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Modified Eye Movement Desensitization Therapy Protocol Treating Substance Abuse Disorders

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MA, California State University, Sacramento, 2012

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Quality substance abuse treatment is needed to help fight the battle against drug addiction. This qualitative study was designed to explore some of the approaches to eye movement desensitization (EMDR) therapy that therapists trained in Parnell's adapted EMDR model use in conjunction with treatment for addictions. The purpose of this narrative inquiry was to investigate the experience of therapists who incorporate substance abuse treatment with Parnell's adapted EMDR model when treating trauma and substance use disorders. The population studied comprised licensed mental health therapists who had completed Parnell's EMDR training and implemented Parnell's modified EMDR protocol in their professional practice. The data from 9 participant interviews were coded and NVIVO data analysis software was used to identify key concepts and themes including deviations from Parnell's modified protocol, incorporating addiction treatment within the modified protocol, and the importance of the resourcing phase in the modified protocol. The study findings provided a deeper understanding of the types of addiction therapies that therapists are using in conjunction with Parnell's EMDR model. The results also showed that that participants perceived Parnell's EMDR model, combined with addiction therapeutic techniques and approaches, as beneficial in treating those with trauma and substance use disorders. By integrating addiction therapies with Parnell's EMDR protocol, EMDR certified trainers may better educate EMDR trainees about useful strategies for treating dual diagnosed clients. The strategies may shorten the client's time in treatment and provide a strong foundation for therapists as they conduct therapy for dual diagnosed people.

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Chapter 1: Introduction to the Study

Eye movement desensitization reprocessing (EMDR) therapy is an extensively researched therapy approach used to treat trauma. However, few researchers have explored the substance abuse therapeutic approaches EMDR therapists use who have been trained in Parnell's (2007) adapted EMDR model (Parnell, 2007) when treating a trauma-related disorder in conjunction with a substance abuse disorder. The adapted EMDR model is tailored to the client's age, culture, education, type of trauma, and intellectual abilities (Parnell, 2007). In Parnell's modified protocol, the first stage is to create safety, the second stage is to stimulate the client's memory network, the third is to proceed to add bi-lateral stimulation, and the fourth reinforces a sense of safety. This protocol simplifies the procedure and skips steps of the original protocol that are not useful for the client. In this study, I aimed to explore the substance abuse therapies therapists use to treat co-occurring trauma-related disorders and substance use disorders when utilizing Parnell's adapted EMDR protocol model. I conducted this study because substance abuse is a significant health problem in the United States. Quality substance abuse treatment is needed to help fight the battle against drug addiction. EMDR may aid in the recovery of those who struggle with addiction (EMDR Institute, 2016). By interviewing therapists who treat trauma and addiction with a combination of Parnell's EMDR model and an addiction therapy, I worked to fill a gap in the literature regarding the addiction treatment therapies EMDR therapists are using. I also examined the therapists' perspectives regarding the effectiveness of the addiction treatment. Recomendations for treatment guidelines and protocols emerged from this study, which

can be used as an aid to better serve clients who are diagnosed with a trauma-related and substance use disorder and improve treatment outcomes for them.

EMDR therapy is an evidenced based form of therapy for treating a variety of disorders that Shapiro (2001) developed. EMDR has a standard protocol that incorporates many different theories such as psychodynamic theory, cognitive behavior theory, and addiction theories. EMDR treatment is primarily used to treat post-traumatic stress disorder (PTSD) by targeting the individual's past traumatic experiences, and by addressing triggers that cause anxiety and stress. It is used to alleviate charged feelings associated with memory by using bi-lateral stimulation (EMDR International Association, 2016). Bi-lateral stimulation may include alternate tapping on the client's legs or hands, shoulders, backs, or knees. Therapists may also use alternating tones via headphones or a tool that produces bi-lateral vibrations in a client's hands. A client may also tap their feet back and forth. The client processes the disturbing information while using their chosen method of bi-lateral stimulation (Parnell, 2007).

In this study, I explored the modified EMDR protocol developed by Parnell (2007) , which I refer to as the Parnell EMDR model throughout this document.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) reported that 17.3 million people had an alcohol addiction and 6.9 million were dependent on illicit drugs in the survey year of 2013. These reports were based on individuals aged 12 or older. In the United States, only 6.3% of individuals with substance dependence received treatment for their addiction, and 9 out of 10 individuals did not think they had an addiction problem (SAMHSA, 2014). SAMHSA also reported

20.7 million adults in the United States were diagnosed with a co-occurring mental health and substance use disorder in 2012. This report is similar to the one SAMHSA issued in 2009—an indication that co-occurring mental health and substance use disorders is a long-standing problem.

In Chapter 1, I discuss the background of this study, offer the problem statement, and outline the purpose of this study and central research questions I explored. Further, I discuss the conceptual framework and the nature of the study. Definitions of concepts, assumptions, scope of the study, delimitations, limitations, and significance will also be addressed.

Background

Previous researchers have examined how EMDR can be useful for those who struggle with addiction and how EMDR is effective in reducing symptoms of PTSD and addiction (Justus, 2004; Perez-Dandieu & Tapia, 2014). Other research has indicated that EMDR is effective in treating core issues that underlie triggers to use drugs (Marich, 2010). Addiction protocols combined with elements of Shapiro's original EMDR model have been shown useful or have been examined in the past (DiGiorgio, Arnkoff, Glass, Lyhus, & Walter, 2004; O'Brian & Abel, 2015). Hase, Schallmayer, and Sack (2008) suggested that EMDR enhances other treatment modalities such as motivational interviewing and relaxation techniques.

There is a gap in scholarly knowledge regarding the substance abuse therapies that trained EMDR therapists are using in combination with EMDR, especially those therapists who follow Parnell's (2007) adapted EMDR protocol model. In an

examination of existing literature, I found research regarding EMDR and substance abuse treatment theories based on Shapiro's original model, but none on Parnell's adapted protocol.

This was a narrative inquiry in which I interviewed EMDR therapists about their experiences integrating addiction theories when incorporating substance abuse treatment with Parnell's adapted EMDR model when treating substance use disorders. By incorporating addiction therapies with Parnell's EMDR protocol, EMDR certified trainers may better educate EMDR trainees about useful strategies for treating dual diagnosed clients. Examining the feedback and strategies mentioned by EMDR therapists may aid in the development of future research that examines the treatment for those who suffer from a dual diagnosis or from a substance use related disorder only.

Problem Statement

Quality substance abuse treatment is needed to help fight the battle against drug addiction. In this qualitative study, I aimed to explore some of the approaches to EMDR therapy that therapists use in conjunction with treatment for addictions because there has been little research on the substance abuse approaches to therapy used by EMDR therapists trained in Parnell's adapted EMDR model (Parnell, 2007). Existing studies have established that EMDR is helpful in therapy; however, those studies have not identified which addiction treatment approaches were used with the EMDR (Marich, 2010). O'Brian and Abel (2010) suggested a need for further research to help clarify ways in which EMDR can be used in combination with other substance abuse treatment models. Hase et al. (2008) reported that more research is needed to help

identify ways in which EMDR can be used as a primary treatment or as an adjunctive treatment for clients who suffer from trauma and addiction. A review of the existing research showed a gap in knowledge regarding which substance abuse therapies trained EMDR therapists are using in combination with EMDR, especially those therapists who follow Parnell's adapted EMDR protocol model.

Purpose

The purpose of this narrative inquiry was to investigate the experiences of therapists who incorporate substance abuse treatment with Parnell's adapted EMDR model when treating substance abuse. Interviewing therapists who treat trauma and addiction with a combination of Parnell's EMDR model and an addiction therapy helped me fill the gap in the literature on which addiction treatment therapies are being used by EMDR therapists. The findings in this study may serve as an aid in the development of treatment guidelines and protocols to better serve dual-diagnosed clients.

Research Questions

RQ1: What is the therapists' experience when incorporating substance abuse treatment with Parnell's adapted EMDR model when treating substance use disorders?

RQ2: What is the therapists' experience in using addiction theories?

RQ3: What do the therapists' report as helpful in the process of integrating substance use treatments and Parnell's modified EMDR model?

Theoretical Framework

The theoretical framework of EMDR therapy is the information processing theory developed by Shapiro (EMDR Insititute, 2011). This theory posits that humans have a

physiologically based information processing system. The information processing system processes and different segments of human experiences and then stores memories of those experiences so they can be accessed or used in the future. This is done through a memory network. In the memory network, images, emotions, sensations, and thoughts are linked together, and learning occurs when new experiences are built or added to the old memories. When a traumatic event happens, the memory network can be disrupted or may be incomplete and dissociation or negative feelings can interfere with the processing of the traumatic memories. Shapiro held that EMDR can assist in processing these memories and linking them to more adaptive information, aiding the person in storing appropriate emotions with the memory. An example of this is when a rape survivor believes it is her fault he or she is raped. The EMDR therapist would aid in accessing the negative emotions of the rape and then help the rape survivor resolve the feelings of guilt or maladaptive thoughts that it was his or her fault (EMDR Institute, 2017).

By interviewing Parnell trained EMDR therapists about their experiences treating substance use disorders, I came to better understand the addiction therapies that Parnell-oriented therapists incorporate into therapy when treating a trauma-related disorder in conjunction with a substance use disorder. O'Brian and Abel (2010) suggested that there needs to be more research to help clarify ways in which EMDR can be used in combination with other substance abuse treatment models. Hase et al. (2008) reported that more research is needed to help identify ways by which EMDR can be used as a primary treatment or as an adjunctive treatment for clients who suffer from trauma and addiction.

Parnell's EMDR therapy model is an adaptation from the original EMDR model that was developed to aid in the processing of the stored memories as described by the information processing theory. In this study, I investigated Parnell's modified model by interviewing practitioners about their experience using it. By interviewing therapists, I learned more about their experiences using substance abuse treatments with Parnell's adapted EMDR model and what they understood to be helpful when using the addiction theories. I interviewed these therapists and analyzed their responses using Cresswell's (2013) the six-step approach to analyze the data. This is a hierarchical approach that includes transcribing raw data, preparing the data for data analysis, repeatedly reading through the data, hand coding the data, identifying themes, and then describing and interpreting the data. I also used Tesch's (1990) eight-step coding process to come up with codes and common phrases that aided in the development of themes. NVIVO data analysis software was used to identify quotes that contained the codes and common phrases in the raw data.

Nature of the Study

Quality substance abuse treatment is needed to help fight the battle against drug addiction. The scholarly literature is missing information regarding the addiction therapies EMDR therapists who use Parnell's adapted model are using when treating addiction. In this study narrative inquiry study, I explored the therapists' reported experience of using substance abuse treatments with Parnell's adapted EMDR model and what they reported to be helpful in using the addiction theories.

