (two method approach, approach 2) | If you can’t resist a difficult situation, what words express your negative belief about yourself? (self-defeating conviction)
What experiences provide the strongest ‘proof’ for this self-defeating conviction? |
| AF-EMDR | 6 | EMDR on negative flashforwards of prolonged abstinence | Fear of sobriety | Hornsveld & Markus, 2016 | This article | What negative associations do you have with prolonged abstinence? |
| | 7 | EMDR on negative flashforwards of relapse | Fear of relapse | Hornsveld & Markus, 2016 | This article | What catastrophic image comes up when you think about relapse? |
| | 8 | EMDR on memories of relapse | Feeling of powerlessness in the face of the addiction | Hase, 2010 | What first / worst / last memories you have regarding relapsing with [name substance or behavior]?
What other first / worst / last memories you have whereby you clearly lost control over using/doing [name substance or behavior]?
What other experiences provide the strongest ‘proof’ that you cannot handle using/doing [name substance or behavior]? |
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<td>AF-EMDR</td>
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Target area 1: Resources - Increasing a sense of safety and strength and the availability of resources

General points for modules 1 and 2

- RDI and installing a ‘safe place’ as well as positive treatment aims are useful procedures, but there is no empirical basis for using eye movements to enhance the intended effects (Hornsved, de Jongh & ten Broeke, 2012). From the working memory point of view we would expect adverse effects, and for this reason the Dutch guidelines advise to omit the eye movements. In other countries in Europe and in the USA the use of very slow eye movements have already been implemented during these procedures.

- According to the Retrieval Competition Hypothesis by Brewin (2006), various associated, positive and negative memory representations compete for awareness. The memory representations which are activated most speedily are those which have been activated most frequently up to that point, i.e. implicitly ‘trained’ to do so. Visualisation exercises can help to temporarily access the helping (adaptive) memory representations which are normally not activated as easily. In order to make this effect more permanent, other than by desensitisation of the memory representations, repetition through explicit training is required, otherwise the effect often remains temporary. Research into COMET (which also includes focused imagination) suggests that this cumulative powerful effect is stable over the course of a few weeks (Korrelboom, Maarsingh, & Huijbrechts, 2012).

- Always finish a session with a positive closure. Remember to assess the level of craving at the end of the session and give instructions for homework.
Module 1: Resources - Increasing a sense of safety and strength and the availability of resources

Estimated time required for this module: approximately 20 minutes.
Valency: positive
Time perspective: present and future.
Primary aim: increasing the availability of personal qualities which enhance the sense of safety and firmness to remain steadfast in risky (trigger) situations.
Resources: this module equals the Safe Place Procedure (Shapiro, 2001) and the RDI protocol.

Introduction and aim
RDI is a technique which can be used at any time during the addictions treatment programme. The 'Safe Place Procedure' is commonly used at the start of a (intensive trauma focused) treatment, interestingly it is far less used in the Netherlands compared to other countries. RDI draws upon the work by Leeds (2009). It is excellent for those patients who tend to become demoralised, in addition to motivational techniques, self control techniques and learning how to deal with relapse and set backs.

Points of note
- RDI is taught during level II training.
- Resources for addicted patients match those of traumatised patients: self esteem, perseverance, resilience, self-control, courage, self-confidence and pride.

Homework
Ask the patient to practice recalling the resources step by step:
- During several times a day going back to the memory of the resource and focus on the positive 'feelings' (approx. 5 minutes each time).
- After a week, try out whether this resource is mentally available, but without activating the memory.
- Practice this on a daily basis. Activate the resources during all sorts of daily activities.
- Perhaps immediately or after some time recall the mental representation of the problem situation(s), and if needed, using the resource(s).
- Use the resources 'for real' when required.

The patient describes their progress in their homework notebook.
Module 2: Installation of a Positive Treatment Goal

**Estimated time required for this module:** approximately 15 minutes per treatment aim, comparable with RDI procedures.

**Time perspective:** future

**Valency:** positive

**Sources:** RDI and motivational techniques. This component occurs in a slightly different form in Popky’s protocol (2010).

**Introduction and aims**

The aim of this module is increasing the motivation by creating, or bringing closer a positive attractive view of the future. It is comparable with the so-called motivational letter: "write a story about your life a year from now, when you have stopped drinking alcohol." Instead of words you use the power of imagery and the knowledge of RDI about strengthening positive memory material by using imaginations.

**Points of note**

- Look for a positive image; formulated positively. It’s about what the patient does and wants and not what the patient does not want to do (anymore). When the patient uses a negative formulation, e.g. "no longer being a couch potato watching telly..", "I will no longer feel so restless", "I will no longer drink", and so forth, say: "So if you don’t .....[watch telly as a couch potato, feel so restless, drink] what would you be doing or experiencing instead?"

- Let the patient choose an image not too distant in the future, e.g. 'in a year's time' and not longer away, otherwise it becomes too abstract and unbelievable.

- Check if it is an attractive, specific and intuitive (emotive) realistic aim for this patient. Use the patient's own words with regards to coping and successful functioning.

- Don't use images of controlled substance usage. This implies almost substance use again and can increase craving.

- If the procedure goes fast you can install more than one positive image, such as for example a work-related image, an image at home, a sporting image and so forth. Any place where the patient wants to increase their functioning.

**Protocol**

Explain, using words that match with your patient and his or her problems, that you will find out together in what way their motivation can be maintained. For perseverance sake, keep the longer term aim in focus, despite short term frustrations like cravings and withdrawal effects.
Discuss with your patient that you will teach him or her to use the resources in order to reach these attractive longer term aims in the future.

"You have had this addiction for so long now, that you may find it difficult to imagine a future without problems with alcohol. To keep motivated to stop drinking, we will create and strengthen a positive image of life without alcohol. It will help you to keep on track."

"Why do you want to stop using alcohol? ... What is most important to you now in your life, what would be the most worthwhile that non-drinking will bring you?... What else?"

Describe briefly some of the positive aims:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

"So now take on the posture of someone who has stopped drinking for a while and has his life under control ... Close your eyes and create an image of having achieved your goals. Think about your life once this is all over, without your alcohol addiction. ... How would you notice you've achieved this life, what would you see? ... What would you be doing in this image? What do you see ... hear... smell?"

Together with the patient, look for a powerful descriptive and positive number of statements, e.g. a good father, going for a run, being an appreciated colleague.

"Make this image even more attractive by making it more clear, bigger, sharper. ... Is there anything else you'd like to change to make this image even more attractive? ... Bring the image closer, step right into this attractive image where you have reached all your aims. Adopt a body posture that goes along with this, take in this successful experience ... Notice what you see, feel, smell, taste, what it is like to be successful. ... Notice how you move, the way you talk, feel, act and how others react. What positive words about yourself go best with this? ... For example: I can do it! ... Notice the positive feelings that go along with this, what you are saying to yourself ... your emotions and your body ... pay attention to all of this and just notice what happens."

10-15 seconds of visualisation and concentration or very slow eye movements.
“What do you notice or What do you get? ... any other positive associations?... Any other positive things you notice? What comes up? ... Keep on going.”

Continue the visualisation until no new positive associations come up or the positive feeling no longer strengthens.

**Homework**

“To make sure you keep your focus on a life without alcohol, also in difficult times, and to keep this within reach, I advise you to practice this on a daily basis in the beginning and later on a few times per week at different times. The purpose is that this image, this attractive alternative for alcohol comes closer in reach each time you practice.”

- Get the patient to practice daily recalling this image [brief description (s)] for as long as the associated positive feeling is maximal (approx. 5 minutes per time). Use a smartphone reminder and/or let him or her practice at set times (e.g. when going to the toilet, has a break, going to bed etc.), gradually making the shift to daily activities.

- Over time test whether the positive feeling that goes along with [positive self statement (s)] can be activated mentally.

- After some time the patient can use this resource if and when required.
Target area 2: Trauma-focused EMDR - Reducing the influence of damaging experiences

General points for modules 1 and 2 (extracted from Markus, De Kruijk, De Weert-Van Oene, Becker, & De Jong, 2014)

- Within the addiction services the assessment and treatment of PTSD is often missed out. The advice is to routinely screen for PTSD. Also, a PTSD frequently only emerges during treatment. If in the assessment phase, two-three weeks of abstinence is not achievable, check whether a probable diagnoses can be made with stable, controlled drinking, using a thorough history taking of the symptoms and possibly an interview with significant others. This can be considered when the symptoms clearly interfere with abstinence attempts or create significant problems.

- Complete abstinence is not a prerequisite for trauma treatments. On the contrary, the consensus is that an integrated treatment of PTSD and addiction is preferable to a sequential treatment.

- There is no evidence base for an increase in risk during treatments for trauma comparable to not treating, not even for vulnerable groups such as addicts. In our opinion there is no absolute, permanent contraindication for trauma treatments for addicts.

- There are some relative contra-indications which can have a (temporary) negative impact on the achievability and effectiveness of treatments for trauma. These include current therapy interfering factors (and not only for trauma treatment), or those factors threatening to become therapy interfering such as regularly showing up under influence, regular no show, or displaying behaviours which are a threat to the patient themselves or others (e.g. aggression). This calls for a tailored treatment.

- When the substance use is interfering with therapy (no show, turning up under influence, using full on straight after the session) a detox program is required. If this is to no avail, then focus on reducing the use or a stabilisation programme first.

- Treat on an outpatient basis whenever possible, but do it inpatient when necessary (in particular when the aforementioned therapy interfering factors are present).

- In an integrated treatment approach it is important to keep a constant check and focus on that what is required (addiction, PTSD or practical issues), without losing the continuity of the treatment as a whole. Monitor the progress of both disorders in order to adjust the treatment and keep the patient motivated.

