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APPLICATION OF EMDR THERAPY IN THE TREATMENT OF A HEROIN ADDICT - CASE REPORT

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INTRODUCTION

Every day we try to understand other people. Determining why another person does or feels something is very difficult. The truth is that we cannot always understand why we feel or behave in a certain way. It is difficult to get an insight into what is considered normal, expected behavior, and it is even more difficult to understand human behavior that does not fit into the normal (Davison & Neal 2002). One type of such behavior, which contains determinants of abnormal behavior, is the use of psychoactive substances.

The addiction to psychoactive substances is not a discovery of modern society. Through the history of the human race, there has been an inexplicable desire to change the state of consciousness. However, addiction today has been constantly increasing and it seriously impairs physical and mental health, reduces working ability, changes personality traits, shortens life duration, and in many cases ends fatal to life (Petrović 2003).

It is manifested as a chronic, relapsing disorder, followed by behavior directed towards seeking and taking the drug, loss of control in taking a psychoactive substance, and the occurrence of a negative emotional state when access to the psychoactive substance is disabled.

The group of experts from the World Health Organization (WHO) defined the dependence on psychoactive substances as: "The state of periodic or chronic intoxication, harmful to the individual and the society, caused by the repeated taking of natural and synthetic substances" (World Health Organization 1957).

According to recent WHO experts thoughts, addiction as a disease is defined as: "The state of physical or psychological or the state of both physical and psychological dependence caused by the constant taking of one or more types of psychoactive substances and the impossibility of abstinence and the existence of craving the use of a psychoactive substance."

According to the American Diagnostic Manual (DSM-IV), addiction to psychoactive substance is defined as: "*Maladjusted behavior associated with the use of psychoactive substances, which significantly leads to damage of the organism or subjective problems, and is recognized based on three (or more) criteria, if they occur anytime in a one-year period."*

The development of addiction is influenced by various biological, psychological, and social factors. Psychological characteristics of users, physical characteristics of users which create susceptibility, the very nature of the psychoactive substance, cultural and social environment, and the availability of substances are of great importance and affect the development of this complex problem.

Special emphasis is placed on the psychoactive substance of heroin. It is thought to be the most dangerous psychoactive substance, with the strongest feature of addiction, which is a few days creates a strong physical dependence. It is rarely the substance with which one starts, so its effect is almost always a cumulative damage previously done to the body. The consequences of chronic heroin use are strong physical and psychological addiction, heart and lung diseases, neurological disorders, infection with non-sterile supplies: HIV, hepatitis C, liver cirrhosis, liver cancer, overdose, and death. The rate of mortality among heroin addicts is 13-17 times higher than non-addicts of the same age, while the risk of suicide is 14 times higher (Lind et al. 1999, according to Radetic Lovric 2011).

EMDR therapy is used to treat a large number of psychological disorders and problems that are based on traumatic experiences. The addicts have multiple traumas also due to their long-time addiction, which makes the treatment very complex and requires longer therapeutic work. There are scientific arguments that show the benefits of EMDR therapy in dealing with addicts and various traumatic experiences (Chen et al. 2019).

Much research has shown that EMDR can be used to help recover from addiction. The challenges with this population can be daunting, and for many years EMDR therapists were encouraged to wait to do any trauma work until the client had months of recovery. This perspective has been found to be untenable in that, because the unprocessed material often fuels relapse, demonstrating the need for concurrent treatment of addiction and trauma (Miller 2014).

The standard EMDR protocol for treating addictions involves reprocessing the earlier (traumatic) memories that set the basis for the dysfunction (including contributing elements to the development of addiction), the present triggers that activate disturbance, and the development of future templates for more adaptive

behavior, which is essentially a form of relapse prevention for this population (Shapiro et al. 1994, Hase et al. 2008).

In addition, EMDR is used to incorporate new coping skills and assist in learning more adaptive behaviors (Shapiro et al. 1994).

After the war in Bosnia and Herzegovina (BH) (1992-1995), a lot of people developed different mental health problems after numerous severe trauma experiences, and mental health workers were in need to increase their professional skills, to help their patients as better as possible. EMDR was introduced in Bosnia and Herzegovina during cooperation with Professor Syed Arshad Husain and his team in Missouri University1998 just three years after the finished. With the help of Humanitarian Assistance Project (HAP) of UK & Ireland, Trauma Aid UK led by Sian Morgan helped with their enthusiasts to train BH mental health professionals in EMDR, so the first training was organized in 2009, and in 2014 Association of EMDR Therapists in Bosnia and Herzegovina was established (Hasanović et al. 2018, 2021).