This study was needed to explain what is working for therapists using Parnell's modified EMDR model to treat trauma and substance use disorders. My primary focus was on substance abuse treatment; however, often times substance use disorders may be a result of a person coping with a traumatic event. For this reason, I did not exclude the possibility of therapists reporting on their experience of treating clients with co-occuring disorder using the adapted EMDR model. In this study, I interviewed nine EMDR trained therapists. The data from these interviews were audio recorded and coded. I used NVIVO data analysis software as an aid to identify key concepts or themes described by the therapists.

Definition of Terms

Bi-lateral stimulation: This technique was developed by Francine Shapiro in the 1980's. Bi-lateral stimuli is a visual, auditory, or tactile stimuli used in EMDR therapy. The stimuli include rhythmic tones, vibrations, or patterns that alternate from left to right repeatedly. Auditory stimulation may be done by listening to music or simple tones from left to right ear repeatedly. Visual stimulation is done by visually following a pattern from left to right repeatedly. A tactile stimulation may be done by hold alternating paddles that produce vibrations from left to right repeatedly or by simply tapping the feet or shoulders alternately (EMDR Humanitarian Assistance Programs, 2016).

Co-occurring: Individuals who have a mental health disorder and a substance use disorder are diagnosed as having a co-occurring disorder. This may also be called dual diagnosis (Dual Diagnosis, 2016).

Dual diagnoses: A term used when a person has a mood disorder and a substance use disorder at the same time. These are two separate illness and are treated individually (Depression and Bipolar Support Alliance, 2016).

Emotional triggers: Emotions or feelings associated with specific events (OMEGA Institute, 2014).

Empathetic break: An occurrence in a therapy session when the client perceives the therapists as being insensitive or hurtful (Doyle, 2014).

Eye movement desensitization reprocessing (EMDR): Eye movement desensitization reprocessing is an extensively researched therapy approach used to treat trauma. EMDR has a standard protocol that incorporates many different theories such as psychodynamic theory, cognitive behavior theory, and addiction theories. EMDR treatment is primarily used to treat PTSD by targeting the individual's past traumatic experiences, and by addressing triggers that cause anxiety and stress. It is used to alleviate charged feelings associated with memory by using bi-lateral stimulation (EMDR International Association, 2016).

EMDR certified trainers: Individuals who have 3 years of experience using EMDR therapy and have completed an EMDR International Association (EMDRIA) approved EMDR basic training. Individuals must also have conducted 300 hours of clinical EMDR sessions, have completed 20 hours of consultation with an EMDRIA approved consultant, and have complete 12 hours of continuing education every 2 years (EMDR International Association, 2014).

EMDR consultants: Individuals who have 3 years experience of using EMDR therapy who have completed an EMDRIA-approved EMDR basic training. Individuals must also have conducted 300 hours of clinical EMDR sessions and have completed 20 hours of consultation to EMDR therapists. EMDRIA-approved consultants must also complete 12 hours of continuing education every 2 years.

Parnell's adapted EMDR protocol model: a modified EMDR protocol adapted from Shapiro's original EMDR protocol that is tailored to the client's age, culture, education, type of trauma, and intellectual abilities (Parnell, 2007).

Resource installation: A protocol used to help clients handle the intense emotions or distress they may encounter by thinking about positive people in their lives or positive situations they can bring up during EMDR therapy. This is used to build the client's ego strength for performance enhancement (Parnell, 2011).

Assumptions

I assumed that participants in this study openly and honestly explored and reported their experience using EMDR therapy treating trauma and substance use disorders. This assumption was necessary because it allowed for a thorough investigation of the substance use theories EMDR therapists who utilize Parnell's modified EMDR protocol use when treating trauma and substance use disorders.

Scope and Delimitations

Quality substance abuse treatment is needed to help fight the battle against drug addiction. In this study, I interviewed EMDR therapists about their experiences using addiction theories in their work. This specific focus on substance abuse provided

information on how Parnell-oriented EMDR therapists incorporate a theory of addiction in their treatment.

There were clinical education boundaries in this study. This study was focused on only those who had received training using Parnell's adapted EMDR protocol. There is already research regarding substance abuse theory combined with Shapiro's original EMDR protocol; thus, I exluded Shapiro's EMDR framework from this study. There is a need for more research on Parnell's adapted EMDR model. This study was limited to those who hold a professional mental health licensed and who have been practicing EMDR for at least 1 year using Parnell's EMDR protocol and who have used this protocol to treat a client who has dual diagnoses of a trauma and substance use disorder. The EMDR therapists interviewed completed both the original protocol developed by Shapiro (2001) and the modified protocol developed by Parnell (2011). These therapists previously agreed to participate in future research studies by putting their name and email address on a sheet during their training sessions.

These limitations and boundaries aided in answering the question of regarding the therapists' experiences when incorporating substance abuse treatment with Parnell's adapted EMDR model and wthe theories that therapists report as helpful when treating those with a substance use disorder.

Findings from this study may be transferable and expanded by other researchers inquiring about which addiction theories therapists are using when treating a trauma and substance use disorders combined with Parnell's modified EMDR model. Other researchers may increase the population size and investigate which substance use theories

are reported as working best with Parnell's EMDR modified protocol. Other protocols may be developed that combine both Parnell's modified protocol and substance abuse theory and that can be used to specifically treat dual diagnosed clients. By exploring addiction therapies in combination with Parnell's EMDR protocol, EMDR certified trainers may better educate EMDR trainees about useful strategies for treating dual diagnosed clients. The strategies may shorten the client's time in treatment and provide a strong foundation for therapists as they conduct therapy for dual diagnosed people. This study's findings may also lead to the development of workbooks reflecting the best combinations of EMDR and addiction therapies.

Limitations

In narrative inquiry, data analysis take a great amount of time and the interpretation of data can be difficult. Methodological weakness includes moderator bias, leading question bias, sampling bias, and difficulties in analyzing and interpreting the information. Moderator bias occurs when the interviewer collecting the data impacts the interview by facial expressions, body language, mannerisms, or tone in voice. This can be controlled by the interviewer being mindful of their mannerisms during the interview. In my study, the interview questions were not leading; however, I monitored follow up questions or clarifying questions. Leading follow up questions or clarifying question bias were reduced by insuring the questions asked were not leading, suggestive, or progressive in nature. I asked neutral questions in order to reduce question bias. Sampling bias was reduced by randomly extracting email addresses from the bank emails of individuals who previously agreed to participate in research. I used NVIVO to aid in organizing the data

after extracting main themes from the interviews. Other limitations in this study included therapists' inability to clearly describe how they combine EMDR and substance use theories or how exactly Parnell's model is modified when interweaving substance use treatment. Some therapist only used elements of a substance abuse theory or had a eclectic style when treating substance abuse. Some therapists had difficulty in identifying the different addiction theories they use in combination with Parnell's adapted EMDR model.

Significance

Continued research of Parnell's adapted model may reveal whether or not there is success with the addiction therapy used with the adapted model. Exploring the different approaches may give EMDR consultants and trainers new insight on what different addictions therapies are useful for therapists when treating trauma and addiction. This study is an original contribution to the literature since I aimed to identify what other addiction therapies are being used with Parnell's adapted EMDR model.

Providing those who suffer from a dual diagnoses with sound treatment protocols will contribute to positive social change by reducing health care costs and time spent in therapy. By exploring addiction therapies in combination with Parnell's EMDR protocol, EMDR certified trainers may better educate EMDR trainees about useful strategies for treating dual diagnosed clients. The strategies may shorten the client's time in treatment and provide a strong foundation for therapists as they conduct therapy for dual diagnosed people. The findings of this research may also lead the development workbooks reflecting the best combinations of EMDR and addiction therapies.

Summary

In this narrative study, I explored the therapists' experiences of using substance abuse therapies combined with Parnell's modified EMDR therapy. I interviewed nine EMDR trained therapists. The audio recorded data from these interviews were coded, and I used NVIVO to identify key concepts and emergent themes described by the therapists. Shapiro's information processing theory served as the theoretical framework for this investigation. A thorough synopsis of the current literature regarding EMDR therapy and substance use disorders will be presented in Chapter 2. Also included in Chapter 2 are discussions of the literature search strategy and conceptual framework, and the literature review related to key variables and concepts.

Chapter 2: Literature Review

Introduction

Quality substance abuse treatment is needed to help fight the battle against drug addiction. The purpose of this narrative study was to investigate the experiences of therapists who incorporate substance abuse treatment with Parnell's adapted EMDR model when treating substance abuse. Past researchers have examined how Shapiro's original EMDR model can be useful for those who struggle with addiction and how EMDR is effective in reducing symptoms of PTSD and addiction (Justus, 2004; Perez-Dandieu et al., 2014). Other research has indicated EMDR is effective in treating core issues that underlie triggers to drug use (Marich, 2010). Addiction protocols combined with elements of Shapiro's original EMDR model have been shown useful or have been examined in the past (DiGiorgia et al., 2004; O'Brian & Abel, 2011). Hase et al. (2008) suggested that EMDR enhances other treatment modalities such as motivational interviewing and relaxation techniques. In this study, I focused on Parnell's adapted EMDR model and how it is being used to treat substance use disorders.

This chapter will include a discussion of my literature search strategy and lists of accessed library databases, search engines used, and key search terms. I will then review studies on EMDR and its use in combination with other approaches to treating trauma and addictions. I also discuss limitations of studies and gaps in the current literature.

Literature Search Strategy

I accessed most of the literature provided in this review through the Walden University Library. Search engines and websites I used were Google Scholar, Google,

the Eye Movement Desensitization Reprocessing International Association (EMDRIA) website, and the Francine Shapiro Library that is linked to the EMDRIA website. The databases used for the literature search were PsycINFO, MEDLINE, Dissertation and Thesis, ProQuest, and PsycArticles. The keywords and phrases used in the search were *EMDR and substance abuse treatment, EMDR and substance abuse, EMDR treating addiction, EMDR treating trauma and addiction, EMDR treating trauma and substance abuse, EMDR treating trauma and substance use disorders, modified EMDR protocol and addiction,* and *Parnell modified protocol and addiction*. I found no research regarding Parnell's adaptive model treating trauma in combination with substance use disorders. This gap is likely due to the fact that Parnell's model is relatively new and her institute opened recently in 2016 (Parnell Institute, 2016). The main body of research that I found on EMDR treatment for trauma and substance abuse disorder addressed Shapiro's original EMDR model described in Chapter 1. Parnell has adapted the original EMDR model, and this study was my attempt to learn more about the adapted model and how it is being used to treat substance abuse disorders by interviewing Parnell trained EMDR therapists who use Parnell's model in practice.