- People with an addiction often get over-aroused more easily because their stress system, which has been deregulated because of early childhood trauma (Langeland, 2009), gets
desensitised further and further by regular substance abuse (Sinha, 2008). It is therefore important to keep a constant check in order to prevent patients exceeding their window of tolerance, ‘the bandwidth of arousal in which cognitive and emotional functioning is possible’ (Ogden & Minton, 2000).

- There can be temporary hypo-arousal (for example because of dissociation or intoxication), which hampers the reprocessing because the traumatic material is not activated enough. In this case it is important to reduce the substance use first or to stabilise. The use of tranquilizers (in particular benzodiazepines) and arousal reducing medication (in particular beta-blockers such as propranolol) requires to be reduced, if possible, and agreements have to be made with respect to (substances and possibly medication) before (and following) the sessions.

- Provide psycho education for the patient and their loved ones (next of kin) about the interaction of the addiction and PTSD. If patients are unable (yet) to have treatment, instruct them how to deal best with the dynamics between PTSD and addiction.

- Relapse is a part of the addiction. Patients and their loves ones need to be prepared for this. It is not a reason to stop treatment, perhaps only temporarily. Always finish a session with a positive closure. Remember to ask at the end of the session what the current level of craving is and give instructions for homework.

**General points for modules 4 and 5**

- Negative experiences can sometimes be historically relevant (i.e. they have played a part in the development and course of the addiction) but this does not mean automatically that it is (still) clinically relevant to focus on this (as a target in EMDR) in a treatment for addictions.

- Think carefully before you start with this module. Many patients find it confrontational and become very avoidant. A temporary relapse or motivational dip lurks around the corner. Be aware of what you are getting yourself into, spend time discussing it thoroughly with your patient. Prepare your patient well for these modules, ‘old pain’ will be activated and they need to be prepared as well as wanting to do so.

- Use module 4 & 5 only if you have enough time to treat the associated symptoms and issues sufficiently. Simply touching upon old pain must at all times be avoided.

- Only select those targets which 1) have a clear relation to the addiction, and 2) which have sufficient emotional charge (SUD>6).
Module 3: Reducing intrusions and re-experiencing.

Estimated time required: for as long as it takes to treat the PTSD symptoms.
Time perspective: past.
Valency: negative (SUD).
Primary aim: PTSD treatment.

Introduction and aims
Given the high co-morbidity between PTSD and addiction is seems clear to routinely screen for PTSD in addiction care. In reverse, in Primary Mental Health Care one should be aware in case of a PTSD with a co-morbid addiction disorder or even an excessive use of substances.
At present, the Dutch guidelines indicate to treat PTSD and addictions from an integrated viewpoint (Snoeks, Wits & Meulders, 2012), but how this is precisely defined or implemented, remains unclear in this guideline.

The guiding principle is to treat existing PTSD symptoms as soon as possible. Frequently however, a PTSD emerges only after the substance abuse has decreased or abstinence has been achieved. In this case it is advisable to shift the focus to trauma treatment because of the high level of suffering from intrusions and re-experiencing, secondly, the fact that PTSD symptoms facilitate the addictive behaviour and lastly because a reduction of PTSD symptoms also has a positive influence on addiction related outcomes, however in the reverse this is less so the case (Hien et al, 2010).

Because this refers to standard PTSD treatment according the existing guidelines, we will not go into this any further.
Module 4: reducing negative emotions

**Estimated time required for this module:** for as long as it takes to sufficiently treat the symptoms.

**Time perspective:** past.

**Valency:** negative (SUD).

**Primary aim:** reducing the affect regulation problems and co-morbidity in addictions.

**Resources:** see (Markus & Hornsveld, 2017).

**Introduction and aims**

For many patients the addictive behaviour is an inadequate way to deal with (emotional) problems. This applies to the addiction as a reaction to PTSD (see module 3), but also for e.g. drinking that started with social anxiety (Dutch courage) or an eating disorder with personality problems. When based on the history taking, the self-medication hypothesis indeed seems plausible, this clearly requires the necessary attention, for example using EMDR.

Gielen, Havermans, Tekelenburg and Jansen (2012) found in their research that 97.4% of the patients who required an addiction treatment had at one point in their life experienced a traumatic experience (an experience which met the A-criteria according to the DSM-IV). Within this group 'only' 36.6% had the DSM-IV diagnoses for PTSD.

However, as indicated before in the general points for modules 4 and 5, even though the relationship between potentially traumatic experiences and the development of the addiction may be strong, it is not automatically necessary or meaningful to treat the particular negative memory. In fact, processing old painful material could be experienced by the patient as very meaningful, but at the same time one is avoiding what is even more painful and difficult, i.e. the stopping with the addictive behaviour itself.

On the other side the approach is very logical: in many functional-analyses the addiction has the function to reduce or avoid painful emotions, emotions which -according to Shapiro's AIP model (Shapiro 2001; De Jongh, Ernst, Marques, & Hornsveld, 2013) - are being maintained by dysfunctionally stored experiences. As an alternative for affect regulation training and self-control techniques, one can try to reduce the emotional problems with EMDR. In the ideal case scenario following the EMDR few intense emotions remain which need to be rigorously suppressed and avoided. Unfortunately research into the treatment of co-morbidity in people with an addiction indicates that the effect of a succesful treatment aimed at the addictive behaviours is disappointing in most studies. However, there are a few small studies which show a more positive result, both on affect as the addiction itself. (for an overview see Markus & Hornsveld, 2017).
Procedures
People with an addiction are often very good at avoiding their emotions; their addiction helps them with this and is therefore their 'best friend'. For both the therapist and the patient it is a balancing act between: 1) trauma processing, 2) dealing with the addiction and 3) remaining in therapy.

Step 1. Investigate which problematic emotions most probably maintain the addiction. In principle, any psychological problem can be the reason for the dysfunctional coping with addiction behaviour.

Step 2. Identify these traumatic (T-trauma and t-trauma) experiences. There are various assessment procedures to get to the relevant target memories, via intrusions for PTSD (module 3), The two method approach (De Jongh, Ten Broeke & Meijer, 2010; Beer, in press) or affectbridging.

Step 3. Treat these traumatic experiences, with EMDR (or another re-evaluation technique, such as imaginary rescripting). Rarely will EMDR alone be sufficient to completely reduce the emotional problems. At the same time the focus needs to be drawn to the addictive behaviour (integrated treatment).
Module 5: improving self-image and self-efficacy

Estimated time required for this module: > 6 sessions
Time perspective: past.
Valency: negative (SUD).
Primary aim: increasing self-esteem, in particular self-efficacy in trigger situations.
Source: EMDR Two method approach: the second method (Ten Broeke, De Jongh & Hornsveld, 2012), focusing on the self-undermining (core)assumptions which maintain the addiction.

Introduction and aims
Self-efficacy concerns the belief in one's own abilities to deal with a specific situation. It's about context related self confidence. Low self-efficacy is a reliable predictor for substance use and relapse. The so called 'fail experiences' such as failed attempts to quit and a relapse following a period of abstinence reduce feelings of self-efficacy (vicious cycle). In this module the focus is on strengthening self-efficacy, by desensitising the self-efficacy undermining memories. These memories often existed prior to the problematic drinking: e.g. someone who was always told that he was good at nothing, could see this confirmed later on in life when failing to refuse alcohol.

In this part of the protocol the difficult, alcohol related, situations are elicited (e.g. 'When I'm tired'). Subsequently the person is asked for a self undermining statement which, as it were, 'explains' why the person is unable to deal with this specific situation. It's about weakening the dysfunctional (core) assumptions which undermine the so called 'situation specific self-efficacy coping '. This module uses the search strategy taken from the Two Method Approach.

General points
- Patients often have several core assumptions. In this module the focus is particularly on those core assumptions which undermine the addiction behaviours mostly. Usually this is an assumption like 'I'm weak, a loser, a wuss' or a variation on this theme.

- Alternatively you can formulate a self-efficacy undermining assumption directly. The advantage of the method described below -using difficult situations- is that your search is much more specific and clarifies for your patient how disabling this self-efficacy assumption is. The NC (target related) for the elicited image in the assessment phase is not necessarily the same as the core assumption (emotively or intuitively always valid whenever one craves alcohol). The NC for a specific target image can be for example: I'm unworthy' and the self-efficacy undermining assumption being 'I can't control myself'.

- The procedure for 'Second Method for repairing self esteem' has been researched in two studies: one study gave disappointing results (Staring et al., 2015) and the other was positive for EMDR (Grifioen et al., 2017). When using the Second Method, based on both studies, the recommendation is to only desensitise those memories which have a high level
of emotional distress (a high SUD) and really suppress a positive self image. The effects of the Second Method only become visible after at least 6 sessions; therefore the advice is: don’t do ‘a bit’ of the Second Method.

- A good alternative for increasing self esteem is COMET for low self-esteem (Korrelboom 2011).

Protocol

"In the situations that increase the possibility of drinking alcohol, our beliefs about ourself and how well we are able to resist craving, temptations and difficult situations, play an important role. Therefore we are going to find out which situations you find difficult. Following this we will find out how we can make sure that you cope with these situations.

Which situations or moods are most likely to get you to drink alcohol?"

____________________________________________________________________

____________________________________________________________________

"What makes it difficult for you to cope with these?"

Additional questions to get an identity based evaluative belief:

"How do you feel about yourself because you find it so difficult to cope with this?"

"What beliefs do you have about yourself regarding your drinking...or, put differently, what would you call someone who can't deal with this?"