The aim of this paper was to present the effectiveness and effects of using EMDR in dealing with a heroin addict.

CASE REPORT

Patient information

In June 2017 a patient (34 years old), a long-time heroin addict, was treated for drug addiction in the Therapeutic Community. The second child of a total of three children in the marriage of his parents. He has an older and younger brother. His father died in May 2013, when the patient was on treatment in the Therapeutic Community. He started with substance abuse at the age of 15, so the past was permeated with various traumatic experiences. He began to use heroin when he was 19 years old, every day by intravenous application. He had several overdoses, the last one in June 2016. He was in the same community in 2013, where he completed the treatment. Having left the community, he maintained the abstinence of psychoactive substances, but continued to consume alcohol and relapsed to heroin use after 2 years.

As a result of many years of addiction, recidivism, and imprisonment, the patient comes for another treatment in a very complex situation and with numerous traumatic experiences. The most prominent symptoms are anxiety, low self-esteem, feeling of guilt, and antisocial behavior. There is no social support network.

Evaluation of a traumatic event

The client lists 10 very disturbing events. During the EMDR treatment, the two most disturbing traumatic memories were targeted and reprocessed. One situation relates to one of his brothers and the other to the father. A total of 11 EMDR sessions were realized. A standard EMDR protocol is used.

EMDR treatment procedure

The application of EMDR started after 10 months of community stay, where he was involved in an intensive treatment and managed to establish abstinence. Due to the mentioned period, the EMDR preparation phase lasted 2 meetings, where the Safe Place exercise was done. During the creating of resources, he was trained to use persons in treatment as a source of support.

Target 1

The first disturbing target is the older brother with whom he has had a bad relationship and has not communicated with for a longer period due to his addiction and the last relapse. The patient said that there were various situations involving his brother and many negative experiences in relation to him, but he thinks that this is because of his addiction, and he feels shame, guilt and feels that he is not worthy. At the assessment phase, we made a float back and the client stated that he had always wanted to be with his brother, but his brother had always pushed him away from himself. So he came to the earliest situation which we took for the target.

At that time, the client was 6 years old, and there was a situation when he was on a bicycle with his brother and his brother's friend, but his brother did not let him go with them and ride a bike, instead he left him alone. He says he feels like "trash." The image that represents the worst part is when "he remains on his bike and watches his brother and his friend go out to ride a bike, and he remains alone." For negative cognition, he chose "I'm not good enough." As a positive cognition, he chose "I am good enough."

The validity of positive cognition for him was VoC = 7. He expressed a sense of sadness, humiliation, and not belonging. On the subjective disturbance scale, the score is SUDs = 5.

He placed this feeling in the lungs, and he feels anxiety, pressure. During the desensitization phase, finger movements were used. Only during one session tapping was used for short, because the client complained of eye pain and dizziness. The client reported that the eye movement processing was better for him.

During the processing, the following emotions were exchanged: sadness, helplessness, disappointment, pity, until the last session where he felt sorry for everything and expressed: "What a fool. I'm sorry I was stupid and I thought so."

During reprocessing, the patient expressed prominent and strong body sensations: pain in the stomach, chest, feeling as if he would explode. Images

and body sensations interchanged in a way as to be intensely disturbed at one point, then a certain image would cause relief, and the next one caused disturbance again. During the desensitization phase, he brought back the image when he, as a little boy, fell into the water, and it was winter and he was drowning.

The first two sessions were not completed because we worked for 90 minutes each session. Because of the lack of time, as well as the assessment of the disturbing content, they were closed as incomplete. Checking the disturbing content of the second session was quite intense SUDs = 8. Between the sessions, he had intense dreams, irregular sleep, even two to three days after the first session. He reported tilting of his stomach, as if a nerve got inflamed and moved constantly, and when someone touched him, he jerked immediately. After a session, he felt tired, nervous, upset. In the meantime, he had a retrial, so there was a disturbance, but he could not distinguish if it was because of the reprocessing or the trial itself. During the third reprocessing session, there was a feeling of peace, relaxation, there was no disturbance.

After the completion of the desensitization phase SUDs were 0, and then the installation was carried out. We did a body scan and no presence of body sensations was detected. During the fourth session, we did a check on what happened after the session. The day after, he felt nervous, and there was insomnia and dreams that he usually does not remember. We talked about his brother, but the client reported that there was no disturbance: "I feel good." A check was made, but there was no content for reprocessing, there was no disturbance.

The client did not feel disturbed when he talked about his brother, he said that he understood the other side and began to accept his brother as he was.