EMDR

EMDR is an evidenced-based theory used to treat PTSD, other psychiatric disorders, and mental health problems. Shapiro (2001) originally developed EMDR in 1989. She found, by chance, that eye movement reduces the intensity of disturbing emotions in certain circumstances. After this realization, Shapiro decided to conduct research on this occurrence. Subsequently, it has been researched worldwide, and EDMR

has been used to treat several mental health disorders (EMDR Institute, 2011). Shapiro developed an eight-phase EMDR protocol that includes client history, preparations, assessment, desensitization, installation, body scan, closure, and reevaluation phases (EMDR Institute, 2011). One of the weaknesses of this protocol is that it is rigid and is not tailored to the client's age, culture, education, type of trauma, and intellectual abilities (Parnell, 2007).

In this study, I explored the modified EMDR protocol developed by Parnell in 2007. I aimed to identify the substance abuse therapies clinicians use for dually diagnosed clients when utilizing Parnell's adapted EMDR protocol model. There is a gap in knowledge regarding which substance abuse therapies trained EMDR therapists are using in combination with EMDR, especially those therapists who follow Parnell's adapted EMDR protocol. When searching the databases, I found research regarding EMDR and substance abuse treatment theories based on Shapiro's original model, but none regarding Parnell's adapted protocol. The lack of research on Parnell's modified model is a weakness, and there needs to be more research regarding the modified EMDR protocol. This study is unique since my focus was on Parnell's adapted EMDR protocol model. Since there is no research regarding Parnell's adapted model when treating trauma and substance use disorders, in the literature review I focused on studies using Shapiro's original model when treating trauma and substance use disorders.

The interview questions investigated whether Parnell-oriented therapists incorporate a theory of addiction in their treatment, and if so, the therapies they typically use and which are considered most effective.

Parnell is one of the leading experts on EMDR therapy and has been training individuals to use EMDR since 1995 (Parnell, 2015). The modified protocol is tailored to the client's age, culture, education, type of trauma, and intellectual abilities (Parnell, 2007). In Parnell's modified protocol, the first stage is to create safety, the second stage is to stimulate the client's memory network, the third is to proceed to add bi-lateral stimulation, and the fourth reinforces a sense of safety. This protocol simplifies the EMDR procedure and skips steps of the original protocol that are not useful for the client. The steps that would be considered not useful are those that cause an "empathetic break in the therapeutic relationship" or that may cause confusion or "deactivate the memory network" (Parnell, 2007, p. 39). Parnell's model is less rigid and is tailored to the client. If a therapist feels it is important to leave out the part of the protocol that asks for negative cognitions in order to protect the therapeutic alliance, the therapist can skip it and move onto processing the event while keeping clients in the moment of being able to feel their feelings and being able to process the trauma. Shapiro's original EMDR model and Parnell's modified EMDR model are both based on the same framework, information processing theory. This study benefits from the information processing theory, which serves as an explanation of how trauma might be stored and processed in the brain.

Conceptual Framework

EMDR is built on the framework of the Shapiro's information processing theory (EMDR Institute, 2017). The information processing theory posits that humans have a physiologically based information processing system. The information processing system processes different segments of human experiences and then stores memories of

the experiences so they can be accessed for future use. This is done through a memory network. In the memory network, images, emotions, sensations, and thoughts are linked together and learning occurs when new experiences are built or added to the old memories. When a traumatic event happens, the memory network can be disrupted or may be incomplete and dissociation, or negative feelings can interfere with the processing of the traumatic memories. Shapiro believes EMDR can assist in processing these memories and linking them to more adaptive information, aiding the person in storing appropriate emotions with the memory. An example of this is when a rape survivors believe the rape is their fault. The EMDR therapist would aid in accessing the negative emotions of the rape then helping the rape survivor resolve the feelings of guilt or maladaptive thoughts that it was his or her fault (EMDR Institute, 2011).

The studies related most closely to my study are primarily phenomenological studies. These studies include a case study and studies based on interviews where the data were analyzed with common themes extracted from interviews. All studies were related to the concepts of treatment of trauma and/or substance-related disorders using EMDR therapy. I also review a preliminary study with a larger sample size related to EMDR treatment for trauma and alcohol dependence.

Literature Review

EMDR and Addiction Treatment

Justus (2004) has noted the efficacy of using EMDR with recovering addicts. Trained EMDR therapists using Shapiro's original model were interviewed about how they incorporate EMDR into their theoretical style of therapy. Justus reported that

EMDR therapy is useful for those who struggle with addiction. She also suggested combining psychotherapy with EMDR therapy, if it is applicable to the client's needs. EMDR helped alleviate shame and guilt stemming from trauma and other emotional triggers that often lead individuals to abuse substances. However, Justus did not answer the question of what addiction theories and therapies were incorporated into EMDR therapy for addiction treatment.

The Justus (2004) study was similar to my study in that it was based on a therapist's experience with using EMDR therapy to treat trauma and addiction. The strength of the narrative interview methodology used is that it enabled participants to describe personal experiences regarding EMDR therapy treating trauma and substance use. The weakness in the Justus study was the lack of questions on how addiction treatment is incorporated in an EMDR session. The Justus study was a good base for me to build on because it indicated that EMDR therapy is useful for those who struggle with addiction. What was not clear in that study is if Parnell's adapted EMDR protocol is beneficial alongside substance abuse treatment. I found that Parnell's adapted EMDR protocol is beneficial when incorporating substance abuse treatment.

Perez-Dandieu and Tapia (2014) researched how Shapiro's eight-phase EMDR protocol differed from treatment as usual (TAU) among 12 individuals who were chronically dependent substance users. In this quantitative study, the authors hypothesized there would be measurable changes in addiction symptoms after being treated with EMDR therapy. These 12 patients diagnosed with drug or alcohol dependence and suffering from significant trauma were randomly assigned via the

stratified randomization procedure. Participants were assigned to either the TAU or TAU plus EMDR therapy group. Participants were given measures including the PTSD checklist, Addiction Severity Index-lite, the Beck Depression Inventory, Coopersmith's Self- Esteem Inventory, and the Toronto Alexithymia Scale. Pre and post scores were analyzed and reported. The participants were also evaluated using secondary outcome measures, which were pre and post evaluations for depression, anxiety, low self-esteem self-blame, guilt, difficulty recognizing emotion, and difficulty expressing emotion. The results of this study were that the TAU plus EMDR treatment group showed drastic reductions in PTSD symptoms, an increase of self-esteem, and lower scores of depression but not lower symptoms of addiction. The findings indicated that EMDR works to treat PTSD when treating an individual with a substance use disorder. Improvements in this group also included positive changes in self-esteem. Researchers concluded that EMDR is helpful in treating PTSD symptoms with the standard protocol for substance abuse clients. The limitations of this study were that participants were all women and the author who conducted the study also provided the treatment. The strength of this quantitative study were the pre and post scores that showed EMDR was successful in reducing PTSD symptoms. Past research has indicated that EMDR is helpful in treating PTSD symptoms (Devilly, Spence, & Rapee, 1998); however, Perez-Danieu, and Tapia (2014) reported more attention and focus on traumatic memories and the effects on addiction would be of value. In this study, I aimed to build on the Perez-Danieu study in which the researcher explored how Parnell-oriented therapists use EMDR combined with addiction therapy to treat trauma and addiction.

Hase et al. (2008) conducted a mixed method study with 34 participants who were previously diagnosed with chronic alcohol dependency. The researchers hypothesized that processing addiction memory using EMDR therapy may reduce the cravings individuals experience post-treatment. Pre-treatment and post-treatment scores on a variety of measures were completed. Measures included the following: the Munchner-Alkoholismus test (MALT), which is a test that measures alcohol dependency; the Diagnostische Interview bei psychischen Störungen Mini-DIPS test which is a screen for mental illness; the Post Traumatic Stress Scale, a screen for posttraumatic stress disorder; and the Dissociative Experiences Scale, a screen for dissociative disorders. Symptoms of depression and anxiety were screened using the Beck Depression Inventory and State-Trait Anxiety Inventory. Perceived cravings of alcohol were screened using the Obsessive-Compulsive Drinking Scale (OCDS). These participants were randomly assigned to two different groups: treatment as usual (TAU) group or (TAU) group plus two sessions of EMDR. Two individuals from the (TAU) plus EMDR group were excluded due to continued alcohol use and two individuals from the (TAU) group alone dropped out. All patients received TAU, which included motivational interviewing, detoxification, group therapy, art therapy, and relaxation therapy. Out of the 34 participants who completed the study, 12 were female, and 18 were male. Ten of the patients met the criteria for comorbid psychiatric disorders in the TAU group. Fifteen patients from the (TAU) group were diagnosed with an alcohol addiction. In the EMDR group, 14 patients were diagnosed with an alcohol addiction and one was diagnosed with a multiple substance dependence with alcohol being the primary drug of abuse. Authors

report the most important findings in this study were the TAU plus EMDR therapy group showed a significant decrease in cravings for alcohol after treatment when compared to the TAU only group. Authors also report the TAU plus EMDR group experienced less depressive symptoms after receiving treatment compared to the TAU only group. Authors report a modified EMDR protocol may be useful in improving relapse prevention and other forms of addiction (Hase, et al., 2008).

The EMDR and Addiction treatment studies described above lack a thorough investigation regarding EMDR sessions and there is lack of research on Parnell's adapted model treating substance abuse disorders. This study further built upon the EMDR and Addiction Treatment studies as it will thoroughly investigate the experiences of the therapist who utilizes Parnell's modified protocol. This study filled in the gap of unknown answers regarding how therapist utilize Parnell's modified model to treat substance abuse disorders.

EMDR Combined with Addiction Theory

Abel and O'Brian (2010), the authors report there are research articles regarding EMDR being helpful in treating addiction, but there is not much research about working with individuals who are in different stages of change when struggling with addiction. In this article, the authors discuss ways in which therapists can incorporate three different EMDR addiction protocols within Prochaska and DiClemente's Stages Of Change treatment model developed in 1983 (Prochaska & DiClemente, 1983). The three EMDR addiction treatment protocols the authors discuss are Hase/CRAVEX protocol, DeTUR protocol, and the Standard EMDR protocol.

Michael Hase's Memory of Addiction/ Craving Extinguished (CRAVEX) protocol targets the memory of the last time the client had an urge to use a drug (Hase et al., 2008). This memory of the urge is processed using standard EMDR protocol techniques.

The second protocol mentioned above is the Affect Tolerance protocol. The Affect Tolerance protocol is used to help clients tolerate distressing feelings. Within this protocol, the client is asked to identify the feeling that is causing the most distress.

The third protocol, resource Development Installation Protocol, is used to strengthen or enhance the prevention plan and coping skills. When dealing with a challenging situation the client might need to boost his or her coping skills in order to better handle the situation.