"What does it say about you as a person that you can't deal with this? For example, I am weak, I'm a loser, I'm spineless, I'm not worthwhile."

Write down the most important beliefs that undermine the self-efficacy:

______________________________________________________________ (Belief)

Explain the rational for the Second Method:
“Statements such as [...] belief generally develop because of many different experiences. Not only alcohol related experiences, but usually experiences which developed before you started drinking. It appears difficult to let go of these negative self statements even though you try so hard. This is because these old experiences intuitively still prove that [...] belief is true. Therefore we must deal with these self undermining memories. We will use EMDR for this.... Do you have any further questions before we continue?

Which experiences do you feel prove at this moment that [name the assumption] (still) holds true? We are looking for evidence preferably before you started substance abusing.”

Additional questions:

“What caused you to (start to) believe that you are a ... [belief]?”

“Where did you learn that (you are a) ... [belief]?”

“Which earliest situation proves to you that you are still (a) ... [belief]?”

“Which recent situation makes it clear to you that you are (a) ... [belief]?”

“Convince me why you are a ... [belief], what reflects this?”

“What have you experienced which has given you the unshakeable idea that you are a ... [belief]?”

Note the memories which feel most strongly as evidence that [Belief] is true.

1. _____________________________________________________________(working title)

2. _____________________________________________________________(working title)

3. _____________________________________________________________(working title)

Following on from this use the Standard Protocol, with some minor adjustments. Firstly, don’t ask for the worst image but instead:

“Now I’m asking you, what is, at this very moment, when you look right now, at the image which proves to you most strongly that [Belief] is true? Look at this so-called movie and freeze frame this so you are looking at a still image.” and so forth.
Secondly, installing the PC is not obvious. The assumption "I am strong" (or something similar) is too ambitious. Choose a less ambitious PC (e.g. I'm on the right track", or I feel more confident". See how much positivity you can achieve at this point.
4. Target area 3: Addiction focused EMDR - Reducing the fear for change

General points for modules 6 and 7 (negative flashforwards)

- In a flashforward we do not specify the NC (See Logie & De Jongh, 2014). Formally the NC would be 'I am powerless (against this image)', but this will not increase the emotional distress. There is always a SUD increasing statement possible which will increase the emotional distress, such as 'I'm a boring fool' or 'life without alcohol has no use' (for flashforwards for long-term abstinence: module 6) or 'I am back at square one' or 'I'm spineless' (for flashforwards for relapse or losing control: module 7). [statements en korte voorbeelden met enkele aanhalingstekens, letterlijke teksten, met name zoals de therapeut die kan juitspreken tussen dubbele aanhalingstekens].

- The PC is 'I am in control' which in fact means: 'I can handle the intrusive image. I can't predict the future; it would be very undesirable if I end up in the gutter, but I am in control of what happens. I will not let it get out of hand as much as I have done in the past. I'm much older and wiser now. In short, I can handle the future.'

- Therapists are sometimes reluctant to desensitise a so called doom scenario because they believe that the mere presence of the doom scenario actually stops the client from using substances. However, this is really not so in our experience. In fact, doom scenarios have a crippling effect. The clearer the patients image of the doom scenario, the greater the felt propability of 'it' (the unbearable life without alcohol or relapse with catastrophic results) going to happen. Reducing this felt sense of probability is precisely the aim of desensitising the flashforwards.
Module 6: Desensitising negative associations with long-term abstinence.

**Estimated time required for this module:** 30 minutes  
**Time perspective:** future.  
**Valency:** negative (SUD).  
**Primary aim:** Reducing ambivalence with regards to abstinence.  
**Source:** This component is a variant of the flashforward procedure. It does not appear in any of the other protocols of other authors.

**Introduction and aim**
People who wish to stop drinking (alcohol) often hold a negative view of the future, a life without the substance (flashforward of abstinence). A flashforward of abstinence often includes an image of a boring, useless, mundane life, or a life in which one has to keep on fighting or a life in which one never belongs.

During EMDR with a flashforward of abstinence we often see people all of a sudden becoming aware of nuances, and the idea grows that they themselves can prevent their worst-case scenario from happening (increasing self-efficacy). A lot of spontaneous rescripting occurs, e.g. a patient with a flashforward in which he is being laughed at by colleagues because he drinks mineral water, decides to go them, the laughing stops and the patient realises that he himself has an active part in how others deal with his abstinence.

**Points of note**
- Even though the patient is aiming for controlled use, we will desensitise a flashforward on being abstinent. In our view abstinence as an objective becomes within reach when it is less dissuasive.
- Examples of negative representations of abstinence can include: 'bored and all alone at the kitchen table'; 'my father being disappointed in me because I won't join in for a drink', 'being laughed at by colleagues having a beer in the Pub Friday after work', 'longing and wandering through the city center', 'yet another cup of tea' 'having no friends', and so forth.
Protocol

'Most people have mixed feelings about wanting to stop drinking. Sometimes someone is reluctant to 'never being allowed alcohol ever again'. Being sober, having an alcohol free life is hard to imagine. It may seem boring or lonely, or sad.

Which negative associations do you have when thinking about being abstinent? ... What image represents this? ... or ... 'if you'd have a nightmare about 'being sober the rest of your life', what would this be about? ... What does your worst-case scenario look like? ... Make a still and detailed picture of this worst image (cf & Logie & De Jongh 2015)"

Help the patient to translate the answers to one or more of the specific flashforwards.

flashforward: __________________________________________________________

flashforward: __________________________________________________________

Get the patient to make a still, detailed image of the identified worst-case scenario and desensitise this as if it were a normal memory representation.

"Which words or comments about yourself or life with regards to this worst-case scenario is most disturbing to you? ... For example: I’m such a bore, my life is over...

When you bring up (state the image of the flashforward) and those words (the statement), what emotion do you feel right now? For example anxious, angry, sad?'

Again, bring up the image how disturbing does this feel now, on a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine?

Where do you feel it (the disturbance) in your body?"

Sets of BLS and associations until no change is noted, then Back to Target - repeat this procedure until SUD= 0.

“Think of the image of the worst case scenario, the way it is now stored in your mind on a scale of 1 (completely false) to 7 (completely true), how true do the words " I can deal with this image", feel to you now?"

Keep applying BLS until VoC = 7.

If necessary do the body-scan.

"This module was about abstinence. How do you feel about this now?"
Module 7: Desensitising flashforwards of relapse and losing control.

Estimated time required for this module: about 30 minutes
Time perspective: future.
Valency: negative (SUD).
Primary aim: Reducing anxiety and increasing the sense of control over the future.
Source: This component is a variant of the flashforward procedure.

Introduction and aim
We often find that with people who wish to stop drinking, that they are not very optimistic about their own abilities to stick with it. In this module the sights are set on possible existing flashforwards with respect to losing control and relapse. Such a worst-case scenario often consists of a confirming image in which the patient sees him or herself not making it ("I can see myself ending up in the gutter' or walking through the streets drunk', 'my family visiting me in the clinic'). This paralyses the motivation and the ability to realistically assess their own abilities to deal with this. Our experience in using this module is that flashforwards rapidly lose power in the desensitisation phase. The patient all of a sudden realises that one 'does not end up in the gutter out of the blue', and many steps, which are rather unrealistic, are needed before this takes place. Also, the patient can undertake many things in order to prevent this course of events. Spontaneous rescripting is rule rather than exception during this module.

Protocol

"What we need to figure out is if there you fear a strong craving or relapse, and the possible consequences for the future. So let's see if you have a 'worst-case scenario' for the future, which makes you anxious to quit and which possibly increases your fears about the future. Do you have such an image in your mind about relapsing? What does this look like? For example, 'being addicted again', 'ending up in the gutter' and so forth. Do you have such a worst-case scenario? ... If so, what does this look like in your mind?"

Help the patient translate the answers to the above questions into one or more specific flashforwards.

flashforward: ________________________________________________________________

flashforward: ________________________________________________________________

Get the patient to form a still and detailed picture of the identified worst-case scenario and desensitise this as if it is a normal memory.
“What words about yourself or your life go best with negative future picture? .... for example, "Now I am back to square one" or "my life is a total failure".

Bring the image to mind and say to yourself ..... [negative statement, not the NC!], which emotion such as anxious, angry, sad do you feel right now?

On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does the image with the words .... [negative statement] feel now?

Where do you feel it (the disturbance) in your body?”

Sets of eye movements with associations until there is no further change, then 'back to target - procedure' until SUD = 0.

“Bring the negative future image back to mind, the way it is stored in your mind right now, and say to yourself "I can handle this image". Rated on a scale of 1 (completely false) up to 7 (completely true), how true does this statement feel to you now?”

Keep going until VoC = 7.

If necessary do a body-scan.

“This module is about relapse. Have your thoughts about this changed?”
Module 8: desensitising memories of relapse and losing control

**Estimated time required for this module:** variable, usually several sessions

**Time perspective:** past.

**Valency:** usually negative (SUD) and at times craving ('Level of Urge': LoU).

**Primary aim:** desensitising powerlessness memories about losing control which maintain feelings of powerlessness.

**Source:** First Method of the Two Method Approach (De Jongh, ten Broeke & Meijer, 2010; Beer, in press) and Hase (2010).

**Introduction and aim**

In this module the search is for memories about events which have lead to (increased) use, or which have lead to people starting to use again after a period of abstinence (relapse). Possibly the same traumatic or intruding experiences as in Module 3 (memories which have lead to intrusions and re-experiencing) and 4 (memories which have lead to negative emotions). The approach is slightly different though. It's not so much those experiences which have left emotional marks but are particularly meaningful as experiences in losing control.