Abel and O'Brian (2010) describe how these protocols can be incorporated within the Stages of Change model, for example, in the action stage, in the Stages of Change model; the client has made a commitment to therapy and has developed goals and a treatment plan. In this stage, the positive treatment goal part of the DeTUR protocol may be used to reinforce the qualities of the maintained changes. Abel and O'Brians article is meaningful to the proposed study as it describes how Shapiro's original EMDR protocol, which is the theoretical foundation of the construct being studied, can be integrated with addiction models; however, they report more research is needed to clarify how EMDR can be used as an adjunct therapy for clients who struggle with addiction. In this study I inquired on how EMDR therapy using Parnell's adapted EMDR model is used to treat trauma and substance use disorders. This article does not address issues of how long

must one be sober in order to engage in addiction treatment or if a client must be sober in order to engage in treatment, this is something that was explored in this qualitative study.

Able and O'Brian (2010) conducted a case study involving a 45-year-old woman diagnosed with PTSD and addicted to alcohol. The woman had a long history of unsuccessful treatments outcomes. Treatment involved using the desensitization of triggers and urge reprocessing protocol (DeTUR), Shapiro's standard Protocol, and Hase's Memory of Addiction Protocol in addition to attending 12 step meetings and meeting with her sponsor. Part of the (DeTUR) protocol was implemented first to identify positive treatment goals. This part of the protocol helped the client focus on her treatment goals by thinking of them and imagining a new way of living while engaged in bilateral stimulation. The therapist also used a different part of the DeTUR protocol to help boost the client's ego strength by reinforcing the client's self-recognized strengths and willpower. Popky (2005) developed the desensitization of triggers and urge reprocessing protocol (DeTUR) and it is used to treat addictions. Although only part of the protocol was used in the case study, the purpose of this protocol is to process core trauma to completion. It is believed that once the trauma is processed thoroughly, the triggers to use drugs are greatly reduced or no longer exist (EMDR International Association, 2016). The next step in treatment that the therapist implemented in Shapiro's original EMDR protocol was to process the trauma the client had experienced. The client responded well to treatment and maintained sobriety for six months until she experienced a trigger and relapsed using mouthwash. After the client relapsed, the therapists used Hase's memory addiction protocol and the client remained clean and

sober for at least two years after treatment. The Hase memory addiction protocol reprocesses the addiction memory using EMDR therapy, which may reduce cravings to use drugs (Hase et al., 2008). The authors go on to report that EMDR may be an effective therapy used as an adjunct to traditional therapies treating substance use disorders. The authors also report it is important to treat each client differently or individually to maximize results. They also suggest there should be more studies on how EMDR enhances addiction treatment and more studies comparing EMDR addiction protocols to the standard protocol. Furthermore, the difference in sober or abstinent rates need to be examined and what treatment should be used first. Other studies addressing when to use the standard EMDR protocol are also needed.

Marich (2010) reported on ten female alumni of a treatment facility over the age of 18 were interviewed about their experience with EMDR treatment and recovery. The alumni were treated for addiction using EMDR and were interviewed six months after treatment. This study was a phenomenological study and four common themes emerged from the interviews. Participants reported having a positive experience with EMDR. They credited EMDR as being crucial to their continuing therapy sessions and noted that EMDR alone aided them to resolve core issues of their substance use. Most of the participants' maladaptive negative suppressed beliefs were reported as the catalyst for negative substance abuse behavior. For example, if a person believes he or she is a failure, the feelings associated with the belief of being a failure could be a trigger to use drugs or alcohol. Participants also engaged in other recovery programs such as the 12-step program while being treated with EMDR therapy. Most participants credited EMDR

as the treatment that changed their perception of self and believed this was crucial to recovery. However, the limitation of this study is only women who had positive experiences with EMDR participated in the study.

The author reports further research is needed in regards to the therapeutic relationship between the therapist and client. This is an area that was examined in this study. One of the components in Parnell's adapted EMDR model is to skip stages in the original model in order to protect the therapeutic relationship between the client and the therapist (Parnell, 2007). In this study, questions regarding the therapeutic relationship and the effects it has on treating trauma and substance use disorders when using the Parnell adapted model were asked during the interviews.

Past research regarding EMDR combined with addiction treatment, as described above, does not address what factors play into the therapist's decision regarding the preparedness of the clients to engage in EMDR treatment combined with addiction treatment. In this study there were interview questions requesting information about the therapist's experience of how they know when their client is ready to engage in EMDR treatment and addiction treatment and how they handle issues of relapse or resistance to treatment. Marich (2010) report further research is needed in regards to the therapeutic relationship between the therapist and client. Abel and O'Brian (2010) report more research is needed to clarify how EMDR can be used as an adjunct therapy for clients who struggle with addiction. This study aimed to fill in the missing information described above by interviewing therapist regarding their experience in using addiction theories combined with EMDR therapy.

Comparing Different Theoretical Orientations with EMDR Therapy

A study with a similar methodology to this current study was conducted by DiGiorgio, et al. (2004). Three male Caucasian therapists 57 to 71 years of age with different theoretical backgrounds were interviewed regarding the integration of EMDR with their primary theoretical orientation. The three different theoretical backgrounds were psychodynamic, humanistic, and cognitive behavioral therapy. The participants were recruited through an email requesting their willingness to participate in the study. The participants were mailed a research packet that contained a demographic form, consent form, and questions that would be asked during the interview. The participants were asked to think about the interview questions before the interview was conducted. Two participants were interviewed by telephone and one was interviewed in person. The interviews were audiotaped and a debriefing was conducted after each interview session. The participant's theoretical orientations were cognitive-behavioral, humanistic, and psychodynamic. The demographic form that was given asked for information regarding race, age, gender, professional degree, number of years practicing as a licensed psychotherapist, specialization, and EMDR training. Participants were asked to report how often they use EMDR as a treatment method in their practice and what theoretical framework they use as a guide. Participants reported answers using a Likert scale on a questionnaire. During the interview process, the participants were asked questions regarding psychotherapy, their training in EMDR, current theoretical orientation, types of clients they treat using EMDR, typical approach used with EMDR and how they use their approach with EMDR. The responses from the interviews were analyzed using the

consensual qualitative research method (CQR). Hill, Thompson, and Williams, (1997) developed the CQR method and described the important components of the method such as asking open-ended questions and studying only a few cases thoroughly. When using this method, panels of researchers analyze the interview data and discuss any ambiguities that may be present in the interviews. The panel discussion allowed multiple perspectives and clarification of data. The makeup of the panel included a doctoral student in clinical psychology with level I EMDR training, a licensed clinical psychologist with level I EMDR training, a clinical psychology doctoral student who completed Level I of the EMDR training, a clinical doctor of psychology student who has not been trained in EMDR, and a licensed clinical psychologist and professor who completed Level I and II EMDR trainings. The panel in this study determined the topic areas and came up with 14 domains. DiGiorgio et al. (2004) left out 3 domains resulting in 11 final domains as follows:

- Interest and training in EMDR;
- Clients and clients issues suitable for EMDR therapy;
- When EMDR be useful for clients;
- Procedural variability with different clients;
- When to decide when to first use EMDR in therapy;
- Ways in which EMDR makes a contribution to therapy;
- Integration of EMDR with primary therapy style;
- Deviations from the protocol, leave out or add to the EMDR protocol;
- Effects of EMDR on the therapeutic relationship with client;

- Challenging experiences with EMDR therapy;
- How EMDR works (DiGiorgio et al., 2004).

DiGiorgio et al. (2004) looked across the three transcripts of the interviews with the therapists and decided to look for similarities in the data. The research team decided to categorize the domains as being general, typical, or variant depending on if the domain applied to one individual, two individuals, or all three individuals. After the domains were categorized the researcher did a cross analysis. All three participants in this study reported integrating EMDR into their practice and regard their theoretical orientation as integrative. All therapists deviated from Shapiro's standard EMDR protocol. The participants reported their theoretical orientation influenced the sequential order of the EMDR protocol. The author reports one participant uses EMDR to enhance the therapy process and adds behavioral approaches to the process. Some leave out certain aspects of the protocol that do not fit with their theoretical orientation. The author also reports that even though there is a growing interest in integrating different therapies into practice, there is little research regarding what therapy clinicians are integrating in their practice and whether or not it is working for the client.

Summary and Conclusion

The major themes in the research are EMDR treating substance abuse disorders, EMDR combined with an addiction treatment theory to treat trauma and addiction and the comparison of addictions treatments being used as an adjunct to EMDR therapy. These studies do not address the experience of the therapists treating substance use disorders with Parnell's model. Researchers report even though there is a growing

interest in integrating different therapies into practice, there is little research regarding what addiction therapy clinicians are integrating in their practice and whether or not it is working for the client (Abel & O'Brian 2010).

What is known about EMDR treatment is that Francine Shapiro's original EMDR model may be effective in treating both trauma and substance use disorders. It is also known that therapists using the original EMDR model deviate from the standard protocol and integrate their own theoretical orientations with the model to treat trauma and substance use disorders. What is not known is what substance abuse therapeutic approaches EMDR therapists use who have been trained in either Shapiro's or Parnell's adapted EMDR model (Parnell, 2007). This study filled in the gap by identifying what substance abuse therapies clinicians use for dual diagnosed clients when utilizing Parnell's adapted EMDR protocol model, by interviewing the therapists about their experience of incorporating substance abuse treatment with the adapted protocol.

Interviewing therapists regarding their experience in using addiction theories combined with the EMDR model helped fill in the gap of what may be helpful in the process of the integration of substance use theory and Parnell's modified EMDR model. Details regarding participant selection, interview questions, data analysis, procedures and the role of the researcher will further be discussed in Chapter Three.

Chapter 3: Research Method

Introduction

The purpose of this narrative study was to investigate the experience of therapists who incorporate substance abuse treatment with Parnell's adapted EMDR model when treating substance abuse disorders. Interviewing therapists who treat trauma and addiction with a combination of Parnell's EMDR model and an addiction therapy helped me fill the gap in the literature regarding the addiction treatment therapies EMDR therapists are using. The data may aid in the development of other treatment guidelines or other protocols used to better serve dual diagnosed clients.

In this chapter, I discuss research design and my role as researcher. The methodology of the design, number of participants, and procedures is also explained. I provide a full description of the instrumentation used, and discuss the data analysis plan along with issues of trustworthiness and ethical procedures.

Research Design and Rational

The research questions in this study were:

RQ1: What is the therapists' experience when incorporating substance abuse treatment with Parnell's adapted EMDR model when treating substance use disorders?

RQ2: What is the therapists' experience in using addiction theories?

RQ3: What do the therapists' report is helpful in the process of integrating substance use theory and Parnell's modified EMDR model?

This was a narrative inquiry study exploring therapists' preferred addiction therapies combined with Parnell's modified EMDR protocol to treat addictions and

trauma-related disorders. Parnell's modified protocol is tailored to the client's background and intellectual abilities (Parnell, 2007). The stages in the modified protocol include creating safety, stimulating the memory network, processing the emotions connected to the memory network, and finally reinforcing safety. This protocol simplifies the original EMDR procedure by leaving out steps not useful for the client or steps that would cause an empathetic break (Parnell, 2007).

In this study, I interviewed nine EMDR therapists about their experiences using Parnell's modified EMDR protocol to treat substance abuse disorders. These therapists opted to participate in studies regarding EMDR therapy. I audio recorded their responses to open-ended interview questions that I asked during telephone interviews.

I selected a narrative design because it was best suited to examining the participants' experience of and meanings associated with a phenomenon (see Cresswell, 2013). Researchers and practitioners may use study results to bring about change or reform to the phenomena being studied (Cresswell, 2013). The participants' stories and perspectives about their experiences using the modified EMDR model to treat substance abuse may lead to other treatment ideas or ideas of how the modified protocol can be altered to better help clients.

Role of the Researcher

My role as researcher in this qualitative narrative study was collecting and analyzing the data from participants' responses to the open-ended interview questions. I did not have personal or professional relationships with the participants and did not include participants who had served as an EMDR trainer in any of Parnell's training or

who have had a supervisory role in the training sessions. Participants may have taken the same course as I took. Bias was managed by not asking leading questions, and I did my best to refrain from asking closed-ended questions during the interview process. A $20 Amazon gift card was given as a "thank you" gesture to participants, not as an incentive to participate.

Methodology

Participant Selection

The population comprised licensed mental health therapists who had completed EMDR training and implemented it in their professional practice. These individuals have completed Parnell's EMDR training and use Parnell's modified EMDR protocol. A criterion sampling strategy was used for this study. Criterion sampling strategy works well when the researcher needs participants who have experienced the same phenomenon (Creswell, 2013). All therapists had experience using EMDR therapy in their practice. All participants who agreed to be contacted for research purposes previously put their name on an e-mail contact list that was generated and passed out among EMDR trainees and given to the EMDR trainer on their last day of the EMDR training course held at Esalen in Big Sur, California. I recruited participants from this list by e-mail, given that they have previously agreed to be contacted for research purposes regarding EMDR therapy. I had access to this list because it is available in the course instruction notes and is also available by requesting it from the EMDR training assistants at the training classes. Participants were known to meet the criteria for this study because they had completed EMDR training. I screened participants by asking whether they had post

training experience using Parnell's adapted EMDR model to treat substance use disorders. Participants had to meet the criteria of using Parnell's adapted model during therapy sessions to treat substance abuse disorders to be included in the study.

Given the limited number of participants meeting criteria for this study and the rigorous data analysis that qualitative research involves, I analyzed the data from nine participants. Data from 8-12 participants is sufficient for saturation in qualitative interview research. Guest, Bunce, and Johnson (2006) further suggested that a sample size of 12 individuals is adequate when the goal of a study is to evaluate perceptions of individuals about a phenomenon. The guiding principle for qualitative research and sample size is saturation, which is achieved when there is no further information that will come forward about an issue that is being investigated (Mason, 2010). Saturation was reached with nine participants on the issues regarding the experiences of therapists using the modified EMDR model. Guest et al. (2006) reported that new themes are no longer developed after conducting 12 interviews. Charmaz (2006) reported that using a small sample size may achieve saturation faster in a small study when a phenomena such as addiction is being studied within a certain group rather than studying a general range of the addiction phenomena.

Instrumentation

Due to the lack of research on treating trauma and substance use disorders using Parnell's adapted EMDR model, a narrative study was needed to ask questions regarding therapists' experiences of the phenomena. The best way to ensure content validity is by conducting interviews about the lived experiences of a phenomena, which adequately

captures the participant's perspective on the phenomena under investigation (Brod, Tesler, & Christensen, 2009). In this study, I asked the participants about their experiences using EMDR therapy and how they incorporate substance abuse treatment.

I served as the primary data collection instrument and asked questions following and interview protocol (see Appendix B). I asked these questions along with 10 follow up questions regarding the use of Parnell's adapted EMDR model to treat trauma and substance use disorders. Two audio recorders were used to record the telephone interviews. Telephone interviews lack visual cues and may result in the loss of nonverbal data and the ability to establish rapport; however, they may also allow respondents to feel more relaxed in the interview process, which may increase the amount of disclosed information about the phenomenon (Novick, 2008). This may also increase the richness of information received. Other advantages of telephone interviews include decreased cost of travel and the ability to reach participants who are not geographically near the researcher; some participants in this study lived out of state.

To establish content validity of the interview questions, two experts in qualitative methods research reviewed them and the interview protocol. I also choose two experts who are experienced in the modified EMDR protocol to review the research questions before the start of the interviews. Sufficiency of data collection techniques was established by examining the feedback from the qualitative methods experts and EMDR experts. I made necessary changes to the interview questions in order to better obtain information I could use to answer the research questions.

Procedures for Recruitment, Participation, and Data Collection

I interviewed participants and collected the data via telephone from my therapy office located in Brentwood, California. I scheduled the interviews with participants based on their convenience. One to 2 interviews were scheduled every week. When interviewing the participants, I used the telephone's speaker in order to conduct the interview "hands-free." This aided in the monitoring the recording instruments, and I was better able to track the interview questions on the interview protocol sheet. The interviews ranged from 20 to 25 minutes. All participants were debriefed at the end of the study and were allowed to ask questions or disclose any thoughts about the study. I sent participants a $20 Amazon gift card as a token of appreciation via postal mail. No other follow-up procedures were necessary.

Data Analysis Plan

The follow-up research questions that relate specifically to the research questions were asked during the interview and represented in the data. Creswell (2013) suggests narrative data from the interview questions that attempt to answer the research questions, should be examined and reduced into themes described by words or short phrases. I put the themes into final narratives and identified emerged patterns.

I analyzed the data by extracting themes from the interviews. I identified any relationship or commonalities and highlighted differences and created generalizations. I divided up the data into meaningful units such as in specific words, phrases or ideas. I then used inductive coding and kept a master note of codes. The codes were thematic in nature as it describes the topics being discussed (QSR International 2016).

Issues of Trustworthiness

Trustworthiness was established by the applications of credibility, and transferability. Trustworthiness is also established by the applications of dependability, and confirmability discussed below.

Credibility

Credibility was established by a persistent observation of the study. Persistent observation techniques ensure the deep understanding of an experience (Qualitative Inquiry in Daily Life, 2011). The researcher ensured credibility by making several passes through the data, transcribing the data, re-reading the data several times, coding and analyzing the data. There was also a focus on the relevant aspects of the phenomena of the study.

Transferability

Transferability was established by providing a thick description of the study. Ponterotto (2006) describes thick description as the researcher's task of interpreting the data within the context of the study. Thick description accurately describes the thoughts and feelings of participants. I recorded the interviews and transcribed the interviews verbatim. I also asked for clarification of any thoughts or feelings regarding the participant's experiences if needed.

Dependability

Dependability was established by thoroughly following the interview protocol when I interviewed participants. I also asked for clarification during the interviews to fully understand the participants experience using EMDR therapy when treating trauma

and substance use disorders. The interview was meticulously transcribed. The accuracy of data collection was insured through the verbatim transcription of the interviews. Dependability is also built by ensuring the study is detailed in nature so that it can be easily replicated allowing future researchers the ability to repeat the study and get similar results (Shenton, 2004). The methods and results of this study are explained in detail in order for it to be replicated if needed.

Confirmability

Conformability was established by keeping an audit trail. Koch (2006) reports a study that provides an audit trail, increases trustworthiness. A researcher should audit the events by tracking the actions and influences of the researcher's decisions. I documented the course of development of this study. Lincoln and Guba (1985) report an audit trail must consist of raw data collection, notes on data reduction, data synthesis, process notes, and materials related to preliminary development of information. I kept notes for all categories mentioned above.

Ethical Procedures

I obtained the approval of gained access to participants from Laural Parnell of the Parnell Institute who conducted the trainings**.** I obtained access to emails of participants who have previously agreed to participate in research regarding EMDR therapy. In the final EMDR training course, participants wrote down their email addresses as an agreement to be contacted to participate in an EMDR study. These emails are available to anyone who has completed the EMDR training sessions. I had access to these emails

as I have also completed all EMDR courses. Institutional permission was given by the Walden Institutional Review Board (IRB) prior to data collection.

Ethical concerns such as minimal risk to participants are addressed by verbally reading through the informed consent with participants and requesting return email from the participants with the words "I consent" (see Appendix C). A debriefing with participants was conducted after the interview. Confidentiality was maintained by using pseudonyms instead of participants' names. There were no participants who withdrew from the study prematurely and no participants ended the interview prematurely.

Confidentiality of the data was ensured by using passcode protected digital recording files and only the researcher will has access to the data. The data will be kept for five years and will be destroyed. The data file and audio file will be permanently erased after five years, and the tape recorder tape will be destroyed by a trash compactor.

Data such as the recordings of individuals and emails are stored in a locked filing cabinet. The email account used for this study is password protected and only I have access to the email account. Closing the email account and erasing the recordings on the digital and tape recorder device will destroy data.

Other ethical concerns for this study is giving a small gift to participants for their time. Individuals were given a twenty-dollar gift card as a thank you, not as incentive, after they have participated in the study. I requested an address of where they would like to have their gift card mailed. The gift card was a token of appreciation and is mentioned in the informed consent. The gift card was mailed to them via postal mail.

Summary

The research questions in this study are:

R1: What is the therapists' experience when incorporating substance abuse treatment with Parnell's adapted EMDR model when treating substance use disorders?

R2: What is the therapists' experience in using addiction theories?

R3: What do the therapists' report is helpful in the process of integrating substance use theory and Parnell's modified EMDR model?

In this narrative study, the I interviewed EMDR therapists about their experience of using Parnell's adapted EMDR protocol. Data was collected analyzed and coded using the NVIVO analysis software (QSR International 2016). Content validity was ensured by conducting interviews about phenomena, which adequately captures the participant's perspective on the phenomena under investigation (Brod et al., 2009). I collected data from 9 individuals at a pre-arranged, scheduled time. A digital recording instrument and a tape recording device recorded data. Trustworthiness was established by the applications of credibility, transferability, dependability, and confirmability. Ethical concerns such as minimal risk to participants were addressed by verbally reading through the informed consent with participants and requesting a signature after review. A debriefing with participants was conducted after the interview. Confidentiality was maintained by using pseudonyms instead of participants' names.

In Chapter 4, data analysis and results are described along with evidence of trustworthiness. A summary of answers to research questions will also be discussed.

Chapter 4: Results

Introduction

The purpose of this narrative inquiry was to investigate the experiences of therapists who incorporate substance abuse treatment with Parnell's adapted EMDR model when treating substance abuse. Interviewing therapists who treat trauma and addiction with a combination of Parnell's EMDR model and an addiction therapy aided me in filling the gap in the literature on which addiction treatment therapies EMDR therapists are using.