For example, a patient has started to drink more once her children were taken into care (a humiliating experience). In Module 3 and 4 we argued that feelings of humiliation (mostly maintained by memories of humiliation) can lead to addiction behaviours, because the substance or the behaviour numbs the distressing feelings (self medication hypothesis). In the current module the whole point is that memories of losing control have a strong disabling effect and often increase cravings. An increase in use or a relapse implies: "there you go, I am powerless", "I am weak", "I am a loser" or "I can’t deal with setbacks", "loneliness", sadness", etc. One could call this 'self-efficacy undermining experiences', related to the addiction.

A memory of losing control often leads to two different targets: 1) the memory of the precipitating reason for relapse (e.g.: the picture of sitting at home all alone after the divorce) and 2) the image of the relapse or loss of control itself (the image of getting hold of the bottle). Both kinds of memory representations seem relevant. Because these often relate to experiences of failure which are associated with substance use, both 'distress' (SUD), shame, craving (LoU) as well as the effects of the substance (e.g. physiological sensations in the mouth, stomach or esophagus) can be brought on.

**Points of note**

- Asking for the relapses or escalations in substance use (e.g. using a time line) occasionally does not lead to any significant experiences: 'e.g. an increase in drinking after someone became a member of a Student Union.' Rarely relevant targets can be distilled from this. As a rule of thumb we only use targets which have a minimum of SUD (or LoU) ≥ 6.
• When strong craving or a relapse occurs following the last session: consider this as a recent target worth desensitising.

Procedure

Step 1. Many questions are possible to identify possible targets as outlined in this module:

"What are your first memories of relapse?"
"What's your worst memory of relapse?"
"What's your most recent memory of relapse?"
"Which other memories do you have whereby you clearly lost control over using/your behaviour?"
"Which experiences prove that you cannot deal with [the substance / behaviour]?"
"When did you start drinking?"
"When did it become a problem?"
"What situations have become a problem because of your substance use?"
"When did you stop and when did you have a set back?"
"Are there any other experiences which prove to you that you can't deal with alcohol?"
"Are there any other experiences which makes prove to you that you absolutely need alcohol?"

Not all questions will deliver appropriate targets. Those memories which can be processed with EMDR are those memories which not only have sufficient emotional charge (SUD and or LoU ≥ 6) but are also substantive easy to see. Sometimes the precipitating event (e.g. job loss) is the most relevant (high SUD and or LoU) and sometimes it is the relapse itself (e.g. first time using the substance after a period of abstinence).

Examples:

"Following the judge's ruling, that my child was placed under Supervision, I had an enormous relapse. What would be the point of it all now?"
"The first time I really lost control was when I failed my exams."
"The strongest piece of evidence for my addiction is when I got drunk at the wedding of my daughter. I still feel so ashamed. I was so determined not to drink. We never spoke of it since, and I feel so ashamed. I have never had the guts to say sorry."
"The first time I realised I was addicted to porn, was when I was at my computer and my friends asked me to come to the pub, but I made up an excuse so not to go and continued masturbating."

**Step 2 (optional).**
Write down all the relevant memories on a time-line. Describe how the addiction has developed over time. Of interest are also the escalations in using, but more often the addiction has increased gradually, or have increased because of a life change.

**Step 3.** The therapist decides together with the patient to choose the most important (powerless inducing) targets to desensitise. Hase (2010) starts with desensitising the most recent memories because these are more accessible. With your patient you can choose a different memory to start with, such as a memory which elicits the highest level of craving, or which seems most relevant because of a high SUD level.

Follow the full Standard Protocol for each of the chosen memories.

Determine both the SUD and the LoU:

"When you look at the picture in your mind and you say to yourself ....... (NC), on a scale of 0 (no craving up to 10 the most craving as possible), how high is your craving now?"

When you look at the picture in your mind on a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now?"

Note down: LoU ______________________ SUD ______________________

During the desensitisation phase ask for the SUD at Back to Target. Only when SUD = 0 also ask for the LoU. In our view this does not to go down to 0. The aim is whether the patient can handle the image. To experience a little craving is normal.

If the LoU>0 and does not decrease:

"When you look at this image, how much control do you experience at this moment over your use, ranging from 1, 'no control at all', up to 7 'complete control'? "

Often to their own amazement the feelings of control are quite high, even though there is still some craving left.

Installation phase: keep strengthening the experienced sense of control in relation to the image until VoC = 7.
Target area 4: Addiction focused EMDR - Reducing the attractiveness of alcohol

Points of note for modules 9-13

• In these modules many patients come up with memory representations with strong physiological aspects (e.g. in module 10: "I recall a warm summers-day in the parc when I was so thirsty, and the smell and taste of beer that slides sown your throat, fantastic." Zooming in on the physiology can increase the craving, so keep on questioning.

• Questioning the attractive aspects of alcohol the patient can respond with "there’s nothing attractive about beer" or "I only have negative memories" or something similar. This answer corresponds with the rationale, the ambivalence which needs to be strengthened, i.e. the conviction that using leads to no good, is bad ...and so forth. In these modules we want to desensitise the other (attractive, to be weakened) side. So keep on questioning, e.g. in module 10: " I understand you are fully aware that using the substance does not get you anywhere but at the same time you you find it difficult to give it up, so which attractive aspects of this memory makes it so hard? Search for other memories from this point onward.

• The memories of craving (module 9) are not for everyone the best way to induce craving in the session. Some people with an addiction hardly experience any craving when asked the questions in this module. However, once they imagine using the substance (module 12), their LoU increases. Therefore, there are more ways than one to induce actual craving (activate the addiction memory).

• Because of this, all modules (from 9 to 15) that induce craving (or positivity) may seem blurred, both for the therapist as for the patient. The modules may look similar and indeed are not mutually exclusive; each module unlocks a slightly different, additional part of the addiction memory. It shouldn't be hard to switch from one module the other, e.g. say: "I notice that memories of the past don't do a lot. Let's close this module and see what happens if I ask you questions about the future."

• All questions need to be aimed at increasing as much craving or positivity as possible in the therapy room. The NC for the negative memories is not used; the undesirability of this memory lies in the fact that craving (or attractiveness) is being induced which makes the person vulnerable. The question that increases the LoPA or the LoU is: "what words about yourself or the substance increases your craving or positive feelings even more?" Often these are the so-called ‘threshold reducing’ statements such as ‘It's my friend’, ‘I need this’, ‘I deserve it’, ‘I'll do it anyway’, ‘I want to feel like this forever’. These statements invite
actual use of the substance and increase craving. So, any statement which increases craving or and or positivity is useful.

- The PC will always be ‘I can deal with it [the image]’ and can be brought to identity level by formulating it into ‘I'm strong.’ The aim of this part is that the positive memory-representation loses its weakening and attractive effect. Once the craving and positivity have sufficiently reduced, the PC ‘I'm strong’ or ‘I can handle it’ can be installed.

- The LoU or LoPA does not need to go all the way down to 0, the main point is that the patient can fully handle the image (PC = ‘I can handle it’, VOC = 7). A little craving can still be experienced. This is normal, similar to trauma treatment when images can still be unpleasant, even though the distress has decreased and a maximum level of control has been achieved. Much to their own amazement the feelings of control are rather high, even though there is still craving. It is important to pay attention to this.

- Following the associations of positive or craving increasing target images we often see that after a few sets, of several Back to Targets, more negatively charged memories come up. Once the patient is less governed by the positive aspects of the memory, negative associations will come up. This is, of course, not wrong. The attractiveness of the behaviour or the substance will be diminished. Negative associations can also involve the consequences of the addiction: ‘It has cost me my marriage’ as well as the underlying problems ‘and all of this just to fit in!’.
Module 9 Memories of Craving

Estimated time required for this module: several sessions
Time perspective: past.
Valency: ‘positive’ (LoU) or negative (SUD).
Primary aim: desensitising memories (of feeling powerlessness) of craving.

Introduction and aims

In this module memories of craving and desire are identified and desensitised. This module is relevant when the experienced craving comes up in the functional analysis as an important maintaining factor. The rational for this module is that craving can be reduced by desensitising memory representations related to craving. The guiding principle is to choose for the first, strongest and most recent memory of craving.

The outcome measures are LoU (Level of Urge) and/or LoPA (Level of Positive Affect). The aim is to reach a maximum level of crave-reduction. Even following a successful treatment it is acceptable that some craving remains, this is inevitable. As long as the experienced sense of control is sufficient, this ought not to be a problem. The sense of control can be increased with a RDI (module 1).

Example: In a case example of GHB (Qurishi et al., 2016) this module was the starting point. The main aim was reducing craving. Three memories of 'intense desire' were identified and subsequently desensitised. In order to maximise LoU and LoPA, the therapist asked for a crave-inducing or a threshold-reducing statement such as ‘using GHB my life becomes so much more fun’. Retrieving these memories lead to a LoU starting point of 8-10 and very soon lead to reductions, which were being maintained during sessions.

A logical next step following desensitisation of the crave-inducing memories (this module) is to explore other crave-inducing memory representations, such as positive flashforwards (modules 12 and 13) and crave-inducing trigger situations from daily life (module 14 and 15).

Point of note

• Whenever an intense craving has remained following the last session: consider this as a recent target, and desensitise if there is sufficient time left over in the session.

Procedure

Step 1. Ask for the first, strongest and most recent memory of craving/desire/urge for carrying out the behaviour. Use if necessary instead of the word 'craving' words that fit better for your patient and their specific addiction.
"In your mind, when did you first experience this intense craving?"

"In your mind, when in your life did you experience the strongest cravings?"

"When did you experience your most recent craving?"