The research questions were:

R1: What is the therapists' experience when incorporating substance abuse treatment with Parnell's adapted EMDR model when treating substance use disorders?

R2: What is the therapists' experience in using addiction theories?

R3: What do the therapists' report is helpful in the process of integrating substance use treatments and Parnell's modified EMDR model?

Chapter 4 includes discussion of the study's setting, demographics and the number of participants, and the professional qualifications of the participants. Next I present the procedures and instruments used for data collection. Finally, I discuss data analysis procedures along with evidence of trustworthiness, and research results before providing a summary.

Setting

Participants agreed to future research on the last day of their EMDR training courses. Participants who were interested in future research provided their contact information at the EMDR trainings. These participants are verified trained EMDR therapist as they were issued a certificate of completion on the last day of the EMDR training. I contacted the participants on the list via email and conducted the scheduled interviews from my home office of those who gave consent and agreed to participate. To ensure privacy, no others were in the room or the home when the interviews were conducted. All interviewed participants were trained using Parnell's modified EMDR protocol. There were no apparent personal or organizational conditions that influenced participants or their experience at the time of the study because they didn't know what research would take place in the future at the time they put their names and contact information on the list at the training. All therapists' had completed EMDR training and had been using it as a therapeutic practice along with other treatment modalities to treat trauma and substance use disorders prior to the interviews.

Demographics

Licensed therapists who participated in this study are verified trained EMDR therapists who use Parnell's modified EMDR protocol to treat trauma and substance use disorders. The individuals I interviewed practiced as licensed therapists in different states across the nation; 90% practiced on the West Coast and 10% practiced on the East Coast of the United States. There were eight female therapists and one male therapist interviewed. I screened therapists prior to the interviews by asking them if they have had

experience treating trauma and substance use disorders using Parnell's EMDR model. Individuals who that stated they did not have enough experience in using Parnell's modified protocol were not a good fit for this study, so were not interviewed.

Data Collection

I emailed 49 individuals an invitation with an attached informed consent form. Ten individuals responded and scheduled an interview. At the beginning of one interview, a participant realized she did not have enough experience to participate and we ended the interview before any interview questions were asked, giving a total sample size of 9 participants. The guiding principle for qualitative research and sample size is saturation; saturation is achieved when there is no further information that will come forward about an issue that is being investigated (Mason, 2010). Saturation was reached with 9 participants on issues regarding the experiences of therapists using the modified EMDR model.

While I allotted 1 hour for each interview, they ranged between 20 and 30 minutes. All interviews were recorded using two recording devices, and I later transcribed the interviews verbatim. There were no variations in the data collection plan, and I encountered no unusual circumstances in the data collection. All recordings from the audio devices were clear.

Data Analysis

In this study, there were 9 audio-recorded interviews, which resulted in 118 transcribed pages of content. During the interviews, I took notes on the interview protocol forms such as the participant number, time of interview, any responses to the interview protocol questions I deemed interesting, and any follow up questions I wanted to ask. After all data was digitally named and filed, I began the data transcription process. I replayed the interviews at a slower speed to ensure accuracy of transcription. I

also used the rewind function on the recording device to ensure accuracy to what was being said. I used the six step approach described by Cresswell (2013) to analyze the data. This hierarchical approach includes transcribing raw data, preparing the data for data analysis, repeatedly reading through the data, hand coding the data, identifying themes, and then describing and interpreting the data. I also used Tesch's (1990) eight step coding process to come up with codes and common phrases that aided in the development of themes (see Creswell, 2014). When coding the data, I read through the transcriptions very carefully several times. Next, I identified the most interesting participant responses to the questions. Then, I took notes on the participants' commonalities in answers to the questions and identified the most descriptive words and phrases that would aid in identifying themes. After I coded the data and identified themes, I entered the data into NVivo and conducted a search for all of the codes, words, and phrases identified in the themes in the raw data and came up with quotes that represented those themes. There were no discrepant cases in this study.

Evidence of Trustworthiness

Credibility

Credibility was established by a persistent observation of the study. Persistent observation techniques such as several passes through the data ensure the deep understanding of an experience (Qualitative Inquiry in Daily Life, 2011). I ensured credibility by transcribing the data myself, re-reading the data several times, coding and analyzing the data. There was also a focus on the relevant aspects of the phenomena of the study.

Transferability

I worked to ensure transferability of this study by providing thick description. Ponterotto (2006) describes thick description as the researcher's task of interpreting the data within the context of the study. Thick description accurately describes the thoughts and feelings of participants. I recorded the interviews and transcribed the interviews verbatim. I also asked for clarification of any thoughts or feelings regarding the participant's experiences when needed.

Dependability

Dependability was established by thoroughly following the interview protocol when interviewing participants. I asked for clarification during the interviews to fully understand the participants' experiences using EMDR therapy when treating trauma and substance use disorders. The interview was meticulously transcribed. The accuracy of data collection was ensured through the verbatim transcription of the interviews. Dependability is also built by ensuring the study is detailed in nature so that it can be easily replicated allowing future researchers the ability to repeat the study and get similar results (Shenton, 2004). The methods and results of this study are explained in detail in order for it to be replicated if needed.

Confirmability

I ensured confirmability by providing an audit trail. Koch (2006) reported that a study that provides an audit trail increased trustworthiness. A researcher should audit the events by tracking the actions and influences of the researcher's decisions. I documented the course of development of this study. Lincoln and Guba (1985) reported that an audit

trail must consist of raw data collection, notes on data reduction, data synthesis, process notes, and materials related to preliminary development of information. I had notes for all of these categories.

Results

In this section, the results are reported and are organized by themes found in the data.

Theme 1: Resourcing Phase

Participants reported spending a lot of time in the resourcing phase when utilizing Parnell's adaptive protocol treating trauma and addiction. Eight participants described the importance of resourcing when treating someone with a substance use disorder; these participants had different techniques in regards to the resourcing part of Parnell's protocol. For example, Participant 1 discussed the importance of spending a lot of time in the resourcing phase especially when treating those with severe PTSD or who have experienced a lot of trauma. Participants 2 and 3 used mindfulness techniques as a resource before engaging in EMDR therapy, assisting the client to feel present and safe in session. Participants 4 and 7 reported that sometimes EMDR cannot be utilized due to session time constraints or lack of clients' ego strength, such as in outpatient settings. In these situations, utilizing only the resourcing part of Parnell's adaptive protocol is helpful, unless the client is in active psychosis, stabilizing the client's psychosis would need to take place before resourcing can begin. Participants 6 and 8 reported therapists can learn a lot about a client through resourcing such as seeing how stabilized a client is and how likely a client will dissociate during the EMDR process.

Table 1

Participants Utilization of Resourcing in Parnell's Modified Protocol

Participant	Description
1	"We resource the hell out of them before we get going. I get guys with complex trauma who went into the military traumatized and so I will resource people for months before we even talk about process.
2	"most definitely, people are more, they feel like they have a better inclination for jumping in, especially if we start off with a little mindfulness using the tappers, the whole idea of trying something different with the tappers doesn't seem as far out so we might do some mindfulness during intake or during the in-depth history taking and then when it comes time to tackling some of the problems head-on, then we will get into resourcing and then how that person is will determine if we just stick to the main 4 ones or how we incorporate some other resourcing into it, I also look at the mindfulness as a part of resourcing too"
4	"It depends on the drug of choice, you know if you are dealing with someone who is, you know, every 3 day IV opiates then you need to detox and stabilize them and do the psychiatric piece, you know also with someone who is manic, you really cannot start working

	with them right away. If there is a drug that causes psychosis, sometimes you have a client who has been in psychosis for a long time, you need to address those issues and sometimes I cannot work with schizophrenia, they don't have enough insight and um, it all depends on the client. Those who have good ego strength, you can start resourcing right away."
7	"if they are in my practice I am comfortable meeting with them and if I am comfortable meeting with them then I am going to use EMDR even if it's just resourcing and don't actually get to processing a memory or something.'
6	Therapist: "How do you know the therapeutic relationship with a client is strong enough to handle EMDR therapy treating trauma and substance use disorders?" Participant: "well, you kinda have to try it out, ummm so I mean you I always start with resourcing of course and you can learn a lot from that and you can learn how likely they are to disassociate, how resilient are they how resourced are they, how easy for it for them to use their imagination, how likely they are to dissociate, you can learn a lot from just doing resourcing."

Theme 2: Deviations from Parnell's modified Protocol

Participants report deviating from Parnell's Adaptive EMDR model. Specifically, seven out of 9 participants report deviating from Parnell's protocol and all seven deviated from Parnell's modified protocol differently. Participant 1 and 5 use somatic techniques. For example, if a client cannot come up with a negative cognition then the therapists instruct the client to describe the body sensation the client is experiencing when processing an event.

Participant 3 reports starting a therapy session with the bilateral stimulation and then the therapist listens for a target as the client describes an event, or the therapist will have a client draw a feeling if they are having a hard time describing how they feel. Participant 6 and 9 do not require clients to identify a negative cognition and is fine with that, as long as the client continues to process the trauma. Participant 8 deviates from Parnell's protocol by alternating EMDR sessions with Internal Family Systems therapy sessions.

Table 2

How therapists deviate from Parnell's Protocol

Participant	Description
1	"If someone can't generate an image or a negative cognition I'll go with body sensation or image." "Sometimes I noticed that something is just blocking them and no matter what interweaves I use, there is something that just feels incomplete and they don’t have words for it, then we just stop the bi-lateral stimulation and

	do something somatic, um so, I just change gears if I need to" (participant 5).
3	"if I have an established relationship with the client when they walk in I just give them the tappers and have them walk through it. If they, oh, as they are tapping through it I am listening for a target, and then I'll set up a target based on the original protocol, sometimes that works, just having the tappers...sometimes people can't imagine things and I'll have them draw it and while they are drawing, I'll have the tappers on while they are drawing. I will have them draw a feeling and have them tell me what that looks like and have them draw it out. We will do interventions with the drawing while the tappers are going, it takes the intensity out that way, just seeing it".
6	"let's say a client has a hard time finding a negative cognition I am not going to fuss about it quite honestly and she wouldn't be either even though it's a part of the protocol. So ya, ill tailor it to meet the client with their needs and as long as the client is in the emotional neuro-network, I just go for it" "often times if the client cannot identify the negative cognition I just start the bilateral stimulation anyway and eventually the negative cognition makes itself is known in about 10 to 20 minutes" (participant 9).
8	"so sometimes I will do an EMDR session and then I will do a

family systems session next time and follow up and see how well that would work and then I will put in another trauma therapy in there as well"

Theme 3: Incorporating Addiction Treatment Methods with Parnell's Adapted EMDR Protocol

All nine participants refer or recommend a 12 step group in conjunction with Parnell's EMDR therapy. Participant 2 and 9 process the clients' feelings that come up with the 12 step work such as shame or guilt. Some therapists also allow time in sessions for clients to discuss the step they are working on with their outside sponsor.

Five of the 9 participants report incorporating motivational interviewing with EMDR therapy. Participant 3 and 5 reports it is helpful to know where the client is in regards to the stages of change but more important to process the underlying issues of what is keeping them there. Three of the 9 participants describe a technique called "connecting the consequences", this is described as the client pairing the behavior with the consequence of the behavior while engaging in bi-lateral stimulation. Doing this causes an aversion to engaging in the behavior that fuels addiction.

Four of the nine participants discuss incorporating the Internal Family Systems Model with EMDR therapy. Participant 9 incorporates Internal Family Systems by asking permission from all of the parts of the client's self if they can proceed with EMDR.

Table 3

Incorporating Addiction Treatment Methods with Parnell's Modified EMDR Protocol

Participant	Description
2	"if even the first step to just acknowledge that you are helpless and this is where you are at, who wants to say that you are helpless over something right? So just doing EMDR around that, what are you feeling in your body when you say those words, so just doing some EMDR around that" "I think with AA especially, I include the steps and see what step they are on and if they are stuck on a step, we explore that and we do EMDR around that step and why they are stuck on it."(participant 8)
3	what is somewhat helpful is identifying where they were in the stage of treatment, but as far as helping them come to understanding the underlying root of the addiction is what needs to be treated, just thinking through something is harder to do than clearing out what is causing it in the first place, so the EMDR is really super effective" " I just mostly draw in the motivational interviewing, to just check in with where they are in the stages of change and then the 12 step recovery... connecting the consequences, they um, I think it just gets clearer when we do the bilateral stimulation, it connects the use with the consequences more than the craving." (participant 5)

Theme 4 Participants experience with using EMDR treating Triggers leading to Substance Use

All nine participants report EMDR enhances addiction treatment. Eight out of nine participants report success with clients in the reduction of triggers to use after processing the underlying trauma that fuels the addictions. Participant 6 reports the only time EMDR did not work for a client with the reduction of triggers was when the client came to session intoxicated and was using benzodiazepines. Participant 3 posits symptoms are reduced after processing the trauma because EMDR changes the "neuro networks in the brain".

Participant 1 reports increasing clients' resiliency alone aids in the reduction of substance use "somewhat," however this participant did not go into detail as to how increasing resiliency was accomplished in her sessions. Table 4 includes quotations from participants regarding their experience of using EMDR to treat triggers leading to substance use.

Table 4

Participants' experience with using EMDR treating Triggers leading to Substance Use

Participant	Description
2	"addiction is a response to the trauma, so what I have been noticing um is that something bad happens and it can be a single event or something chronic and the chronic needs a way to cope and so they keep trying different things and they find themselves unsuccessful and they move from one maladaptive coping mechanism to the

	next and then they move to the next addiction...the addiction is a symptom of the trauma so if the trauma is processed then the symptoms are reduced"
3	"symptoms are reduced and it's because we're actually changing the neuro-networks in the brain to adapted resolution, it just changes everything about what the client experiences internally, so something that would trigger them in the past doesn't trigger them going forward, so therefore there is no reason to drink or use substance"
4	" OK, the thing is, is that any type of addiction any type of obsessive compulsive behavior such as cutting or whatever, it's not the symptom, there is always the underlying issue, they are self-medicating and they are medicating their emotional self-distress so when you work through the trauma, it's not driving them to use anymore."
5	"I have seen symptoms reduced and that is mostly because after reprocessing the trauma they feel a less need for it. They feel like they can tolerate more of their uncomfortable feelings, they feel more empowered once they can revisit difficult times sober, they feel less run by anxiety, so it's just an overall picture of overall self-efficacy and confidence so there is less reason to use and it would jeopardize their gains if they start using again."

6	"it heals the traumas that cause the triggers and I don't know of any other therapy that does that, so absolutely, it works wonderfully well for addiction... you are processing the trauma that cause the triggers that cause the behavior, so you are working out the root of it"
7	" the addiction tendencies, cravings, intensity and all is reduced if it for instance if it's really linked with like a trauma, symptoms are sitting right underneath the propensity to do the addiction if the trauma is lessened then the symptoms of addiction are"
8	"symptoms are reduced and I think I attribute it to dealing with the early on traumas that they may not have linked up unless they did EMDR and then they have the ah-ha moments and when you go through and do EMDR in their early experiences in memories that helps to bring it to light and they focus on it and realize it and heal those wounds"
9	"I contribute it to them working through their underlying trauma so that there sympathetic nervous system isn't getting rung all of the time, and they are not trying to calm it down on their own"

Summary

The purpose of this narrative inquiry is to investigate the experience of therapists who incorporate substance abuse treatment with Parnell's adapted EMDR model when

treating substance abuse. One-on-one interviews were conducted with 9 trained EMDR therapists who utilize Parnell's EMDR modified protocol treating trauma and substance use disorders.

The first primary research questions examined the therapists' experience when incorporating substance abuse treatment with Parnell's adapted EMDR model when treating substance use disorders. The results indicate that they believed Parnell's EMDR model enhances substance abuse treatment and aid in processing the underlying issues that fuel the addiction behavior.

The second research question examined the therapists' experience in using addiction theories. The results indicated that therapists reported utilizing other addiction treatment modalities in conjunction with Parnell's EMDR model, such as motivational interviewing, internal family systems, and outside support groups such as AA, and find it helpful.

The third research question examined what therapists' find to be helpful in the process of integrating substance use treatments and Parnell's modified EMDR model. The results indicate resourcing to be very helpful when conducting EMDR therapy and integrating substance use treatments, even if there is not enough time allotted for a full EMDR session. Interpretation and the implications of these results will be further discussed in chapter 5.

Chapter 5: Discussion

Introduction

EMDR therapy is an extensively researched therapy approach used to treat trauma. However, few researchers have explored the substance abuse therapeutic approaches EMDR therapists use who have been trained in Parnell's (2007) adapted EMDR model (Parnell, 2007) when treating a trauma-related disorder in conjuction with a substance abuse disorder. In this study I aimed to explore the experiences of EMDR therapists who use Parnell's adapted EMDR model to treat trauma and substance use disorders. I conducted this study because substance abuse is a significant health problem in the United States and quality substance abuse treatment is needed to help fight the battle against drug addiction.

There were four themes that emerged from the interviews in this study. The first them was that participants reported spending a lot of time in the resourcing phase when utilizing Parnell's adaptive protocol treating trauma and addiction. This phase was reported as being extremely important due to the nature of treating addiction and triggers to substance use. Resourcing was reported to be important in regards to boosting clients' ego strength and acted as an aid to gage a client’s ability to deal with the intense emotions that can come up during EMDR therapy when processing traumatic events.

The second theme was that participants reported deviating from Parnell's Adaptive EMDR model when treating substance use disorders. Therapists reported incorporating somatic therapy techniques. For example, if a client could not come up with a negative cognition, a step in Parnell's protocol, some participants reported

instructing them to describe the body sensation the client is experiencing. Some therapists' skip the negative cognition part of the protocol altogether and some therapists incorporate internal family system therapy within Parnell's EMDR protocol. An example of this is asking the parts of the client's self if it is OK to proceed with EMDR therapy.

The third theme was that Parnell trained EMDR therapists incorporate addiction treatment models when utilizing Parnell's modified EMDR model to treat trauma and substance use disorders. All participants refer or recommend AA groups to clients, and two participants reported processing clients' AA step work with Parnell's EMDR protocol. Other addiction techniques used in conjunction with the EMDR include connecting the consequences with the behavior using bilateral stimulation and motivational interviewing.

The fourth theme was the participants' experiences with using Parnell's EMDR model treating triggers leading to substance use. Participants reported EMDR to be effective in reducing the triggers to use drugs. Triggers are reported to be reduced because EMDR is used to process the underlying trauma that fuels the addiction.

Interpretations of the Findings

Research Question 1

RQ1 was: What is the therapists' experience when incorporating substance abuse treatment with Parnell's adapted EMDR model when treating substance use disorders? Perez-Danieu and Tapia (2014) researched how Shapiro's eight-phase protocol differed from (TAU) among 12 individuals who were chronically dependent substance abuse users. The results of this study indicated that the TAU plus EMDR treatment group

showed drastic reductions in PTSD symptoms, an increase of self-esteem, and lower scores of depression, but not lower symptoms of addiction. This is contrary to the findings in my study. All 9 participants in my study reported that Parnell's adapted EMDR model enhances addiction treatment. They attributed this to processing the underlying issues that fuel the addiction behavior. Therapists reported that addiction may be a symptom of trauma, and when the trauma is resolved, then the triggers to use decrease. In regards to substance use, Participant 5 stated, "I have seen symptoms reduced and that is mostly because after reprocessing the trauma, they feel a less need for it." This is consistent with the Hase et al. (2008) study which showed there was a significant decrease in cravings for alcohol after treatment when compared to the TAU only group. They also reported that a modified EMDR protocol may be useful in improving relapse prevention and other forms of addiction. My study was based on Parnell's modified protocol and got similar results. The findings were also consistent with the conceptual framework, the information processing system developed by Shapiro. When a traumatic event happens, the memory network can be disrupted or may be incomplete and dissociation or negative feelings can interfere with the processing of the traumatic memories. Shapiro has contended that EMDR can assist in processing these memories and linking them to more adaptive information, aiding the person to store appropriate emotions with the memory (EMDR Institute, 2017).

Research Question 2

RQ2 was:What is the therapists' experience in using addiction theories? Hase et al. (2008) reported that more research is needed to help identify ways by which EMDR

can be used as a primary treatment or as an adjunctive treatment for clients who suffer from trauma and addiction. Researchers have reported a growing interest in integrating different therapies, but there is little research regarding which addiction therapy clinicians are integrating in their practice and whether or not it is working for the client (Abel & O'Brian 2010). O'Brian and Abel (2010) also suggested that there needs to be more research to help clarify ways in which EMDR can be used in combination with other substance abuse treatment models. The participants in this study reported the EMDR modified protocol was alone sufficient in treating substance use disorders; however, adding other addictions protocols to the treatment is beneficial.