"Which memory brings up the strongest craving?"

"What do you need to remember so that you feel the craving most strongly?"

**Step 2.**
Start with the memory that induces the craving most strongly.

**Step 3.**
Apply the Standard Protocol for each memory. Instead of using the NC (which will always be about having a sense of control over the substance/behaviour, instead you ask for a crave-increasing or threshold decreasing statement:

"Which words go best with increasing your desire/urge to carry out the behaviour?"

"Which words express your craving for this substance/behaviour best?"

"What words do you say to yourself to, in a way, give yourself permission to use?"

Ask for the emotions, LoU and where in the body this craving is noted (EMDR standard protocol from phase 3). Determine both SUD as LoU:

"When you look at the image and you say to yourself … (threshold-reducing statement), how high is your craving right now on a scale of 0, no craving at all up to 10, as much craving as possible?

*Where in your body do you feel this most strongly?*

During the desensitisation phase (phase 4) when eliciting a Back to Target ask for the LoU instead of the SUD. If the LoU does not decrease:

"When you bring up the image, how much control about using do you experience right now on a scale of 0, no craving at all up to 10, as much craving as possible?"

Continue strengthening the experienced sense of control with the image in mind up to VoC = 7. Also see Hase (2010) for a description of this procedure without crave-inducing statements.
Module 10: Positive memories of the substance /behaviour

Estimated time required for this module: approximately 1-2 sessions.
Time perspective: past.
Valency: positive ('Level of Positive Affect': LoPA) and/or craving (LoU).
Primary aim: desensitising memories (of feeling powerlessness) of craving.
Source: This module has been inspired by Knipe's work (2009; 2010) in the field of dysfunctional positive affect and scientific research which shows that positive memory material becomes less positive when using eye movements.

Introduction and aims
The therapeutic goal of this component is to diffuse the crave-inducing positive memory representations by weakening the (stimulus-, response- and meaning aspects of the) memories. At the start-up the aim is to get the LoU or LoPA as high as possible.

There are vast individual differences. Some people have very clear positive autobiographical memories about the substance, e.g. the first time using heroin. For other, the positive memories came later, and even perhaps the first experiences were aversive (e.g. smoking). The positivity of the memory can pertain to: a) the substance or the behaviour itself (e.g. the idea of using heroin, eating, standing behind the slot machine), b) the desired outcome (e.g. winning a large sum of money) or c) the context of using (e.g. smoking a joint with your first true love).

Point of note
- Patients can come up with a positive image about the future ("I can feel the cool sensations of that first sip of beer down my throat tonight"), however that's not what's meant here and will be dealt within module 12: positive flashforwards of substance use /behaviour. "The cool sensation of beer down my throat" can be a way to get to relevant memories.

Protocol
Provide a rational for desensitising positive memories:

"Drinking alcohol can be rewarding in two separate ways. Firstly because it can be a pleasant experience in itself and secondly because it helps you avoid disturbing things. In this module we will focus on the pleasant sides of the addiction. The aim is to, as best we can, lose the appealing qualities of drinking. That's why I will ask you several questions about drinking alcohol as a pleasant experience."

Set the chairs up in the right position as ships passing and try out the correct speed of the eye movements, the faster the better.
"I am going to ask you some questions about your positive memories about drinking alcohol. At some point I will ask you to concentrate on certain aspects of a still picture in your mind. I will ask you in particular for the image that gives you the highest level of craving or a pleasant feeling when you look at it in your mind’s eye”.

If required give a more general EMDR instruction:

“I want to ask you to be a spectator who is observing the things that are happening to you from the moment you start following my hand. Those things can be thoughts, feelings, images, emotions, physical reactions or maybe other things. These can relate to the event itself, but also to other events, that seem to have no relationship to this particular event. Just notice what comes up, without trying to influence it, and without dwelling on the question whether it’s going well or not. It’s important that you don’t try to keep the image that we will start with, in mind all the time. The image is just the starting point of anything that can and may come up. Every once in a while we will go back to this image to check how disturbing it still is to look at. Keep in mind that is impossible to do anything wrong, as long as you just follow what’s there and what comes up.”

Continue with one or more of the questions below:

"What is the most pleasant memory you have about drinking?"

"Which positive memories give you the highest craving or positive feelings in your mind?"

"Which positive experiences with alcohol have increased your drinking?"

"Which image in your mind, however nice, needs to be wiped out to reduce your desire for alcohol?"

Global description:

[Working title]___________________________________________________________

[Working title]___________________________________________________________

Choose one of these memories (i.e. treat these memories separately and fully).
“Now tell me, without too many details, the memory of the event, from the moment where you feel it starts, until the moment that you feel it ends. Outline your memory in general. It’s about what you remember of it now and not what happened exactly.” …

"Is this the complete memory, or are there things that happened - on the same day- before or after the event, that according to you, also belong to the memory?" …

"You’ve just told me how you remember this event. Now I’m asking you, which part of this memory gives you the highest craving or positive feelings, right here right now? As if it is a movie of the memory, press the play button and then pause it, when you’re at the image which gives you the most craving or positive feelings. We are searching particularly for an image in which you can see yourself. It should not be the picture of what you gave you the most craving or positive feelings at that time, but what is now, the picture that gives you the most craving or positive feelings at this very moment”… “What does this image look like?”…

"Which words about yourself or the substance increases your craving of positive feelings even more? For example: ‘I need this’ … ‘I’ll end up doing it anyway’ … ‘what the point anyway?’” …

Write down the threshold-reducing statement: ________________________________________

“Bring up the image, and say to yourself [...] (craving-inducing statement), which emotion do you feel at this very moment?"

"Looking at the image in your mind how strong is the urge on a scale of 0, no urge at all, up to 10 as much urge as possible?"

Level of Urge (LoU): _________________

"Looking at the image in your mind, how attractive or how positive is the image on a scale of 0, not at all up to 10, as positive as possible?"

Level of Positive Affect (LoPa): _________________

NOTE: continue with LoU or with LoPA depending on what is being experiences most intensely.

"Where in your body do you feel the urge/positive feelings most strongly?"

Hold your hand in front of the patients eyes:

“Look at my fingers (or: dot on the screen). Keep the image in mind and say to yourself ............ [threshold reducing statement]"

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“Be aware of the urge or positive feelings in your .......[location of body sensation]”

Allow the patient time to concentrate....

“....and follow my fingers”

Desensitise as usual.

Back to target:

“Bring the image with which we started back to mind. How strong is the urge on a scale of 0, no urge at all, up to 10 as much urge as possible?”

(Don’t use the threshold reducing statement!) If LoU/LoPA > 0:

“Which aspect in this image gives you this urge/positive feeling?” or: " What aspect of the image is giving you this craving/positive feeling (You may state the number, e.g. ‘What precisely in the image is causing the 4?’). “What do you see?....... Concentrate on this aspect......Okay, got it?”

Continue until LoU/LoPA= 0, or has been reduced significantly.

LoU/LoPA does not need to be 0 in order to install the PC.

“Go back to the image we started with, [perhaps naming the working title] as it is stored in your mind now, and say to yourself ‘I can handle it’ or ‘I’m strong’, which of these do you prefer? On a scale from one (completely false) to seven (completely true), how true does this statement feel to you now?”

Instructions (even if VoC is 7 right away):

“Look at the image and say to yourself....[PC].........“Have you got this?”

Keep going until VoC = 7

If required do a body scan.
Module 11: Linking memories

Estimated time required for this module: approximately 1-2 sessions.
Time perspective: past.
Valency: positive (‘Level of Positive Affect’: LoPA) and/or craving (LoU).
Primary aim: reducing the attractiveness of the substance and uncovering the 'linking' psychological needs.

Introduction and aims

This module is extensively based upon the work of Miller (2010; 2012). An important principle of Miller is that people are not addicted to (unhealthy) behaviour or (unhealthy) substances, but more so to the positive feeling behind the addiction.

His approach emphasises the psychological aspects of the addiction, rather than the physical aspects. In our view his approach is of particular use for so-called behavioral addictions and impulse control problems, such as eating-, sexual-, shopping or gambling addictions.

In the protocol the most rewarding aspect of the behaviour is assessed, e.g. ‘just letting myself go for a change’. Subsequently these rewarding aspects are further questioned and e.g. it may emerge that the person has too many commitments. This can also be an entry point of the treatment, see modules 3, 4 and 5. However, in this module the emphasis is on 'unlinking or disconnecting' the addictive behaviour (e.g. several glasses of wine at the end of the day) from the psychological need (in our example: feeling freed from the burden of the commitments.) In the learning history these linking memories are assessed, the conditioning experiences in which a link is made between 'drinking' on the one hand and 'feeling freed from the burden of commitments'.

Both questions used in the First Method and the Second Method can assist in assessing these memories: "When in your life did you learn that alcohol can help you letting go of the burden your commitments?" "When did this start?" (First Method strategy) or " Which experience proves to you emotionally strongest that alcohol can help you feeling freed of the burden of your commitments?" (Second Method strategy).

These identified memories become EMDR targets.

These experiences are often stored as positive memories. Therefore it is not easy to elicit a NC. The dysfunctional aspect is often best expressed - in the above example an image in which someone sees themselves sitting in the pub with friends - with the words: ‘being freed from all the commitments’. This statement increases positivity and expresses the link most adequate.

Moreover, even though the positive association between the substance and the need is clear (‘By continuing smoking dope, I felt I belonged’), this does not mean this memory needs to be
processed with EMDR. The experience can be historically significant but may not be clinically relevant, if and when for example this memory is not distressing when evoked.