Justus (2004) reported that EMDR therapy is useful for those who struggle with addiction and it helps alleviate shame and guilt stemming from trauma and other emotional triggers. However, Justus (2004) did not answer the question of which addiction theories and therapies were incorporated into EMDR therapy for addiction treatment. In an EMDR study, Marich (2010) interviewed 10 female alumni of a treatment facility over the age of 18 about their experience with EMDR treatment and recovery. They credited EMDR as being crucial to their continuing therapy sessions and noted that EMDR alone aided them to resolve core issues of their substance use. My study supports the findings of the Justus (2004) study and the Marich (2010) study, the difference is Parnell's modified protocol was used instead of Shapiro's eight phase protocol. During the interviews, therapists mentioned that EMDR alone does a good job treating trauma and substance use disorders. They hypothesized how this works. For example, Participant 4 reported,

> "OK, the thing is, is that any type of addiction any type of obsessive compulsive behavior such as cutting or whatever, it's not the symptom, there is always the underlying issue, they are self-medicating and they are medicating their emotional self-distress so when you work through the trauma, it's not driving them to use anymore."

Likewise, Participant 7 reported that "the addiction tendencies, cravings, intensity and all is reduced, if it for instance, if it's really linked with like a trauma, symptoms are sitting right underneath the propensity to do the addiction if the trauma is lessened, then the symptoms of addiction are."

The participants in the Marich (2010) study also participated in a 12-step program, and even though they found EMDR alone helped to resolved the core issues of substance abuse, 12 step was found to be beneficial in conjunction with EMDR. My study supports these findings. Even though Marich (2010) used Shapiro's original model, the findings in my study also indicated Alcohol Anonymous groups are helpful for clients in conjunction with EMDR sessions using Parnell's modified model. Therapists reported that it is helpful when clients incorporate and process 12 step work from their AA groups in the EMDR sessions, such as processing feelings of shame and guilt that is a result of substance use behavior. Participant 8 stated, "I think with AA especially I include the steps and see what step they are on and if they are stuck on a step we explore that and we do EMDR around that step and why they are stuck on it."

Abel and O'Brian (2010), the authors report there are research articles regarding EMDR being helpful in treating addiction, but there is not much research about working

with individuals who are in different stages of change when struggling with addiction. In my study, one of the therapist reported incorporating Prochaska and DiClemente's (1983) stages of change treatment model within Parnell's EMDR protocol and noted its benefits. For example, asking where the client is in regards to the stages of change and what keeps them at that stage; then processing the clients feeling about being in their current stage with bilateral stimulation.

Therapists in my study reported using a technique called *connecting the consequences*. Bi-lateral stimulation is used to process the consequences of drug addiction behavior. There is no research regarding the use of this technique; however, three of the nine participants mentioned its effectiveness. In sum, therapists in this study reported using other substance use treatment modalities in conjunction with EMDR therapy. These other treatment modalities include motivational interviewing/stages of change and outside resources such as group therapy or (AA).

Research Question 3

RQ3: What do the therapists' report is helpful in the process of integrating substance use treatments and Parnell's modified EMDR model? There is no research regarding what therapist report as helpful in the process of integrating substance use treatments and Parnell's modified EMDR model. This study aids in filling that gap. The described techniques therapists use during EMDR sessions is worth noting. In this study therapists report resourcing is very helpful when conducting EMDR therapy and integrating substance use treatments. When there are time constraints therapists report

solely using the resourcing part of Parnell's adapted protocol to increase clients ego strength.

The findings in this study suggest deviating from Parnell's protocol can be beneficial, for example, skipping a step in the protocol is ok if the client cannot answer the question that is a part of the protocol. Skipping the step may avoid an empathetic break between the client and therapist during a therapy session and may preserves the therapeutic relationship. The client may not understand the question and instead of stopping the process of EMDR therapy and explaining the question further, the therapist can skip the question and move on keeping them in the empathetic moment. For example, participant 1 reports "If someone can't generate an image or a negative cognition I'll go with body sensation or image." Participant nine reports "often times if the client cannot identify the negative cognition I just start the bilateral stimulation anyway and eventually the negative cognition makes itself is known in about 10 to 20 minutes". Therapists report liking Parnell's adaptive EMDR protocol because it is not a rigid protocol. One of the components in Parnell's adapted EMDR model is to skip stages in the original model in order to protect the therapeutic relationship between the client and therapist (Parnell, 2007).

Limitations of the Study

Limitations included small sample size. Due to the small sample size, findings cannot be transferred to the entire population of therapists utilizing Parnell's EMDR model. There were many different therapeutic substance abuse techniques mentioned in the interview, however, for this study, the techniques and themes that were most

discussed by the participants were reported. If there was a bigger sample size, other themes may have emerged from the data. Some therapist used elements of substance abuse theories but could not identify where these therapeutic techniques originated from when treating trauma and substance use disorders using EMDR therapy. The sample size was also biased as only Parnell trained EMDR therapists were interviewed.

The instrumentation was also a limitation in this study. The researcher developed the interview questions. Although the interview questions were peer reviewed, there was not a pilot study to test whether or not the questions accurately generate the information needed in this study.

Recommendations for Future Research

An increase in sample size would be beneficial in future research. Bigger sample sizes will allow other themes to emerge regarding substance abuse techniques used in conjunction with EMDR. Research comparing Parnell's EMDR protocol to other treatment modalities would also be beneficial. For instance, interviewing individuals who utilize Francine Shapiro's original EMDR model treating substance use disorders and Parnell's EMDR model and comparing the techniques used in conjunction with the differing EMDR protocols.

In this research, participants mentioned treating other addiction issues such as pornography and food addictions. Future research could include questions regarding a variety of addictions, not just substance use addiction.

Implications of The Findings

The findings in this study help increase the knowledge on what substance abuse techniques and theories work well with Parnell's modified EMDR protocol. Trained EMDR therapists would be interested in knowing the results when working with individuals who suffer from the effects of trauma and who have a substance use disorder.

The findings of this research are consistent with the theoretical conceptual framework, the information processing system developed by Francine Shapiro (EMDR Institute, 2017). When a traumatic event happens, the memory network can be disrupted or may be incomplete and dissociation or negative feelings can interfere with the processing of the traumatic memories. Shapiro believes EMDR can assist in processing these memories and linking them to more adaptive information, aiding the person to store appropriate emotions with the memory (EMDR Institute, 2017). EMDR processes traumatic events and individuals come to more of an adaptive resolution which may decrease triggers to use alcohol or drugs which were the findings in this study.

Those who are certified EMDR trainers may be interested in holding discussions in regards to these findings and open the conversation to trainees in order to discuss other addiction treatment techniques or theories they are using in conjunction with EMDR. Implementing an addiction protocol within the Parnell EMDR protocol would be beneficial along with conversations regarding the experiences of therapists who already do this in practice. The strategies may shorten the client's time in treatment and provide a strong foundation for therapists as they conduct therapy for dual diagnosed people.

None of the participants in this study had a negative outcome regarding the EMDR treatment combined with a substance use technique. However, this doesn't mean a client will never unravel and decompensate after treatment. A specific EMDR protocol which combines Parnell's model and addiction treatment would be beneficial. Parnell's EMDR model is adaptive to individual clients and is not as rigid as Shapiro's protocol thus discussing techniques that aid the therapist when a client is stuck in the process and not able to move through the emotions; would be of great help. A specific protocol would be beneficial because safeguards and peer support can be addressed in the training sessions. This is essential as this treatment is intense in nature and if not done correctly, an individual may get emotionally overloaded and decompensate. This protocol should be taught by well trained instructional EMDR therapists who have a lot of experience in the field and there should be regulations regarding how much experience one should have before implementing this type of therapy to help prevent decomposition of a dually diagnosed client.

Conclusion

This study was a narrative study investigating the experiences of therapists who incorporate substance abuse treatment with Parnell's adapted EMDR model when treating substance abuse. A review of the existing research shows a gap in knowledge regarding what substance abuse therapy is being used in combination with EMDR among trained EMDR therapists, especially those therapists who follow Parnell’s adapted EMDR protocol model. More research is needed to help identify ways by which EMDR can be used as a primary treatment or as an adjunctive treatment for clients who suffer from

trauma and addiction. This study provided a deeper understanding of what types of addictions therapies are being used in conjunction with Parnell's EMDR model.

The findings in this study conclude that participants perceptions of Parnell's EMDR model, combined with addiction techniques, are beneficial in treating those with trauma and substance use disorders. Helpful EMDR techniques were discussed along with the incorporation of substance use treatment models within the protocol. This study provided practical information on how to better treat dual diagnosed clients using Parnell's EMDR model. This study is also a catapult in the development of ideas for treatment guidelines when treating trauma and substance use disorders with EMDR and the incorporation of addiction models.

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Appendix A: Screening Questions

1. Have you completed EMDR training and do you use it to treat trauma and substance use disorders?
2. Do you use Shapiro's original model of EMDR therapy or Parnell's modified EMDR protocol?

Appendix B: Protocol

Interview Protocol: Evaluating Theoretical Treatment Modalities and EMDR Therapy

Time of Interview:

Date:

1. What is your primary theoretical orientation used in your therapy sessions and why do you use it?
2. Which types of addictions have you treated using EMDR?
3. What addiction therapies do you typically use and find most effective or most ineffective and why?
4. What conditions do clients need to meet for you to feel comfortable to use EMDR therapy?
5. How do you know the therapeutic relationship with a client is strong enough to handle EMDR therapy treating trauma and substance use disorders?
6. Do you deviate from the adapted EMDR protocol developed by Laural Parnell when treating a client with a dual diagnosis of trauma and substance use disorder, if so how?
7. Do you incorporate substance abuse treatment methods with EMDR treatment, if so how?
8. What addiction treatment would you recommend using with the adapted EMDR model and why?

9. Does the modified EMDR model enhance addiction treatment, if so how?
10. When using EMDR to treat a client with a trauma and substance use disorder, are symptoms of addiction reduced after treatment, if so, what do you contribute this to?

Appendix C: Research Questions and Themes

	Research Questions	Theme Number
RQ1	What is the therapist's experience when incorporating substance abuse treatment with Parnell's adapted EMDR model when treating substance use disorders?	4 The participants experience with using Parnell's EMDR model treating triggers leading to substance use. Participants reported EMDR to be effective in reducing the triggers to use drugs. Triggers are reported to be reduced because EMDR is used to process the underlying trauma that fuels the addiction.
RQ2	What is the therapist's experience in using addiction theories?	3 Parnell trained EMDR therapists incorporate addiction treatment models when utilizing Parnell's modified EMDR model to treat trauma and substance use disorders. All participants refer or recommend AA groups to clients and two participants report processing clients' AA step work with Parnell's EMDR protocol. Other addiction techniques used in conjunction with the EMDR are connecting the consequences with the behavior using bilateral stimulation and motivational interviewing. 2 Participants report deviating from Parnell's Adaptive EMDR model when treating substance use disorders.
RQ3	R3: What do the therapists report is helpful in the process of integrating substance use theory and Parnell's modified EMDR model?	1 Participants report spending a lot of time in the resourcing phase is helpful when utilizing Parnell's adaptive protocol treating trauma and addiction. This phase was reported as being extremely important due to the nature of treating addiction and triggers to use substances.