Example
The aforementioned patient describes how drinking makes him feel 'free' (step 1). He remembers a period feeling locked up in his marriage and often went out at night with friends (step 2), and having a great time! During the desensitisation phase (step 3) the memory of going out with friends rapidly lost its' positivity. He realised how little he was able to stand up for himself, how un-free he really was at that time. Drinking as a way to feel free became less attractive. The next phase was learning social skills in order to stand up for himself to get his need met (a stronger feeling of freedom).

Points of note
• Basically all behaviour can be associated with meeting particular needs. In the aforementioned example, alcohol did not only mean 'a feeling of freedom', but also included the importance of 'being included'. For each need a separate inventory can be made of relevant memories (Miller 2010).

• Memories can evoke -after the initial positive feelings- many negative associations and other negative memories. This is fine, the memory loses its' attractiveness, however, this module is not meant for reprocessing associated negative memories and emotions fully. The purpose is to get these disconnected. In this way the unfulfilled needs and desires become more apparent and will 'surface'. For patients it becomes tangible what drinking alcohol is about and the motivation to deal with the underlying problems increases. The treatment can of course be followed up focusing on these underlying problems, whether or not using EMDR (e.g. modules 3,4, and 5).

• In addition to a lack of social skills often self-esteem problems are be identified. Using the Second Method with EMDR, or a different intervention aimed at increasing self esteem is a logical next step.

Protocol

Step 1. Identifying the desire underneath the substance

"In this session we will be looking at the reasons for your alcohol addiction. We assume that it must bring you something positive, otherwise you wouldn't have gone through with it for so long. And you are really motivated to work in this, otherwise you wouldn't be here. We think that your drinking is not only about your desire for having alcohol, but also to feel differently, for example less lonely, or down."
These aspects will be the focus in this module. I will be asking you further questions about your drinking behaviour. Then we will be looking which unmet needs you are trying to meet with drinking. Lastly, we will find out when when this started in your life. From there on we will be using EMDR. Let's start talking about the drinking. At this moment, what is the nicest thing about drinking for you? Can you describe a typical situation from the start right up to the end.”

Helpful questions in identifying the rewarding aspects of the substance:

“Which feelings or thoughts or desires do you have just before carrying out this behaviour?”

“What do you feel you really need when you have this craving?”

“What does it get you, this [behaviour, addiction]? ...

“Why do you think you keep on having this behaviour despite all the negative consequences?”

“What's so good about ...?”

“What would happen if you wouldn't drink?”

“What do you actually need in this situation?”

Keep questioning until you have clarified the desire (not the substance use, but the underlying psychological need), such as: 'feeling free', 'feeling connected', 'belonging', 'being liked', feeling strong', 'feeling autonomous', 'feeling appreciated', and so forth.

Step 2. Identifying linking memories'

“So, drinking means for you: [name the identified need which is met by drinking]. When in your life did you first notice that drinking helped you with this? You weren't born using this substance, so it must have started somewhere. Can you remember the first time alcohol had this function? Are there any other memories which have strengthened the connection between alcohol and meeting this need?”

In this way you are trying to understand how the connection between alcohol and the psychological need has developed. You can choose to draw a so called time line, plotting the events (on the horizontal line) and the alcohol use (start and increases).

Other questions that can be helpful:
"When did you notice that alcohol fulfilled your need for [...]?"
"Which early memories feel like the strongest proof to you that alcohol can help you get your need for [...] met?"
"Which recent experience feels like proof to you that alcohol can help you get your need for [...] met?"

Note the relevant experiences:
1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________

**Step 3. Desensitising the memories**

Preferably start with the earliest memory, but if there isn't one, or has little to no current distress, start with another representative experience. Follow the Standard Protocol as much as possible. When selecting the still detailed picture, ask for the image which expresses the need for [...] most strongly.

Also in this module it is of little value to elicit the 'dysfunctional self statement' (NC). The dysfunctional aspect is best expressed in the statement which identifies the strongest connection: ‘Having a glass of wine gives me a break from all the obligations.’ ‘I deserve this bag of crisps’, ‘Having attended to other people’s needs all day, this is my moment all to myself’.

Instead of a 'functional self-statement in relation to the image (PC) the emphasis can be placed on the positive closure (Phase 7 closure). It’s about consolidating the achieved results on identity level, "What would you call someone who can feel free without having a glass of wine?", "What would you call someone who does not need a limousine to feel worthwhile?"

...and so forth.

"Which words about yourself describe best your need for [...] name the psychological need]?”

Note self statement _______________________________________________________________
"When you bring the image to mind and say to yourself ...(threshold-lowering statement), which emotion do you feel at this moment?"

"When you bring the image to mind, how strong does the connection feel to you between ...[name the need] and alcohol, on a scale of 0 'not at all' up to 10 'maximum connection'?"

Level of Urge (LoU): __________________

"When you bring the image to mind, how attractive, or how positive is this image to you on a scale of 0, 'not at all' up to 10, 'as positive as possible'?"

Level of Positive Affect (LoPA): __________________

NOTE: continue with LoU or with LoPA, depending on what is experienced most strongly.

"Where in your body do you feel this desire/positivity most strongly?"

Place your fingers in front of the eyes and say:

"Look at my fingers (or the dot on the screen). Keep the image in mind and say to yourself ........ [threshold reducing statement].

Be aware of the urge or positive feelings in your ........ [location of body sensation]"

Desensitise as normal.

Back to target

"Bring the image we started with back into your mind, exactly the way it is stored in your mind now. How strong is the urge or the positive affect, on a scale of 0 'not at all' up to 10 'maximum craving/positive feelings'?"

(Don’t use the threshold reducing statement here!)

If LoU/LoPA > 0:

"Which aspect in this image creates this craving/positive feeling?" or "What in this image creates this 4?". "What are you looking at? ... concentrate on this aspect... Yes, you’ve got it?"

Continue until LoU /LoPA = 0, or has reduced significantly. LoU /LoPA need to go down to 0 in order to install the PC.
"Bring the original image (if necessary name the working title) we started with back into your mind and say to yourself 'I can handle this' or 'I'm strong', which has your preference? ... On a scale of 1 (completely false) up to 7 (completely true), how true does this statement feel to you now?"

Continue until VoC = 7.

If required a body-scan.

Use brief association sequences. Continue the protocol for all the 'Linking Memories'.

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Module 12: Positive flashforwards of using / behaviour

**Estimated time required for this module:** approximately 30 minutes per target

**Time perspective:** future

**Valency:** positive (LoPA) and/or carving (LoU).

**Primary aim:** reducing the credibility of the overrated ideal.

**Source:** This component has been inspired by the work of Knipe (2010) regarding the dysfunctional positive affect as well as scientific research showing that positive memory material becomes less positive by eye movement.

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**Introduction and aims**

Module 12, 13 and 14 appear to be similar, but considering the behaviorist basis one can differentiate these well. In module 14 (desensitisation of trigger-situations) the focus is on those situations which induce a high level of craving, like parties, the supermarket around the corner, feelings of loneliness. Formulated in learning theoretical terms this is the conditioned stimulus-situation (CS). These situations have become associated with the rewarding aspects of using and therefore induce craving (conditioned responses, CR).

So what really does get triggered in so-called trigger-situations? These can be several aspects of the ‘addictions memory network’. On the one hand these can be the memories, e.g. increased powerlessness, crave inducing and positive memories (respectively from modules 8, 9 and 10). On the other hand, patients often report that triggers elicit images of the addictive behaviour (“whenever I see a thin person, I want to lose even more weight”). So possibly the positive flashforwards, representations of anticipated positive aspects of the behaviour or the substance are being elicited.

Two types of positive flashforwards can be distinguished: 1) representations related to the attractive behaviour or the substance itself (module 12, this module) and 2) representations related to the positively anticipated consequences of the behaviour or the substance (module 13). In the second type the behaviours itself need not be positive: the behaviour is functional and is being carried out with a particular positive aim. Examples are: ‘Tonight I’m going to win the Lottery’ (the gambler), ‘One day he will hold me in his arms’ (the stalker), ‘I hate shopping, but I want to show off with a new dress’ (Shopaholic).

In this module the behaviour is rewarding in itself. Examples are: ‘Once I get home I can totally relax with a beer’ (‘the drinker’), ‘I have this lovely tub of ice cream in the freezer and I really deserve this.. I can just image myself in front of the TV’, (‘the binge eater’).

Clearly it is only useful to desensitise flashforwards if these have sufficient levels of distress (general rule of thumb: LoPA and/or LoU ≥ 6) and contribute significantly to maintaining the
undesired behaviour. Positive flashforwards did not 'accidentally' end up in the patients' head: there has been a learning history. However, this will be disregarded in this module.

It is likely that desensitising a positive flashforward is especially effective when a) the intuitively estimated chance is not realistic (overestimated) and/or b) when the estimated effects are considered too good to be true. It is expected that by using EMDR the patient will be able to create a more realistic view of the effects of the substance or the behaviour (positive and negative).

Positive flashforwards like 'smoking a cigarette', 'just one more season', 'having a glass of wine on the sofa' are possibly realistic behaviours, but it is known that the expected effects are seen as too rosy and actually lasting much shorter than imagined. The person with the addiction has created a kind of ideal of the substance or the behaviour in his or her head, and this is precisely the point of this module, i.e. making this ideal 'harmless'.

**Points of note**

- Patients often report that they are unaware of positive images, but when thoroughly questioned, often a very rosy view of the behaviour is present. This insight in itself can be healing.

- Similar to the anticipatory anxiety in which there is a disaster underneath the disaster (negative flashforward), in cravings the anticipated ultimate pleasure is assessed. When the arousal increases and for example 'the eyes start to shine', you are spot on.

- In this module the ultimate pleasure can also be in the physiological details, e.g. ‘seeing yourself having a drink and feeling the specific feelings in your throat.’

**Protocol**

"What we will need to find out is whether you have a specific positive or rosy view in mind as to what alcohol offers you. We are looking for a specific image you have which gets you to go for this substance, despite all the disadvantages. What image do you need to keep in mind to really feel like having alcohol? In other words, which image should you get rid of so you don't feel like having alcohol? We are looking for an image in which you can picture yourself. It can include a strong physical sensation, a particular feeling in your body when you are having alcohol."...

Help the patient to translate the answers to the above questions to one or more specific flashforwards.

Positive flashforward:
Positive flashforward: ____________________________________________________________________________

Start with the first image.

... "What does this image look like?" ... "What words about yourself or the substance increases your desire or the positive feelings even more?" e.g. ‘I really need this’, ‘Beer is my best friend’, ‘Letting go completely for a change’, ‘Just doing whatever I feel like’.

Write down the threshold reducing statement for the first flashforward:

________________________________________________________________________________________

"Bring the image back to mind and say to yourself ...( threshold-reducing statement), what emotion comes up at this moment?"

"When looking at this image, how strong is the craving you experience right now, on a scale from 0 'not at all' up to 10, maximum craving?"

Level of Urge (LoU): ____________

"When you bring the image in your mind, how attractive or positive is this image to you now, on a scale of 0 - 'not at all' up to 10, 'as positive as it can be' ?"

Level of Positive Affect (LoPA): ________________

PLEASE NOTE: continue with LoU or LoPA, depending on what is being experienced most strongly.

"Where in your body do you feel this craving / positivity most strongly?"

Keep your fingers in front of the eyes of the patient and say:
"Look at my fingertips (or the dot on the screen). Look at the image in your mind, say to yourself: .......................(threshold-reducing statement). Be aware of this desire (craving) or positive feelings in your ......[state body location]."

Desensitise as usual.
Back to target

"Bring the image we started with back to mind. How strong is your craving or the positive feeling now, on a scale of 0 - 'not at all' up to 10, 'maximum craving/as positive as it can be'?

(Don’t use the threshold reducing statement!)

Level of Positive Affect (LoPA): __________________

LoU/LoPA > 0:

"Which aspect if this image creates this carving/positive feeling." Or: "What in this image makes this a 4?" ... Concentrate on this aspect .... yes, have you got this?"

>>> set EM <<<.

Continue until LoU/LoPa = 0, or has reduced significantly. LoU/LoPa need not to go down to 0 in order to install the PC.

"Bring the image we started with back to mind, the way it is stored in your mind right now, and say to yourself "I can handle it or I am strong, which of the two do you prefer? ... On a scale of 1 (completely false) up to 7 (completely true), how true does this statement feel to you now?"

Continue until VoC = 7.

Body-scan if necessary.
Module 13: Positive flashforwards related to the outcome of using or the behaviour.

<table>
<thead>
<tr>
<th>Estimated time required for this module:</th>
<th>approximately 30 minutes per target</th>
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<tr>
<td>Time perspective:</td>
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<td>Valency:</td>
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<td>reducing the credibility of the overrated ideal.</td>
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<tr>
<td>Source:</td>
<td>This component has been inspired by the work of Knipe (2009; 2010) regarding the dysfunctional positive affect as well as scientific research showing that positive memory material becomes less positive by eye movements.</td>
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Introduction and aims

In this module the focus is on the representations that refer to the positively anticipated consequences of the behaviour or the substance. The behaviour itself need not be pleasant (e.g. 'stalking' 'stealing' 'harming yourself') but the behaviour is carried our with a positive aim in mind ('getting drunk', having loads of money', peace in mind'). In this module, this positive outcome is magnified in a highly attractive image, clearly with the intention to reduce the attractiveness with EMDR. Clearly the module is only useful if the concerning flashforward generates enough emotional charge (general rule of thumb: LoPA and/or LoU ≥ 6) and (based on the functional analyses) contributes significantly to maintaining the undesired behaviour. Next to the substance addictions and behavioural addictions also e.g. self-harm and suicidality could be worthwhile investigating to see whether these specific positive flashforwards have a chance of succesful desensitisation.

Just like in the last module, it is plausible that desensitising a positive flashforward is particularly effective when it is clearly unrealistic because: a) the intuitively estimated chance is not realistic or b) because the outcome is looked upon as far too positive.

Being overoptimistic often implies that the negative aspects are not being experienced. The person with the addiction is, in a way, emotionally flooded /blinded by the positive view in a similar way as a trauma patient is flooded by memories and therefore doesn't realise that the traumatic event has actually passed. The exhibitionist, described by Ten Hoor (2014) has indeed a very pleasant view of frightening women by flashing his genitals, but during the EMDR all kinds of associations come up which rapidly decreases the attraction of this image.

Negative associations are often related to the harmful nature of the behaviour, the negative consequences and at times also the underlying needs ‘Now that wine has lost its' attraction somewhat, I can now feel the sadness and loneliness’. In relation to this, compare with module 11 (linking memories).

In EMDR the aim is that the patient has a more realistic viewpoint of what he or she wants to achieve with this behaviour. A patient who stalked her ex boyfriend in an obsessive way held a
far too optimistic viewpoint of a possible reunion. During EMDR this positivity disappeared and she realised that the chance of a reunion was non-existent (Tjon Pian Gi & Hornsveld, 2014). The same focus applied for a person with a gambling addiction so he could realise that he will not be able to win back all the money he has lost. Just like in the previous modules, certain flashforwards are not unrealistic in itself, like ‘the high following a heroin shot’, 'the nose job' or 'a new kitchen', but the to be expected effects are often overestimated in both the idealistic viewpoint or lasting effects. The person with the addiction has a kind of prototypical idealised image of the substance, and it is precisely the aim of this module to 'dis-harm' this ideal.

Points of note
• Thorough questioning. Patients often say they are not so aware of any positive images, but with further questioning, they expect far too optimistic outcomes. This insight itself can be healing.

• A positive flashforward can be the appetiser (requiring something positive, like the picture of winning the Lottery, or walking around in the new kitchen) as well as removing something negative (gaming, getting away from it all). Usually it's a combination of both aspects. From the literature on addictions, it is known that substance abuse usually is being maintained at the start by positive reinforcement (+S+) but over time is influenced by negative reinforcement (-S-).

• Just like with the negative flashforward where the disaster behind (anticipatory) anxiety is assessed, in the positive flashforward the anticipated ultimate pleasure is assessed. The 'train on the positive mountain: when the eyes start to shine and the arousal increases, you are spot on).

• Cognitive interweaves can be aimed at reducing the intuitive overestimated probability.

"What we will need to find out is whether you have a specific positive or rosy view in mind as to what alcohol can offer you. We are looking for a specific image in your mind which every time, gets you to go for this substance, despite all the disadvantages. What image do you need to keep in mind to really feel like having alcohol? In other words, which image should you get rid of so you don't feel like having alcohol? We are looking for an image in which you can picture yourself. It can include a strong physical sensation, a particular feeling in your body when you are having alcohol."...

Help the patient to translate the answers to the above questions to one or more specific flashforwards.

Positive flashforward:

Positive flashforward:
Start with the first image.

... "What does this image look like?" ... "What words about yourself or the substance increases your desire or the positive feelings even more?" e.g. 'I really need this', 'beer is my best friend', 'letting go completely for a change', 'just doing what I feel like'.

Write down the threshold reducing statement for the first flashforward:

___________________________________________________________________

"Bring the image back to mind and say to yourself ...(threshold-reducing statement), what emotion comes up at this moment?"
"When looking at this image, how strong is the craving you experience right now, on a scale from 0 'none' up to 10, maximum craving?"

Level of Urge (LoU): ______________

"When you bring the image in your mind, how attractive or positive is this image to you now, on a scale of 0 'not at all' up to 50, 'as positive as it can be'?"

Level of Positive Affect (LoPA): ______________

PLEASE NOTE: continue with LoU or LoPA, depending on what is being experienced most strongly.

"Where in your body do you feel this craving / positivity most strongly?"

Keep your fingers in front of the eyes of the patient and say:
"Look at my fingertips (or the dot on the screen). Look at the image in your mind, say to yourself: ..................(threshold-reducing statement). Be aware of this desire (craving) or positive feelings in your ......[state body location]."

Desensitise as usual.

Back to target

"Bring the image we started with back to mind, exactly the way it is stored in your mind right now. How strong is your craving or the positive feeling now, on a scale of 0 - 'not at all' up to 10, 'maximum craving/as positive as it can be'?"

(Don't use the threshold-reducing statement!)
Level of Positive Affect (LoPA): __________________

LoU/LoPA > 0:

"Which aspect if this image creates this craving / positive feeling." Or: "What in this image makes it a 4?" "What do see?" ... "Concentrate on this aspect" .... "yes, have you got this?"

>>>EM<<<

Continue until LoU/LoPa = 0, or has reduced significantly. LoU/LoPa need not to go down to 0 in order to install the PC.

"Bring the image we started with back to mind, the way it is stored in your mind right now, and say to yourself ‘I can handle it or I am strong, which of the two do you prefer? ... On a scale of 1 (completely false) up to 7 (completely true), how true does this statement feel to you now?’

Continue until VoC = 7.

Bodyscan if necessary.
5. **Target area 5: Addiction focused EMDR: reducing relapse.**

**General points of note with modules 14 + 15**

- Nowadays in anxiety disorders, instead of using future templates a mental video check is used for the desired behaviour. (see the Dutch version of the First Method, De Jongh et al., 2018). This applies for these modules as well.

- The future template and mental video check are standard being carried out without opening up any channels by allowing associations to occur. The argument for this is that it works well without and is often not necessary. In addictions we wonder whether this is wise. Often triggers hold so much emotional charge (probably because of the repetitive behaviour the triggers have become predictors of the behaviour.) Experience teaches that allowing room for associations leads to spontaneous positive rescripting of the situation and or the own possibilities to deal better with the situation. The guiding principle is 3 to 4 sets and then back to target.
Module 14: Desensitising (problematic) ‘trigger-situations’

**Estimated time required for this module:** approximately 1 session
**Time perspective:** present, current problematic situations
**Valency:** negative (SUD), positive (LoPA) and/or craving (LoU).
**Primary aim:** increasing the sense of control in frequent trigger situations.
**Source:** This component appears in the protocols of Popky (2010) and Hase (2010).

**Introduction and aims**
This part of the protocol is not about specific events from episodic memory, but includes more general images or memory representations which induce cravings and/or substance use in daily life. This procedure is comparable to the Future Template from the Standard Protocol, as well as selected situations for CS-exposure (behavioural experiments) in cognitive behavioural therapy. Desensitising trigger-situations we aim for the extent to which these elicit craving or a positive feeling. Images of trigger-situations can be positive (e.g. 'meeting friends in the pub') but can also be negative (e.g. 'feeling lonely'). In the former it involves a positive promise and the person will experience positivity or desire ('reward craving'). In the latter the reward consists of the elimination of something negative. Next to positivity or desire ('relief craving') distress (SUD) will be especially reported. Clinical practice has shown it is more often than not about craving (LoU).

**Points of note**
- In this module situations are assessed which currently often elicit cravings in daily life, or which are for some reason more difficult to resist alcohol. When your patient denies this tendency, question further: "I know that rationally you’d rather not think about those situations which make you crave because you are motivated to work on your addiction. However, it is important that difficult situations become less difficult. Are there any difficult situations that you'd rather avoid, in real life or in your mind?"

- Attractive images in which the substance is taken or the behaviour is carried out are treated in module 10 (memories) or 12 (flashforwards).

- The 'film' is freeze framed on the image which elicits the highest level of craving (not the behaviour itself). Usually more than one target image can be identified, e.g. : 1) the image of 'seeing themselves at home all alone on the sofa feeling lonely', 2) 'seeing someone having a beer on the telly', 3) 'going to the fridge and seeing a beer on the shelf' and so forth. Once again, the image in which someone falters and in a way already senses those very first gulps, is a target as meant in module 12.

- Don't start a dialogue during the desensitisation. Feelings of well-being, happiness, mild drowsiness etc. can be the consequence of the reprocessing of the effects of using and do not indicate the end of a channel.
Experience teaches that these targets can be desensitised rapidly, at times within several minutes; so you can treat more than one trigger situation. Restrict yourself to the most important situations, preferable both positive and negatively charged trigger situations.

Protocol

“We will now be discussing problematic situations. In which situations or moods is it hardest to resist using alcohol? So what are typical trigger situations for you, describe these separately.”

Only if the patient has trouble identifying these help them by saying:

“I will give some examples, just let me know if recognise any of these....”:

“If you feel depressed, anxious, lonely, bored, sad, wound up, angry, ill, fed up or when you’ve had an argument?"

“When you feel relaxed, happy or in top shape, physically fit?”

“When someone offers you alcohol, when you are together with other users, seeing someone else use, or when you are together with other non-using friends?”

“When you are on your own?”

“When you are in an environment in which you used to use a lot, you have alcohol at your disposal or if you’ve had some alcohol?”

The most difficult situations are:

Working title trigger-situation 1: ____________________________________________

Working title trigger-situation 2: ____________________________________________

Working title trigger-situation 3: ____________________________________________

Working title trigger-situation 4: ____________________________________________

Working title trigger-situation 5: ____________________________________________
Carry out the protocol as described below for each of the trigger situations.

“I will be asking you some questions about the situations which we have just selected. I will be asking you for the image in your mind which gives you the most craving when you look at it in your mind’s eye. The procedure is the same as before. Just observe your own images, once in a while I will be asking you what comes up and then we will continue. Anything that comes up is fine. Just let it happen. Once in a while I will take you back to the original image and I will ask you how much craving or distress/tension this picture still gives you. Then we will continue. You cannot get it wrong, everything is fine."

"So now tell me in general terms in what way does this situation usually happen, from the moment from which it starts to the moment where you feel it really ends. Just outline the whole situation broadly."

"What is, at this very moment, when you look at it here and now, the picture which gives you the strongest craving? Imagine it as a movie and freeze-frame this so it becomes a still picture."

"What words or excuse makes you crave even more? e.g. ‘I’ve deserved it’, ‘Just the one’, ‘It feels so good’, ‘sooner or later I’ll have one anyway’, ‘others can have one so why not me’, and so forth?"

Threshold reducing / craving increasing statement: ____________________________

Don’t ask for the PC; this is standard: ‘I can handle it’ or ‘I’m strong’ during the installation phase.

"When you bring the picture back into your mind, and say to yourself: …… [threshold reducing / craving increasing statement] which emotion do you feel right now?"

"When you bring the picture back into your mind, and say to yourself: …… [threshold reducing / craving increasing statement], how much craving do you experience right now, on a scale of 0 'none at all' up to 10, 'maximum craving'?"

LoU: __________________

"When you bring the picture back into your mind, and say to yourself: …… [threshold reducing / craving increasing statement], what’s your level of distress (tension) right now on a scale of 0 'none at all' up to 10 'maximum distress (tension)'?

SUD: __________________

"Where in your body do you feel this craving and/or distress the most?"
Keep your fingers ready in position in front of the eyes and say:

"Look at (the top of) my fingers (or the dot on the screen). Bring the image to mind and say to yourself .... [threshold reducing / crave increasing statement]. Be aware of the craving and/or the tension in your .... [body location]."

<SET>

"What comes up?" / What do you experience?" / "what do you notice?" and so forth.

Back to target

"Bring the picture we started with back to mind the way it is stored right now. How much craving or distress (tension) does this picture give you right now, on a scale of 0 'none at all' up to 10, 'maximum craving/distress'?".

(Don’t use the threshold reducing / crave increasing statement!)

If SUD / LoU > 0:

"Which aspect of this picture gives you this craving/distress (/tension)? Or: "What in this picture gives you this 4?" ... "What are you looking at?" ... "Concentrate on this aspect... Yes, you got it?"

Repeat the Back to Target procedure until the craving does not decrease any further. Just like with the future template some craving or tension is allowed, as long as it has decreased to the extent whereby the VoC can maximise for the PC ‘I can deal with it’.

Installation of the PC:

"Bring the original image back into your mind's eye, the way it is stored in your mind right now, and say to yourself 'I can deal with it'. On a scale from 1 (completely false) up to 7 (completely true), how likely is it that you can really deal with this and do it in this way?"

Even when VoC is at a 7 say:

"Look at the image and say to yourself 'I can deal with this'. Have you got this?"

New set of EM.

Don't ask for associations! Keep going until VoC is 7.

Body-scan.
Module 15: Installing future templates and mental videos checks.

| Estimated time required for this module: approximately 1 session |
| Time perspective: future |
| Valency: negative (SUD) and/or craving (LoU). |
| Primary aim: increasing the sense of control in frequent trigger situations. |
| Source: This component is a logical continuation of desensitising trigger situations. |

**Introduction and aims**

In situation specific complaints, such as fears and addictions, the Future Template can often be (better) replaced by a mental video check. Future templates and mental video checks are central in this module. It makes sense in preparation of 'in vivo' exposure exercises to carryout a 'in vitro' mental video checks. The aim is to assess and desensitize crave-inducing or fear eliciting elements ('cues') which can obstruct the patient to seek out these situations and therefore require specific desensitisation.

In such a video check the patient is asked to imagine, with the eyes closed to go through a typically difficult situation from start to finish. The patient describes what he or she experiences and difficult parts are desensitized.

**Protocol**

By asking the patient to open their eyes at the very moment craving or emotional tension is being experienced, the therapist also knows that a particular aspect of the situation is still considered to be difficult. At this point the therapist asks the patient to concentrate on this followed by one single set of eye movements by the therapist. After this set, the therapist asks the patient to continue with the mental video check and whenever craving or tension is once again being experienced to open their eyes and concentrate on the anxiety provoking cue followed by another set of EM.

Once the several cues have been successfully desensitised the mental video check is repeated until the situation is imagined without any tension or craving.

“I’d like to ask you to close your eyes and bring to mind a typical situation which up to now you have found difficult or anxious. Start from the beginning and play this future -and therefore imaginative – situation in your mind’s eye as if it were a kind of movie. Check whether you feel at any point tension or craving whilst viewing this movie. I’d like to ask you that whenever you do feel this to open your eyes so I also know that this is a difficult or anxious moment. Precisely at that moment I will ask you to focus on the most anxious aspect of this situation. Are you okay with this?”
“So now close your eyes and tell me what you are experiencing. Whenever you feel tension open your eyes, concentrate on whatever makes the movie difficult to look at, and I will do a set...”

“Go on with the movie and whenever you feel tension or craving open your eyes, concentrate on whatever makes you anxious or tensed ...”

At the end of the mental video the check is repeated as frequent as need be until the patient can imagine the situation without any tension or craving.

**Homework**

If necessary: together with the patient, think of a behavioural experiment and have this carried out (in the coming week).
Literature


Casusconceptualisatie en specifieke patiënten groepen (pp. 437–491). Amsterdam: Pearson.