It took 4 sessions for treating this target, and the whole network of disturbances and negative experiences in relation to the brother was cleaned.

Target 2

The second disturbing target is the father. Although the patient reported at the beginning that a disturbance was caused by the disease and death of his father, during the assessment, the patient reported a situation that caused the most disturbance. It was a car accident that he had caused, but his father did not show any concern, and immediately criticized him. Again, we did a float back and then he got to the earliest image, which caused the same feeling and distress.

The patient was 5 years old, and it was a situation when he ran home fearfully to call his father because the brother was supposed to fight with another boy whom the client considered stronger, even though they were peers.

Frightened for his brother, he ran home in fear to call his father for help, but his father did nothing.

The image that represents the worst part is when the father said: "They are peers. Why they fight when they do not know.", and he showed indifference and did not react to the client's expectations.

For negative cognition, he chose from the list "I cannot trust anyone". As a positive cognition, he chose "I can choose who I trust". He thinks that all people are not the same, and that everyone has some reason. The validity of positive cognition for him was VoC = 4. He said he felt disappointment, sadness. On a scale of subjective disturbance, he gives a rating of SUDs = 9. This feeling was placed in the lungs, the bone in the chest, throat, and verbalized that he was perspiring. Eye movements were used during the desensitization phase. The following emotions and body sensations were exchanged: nervousness, severe breathing, chest pain, stomach pain, anger, anxiety.

In the second session, the client changed negative and positive cognition. For negative cognition, he chose "I am a disappointment." As a positive cognition, he chose "I'm good just as I am".

During the reprocessing, the client had prominent and strong body sensations: nervousness, restlessness, stomach burning like on fire, chest pain, anger, distress, dizziness.

Three sessions were closed as incomplete because the disturbing content was still present (SUDs = 6), and each session was done for 90 minutes. Between the sessions, he had intense dreams, stomach pain, headache.

In the fourth session, he verbalized that he felt improvement in functioning, that he understood things that had been happening, and that that did not cause a disturbance at the moment, he got the opportunity to think differently. During the previous session, he had an image from childhood, so a few days after reprocessing, he went to that place, and verbalized that he felt very slight distress. This session began with an estimate of SUDs = 1.

During the desensitization phase, he came to the image of the first grade of primary school and returning from school, when no one came for him. He was afraid to go home alone, he felt irrelevant, that they had forgotten him. At the same time, he felt the fear that something had happened to the parents. What happened was that his father followed him all the way to see how he behaved, and after arriving home he bought a chocolate for him and everyone praised him. The client felt happiness, joy, and stated that he still had this feeling of happiness. As it was estimated that there was no disturbance (SUDs = 0), we did the installation. We did a body scan and no presence of physical sensations was detected.

During the fifth session, we did a check on what happened after the session. A check was made, but there was no content for reprocessing, there was no disturbance.

Five sessions were needed to handle this target. In the following period, the father's death and saying goodbye to his father before death must be done.

DISCUSSION

The use of EMDR therapy in dealing with the heroin addict in this case report indicates significant positive outcomes. The client feels good, there is an increase in self-confidence, the feeling of guilt is reduced, as well as anxiety. The achieved treatment effects positively reflect on his functionality, especially in relation to recovery from addiction, but also in family relationships and the social environment. The result of this processing is solving a network of negative experiences concerning the brother. Reprocessing contributes that the patient feels better, now certain behaviors are clear to him and also what he did in the past. There has been a change in the client's insight into his own problem and the difficulties he is currently facing. The effects of processing have shown to be positive for the client also in his work on the chosen target concerning the father. This target has not been completed because there is a plan to go through the loss of the father, as well as saying goodbye to the father before death, which was not done because he was on the treatment in the therapeutic community.

Although addiction behaviors are multifaceted EMDR can be used to treat addictions. EMDR therapy has been successful with addiction disorders. Hase and colleagues (2008) provide evidence to support the successful application of EMDR in addiction. Marich (2009) illustrates EMDR in the addiction continuing care process with a case study. In this case study, a female addicted was able to achieve 18 months of sobriety and important changes in functional life domains after applying the EMDR.

The study that investigated the effects of standard EMDR protocol in 12 chronically dependent patients, suggests that PTSD symptoms can be successfully treated with standard EMDR protocol in substance abuse patients (Beatrice & Tapia 2014).

Among the psychological interventions, EMDR remain as one of the effective therapies. A relatively small but growing literature indicates that EMDR may be an effective adjunctive treatment for substance abuse (Abel & O'Brien 2010). Zweben and Yeary (2006) reported on the potential uses of EMDR in addiction treatment. When combined with traditional addictions treatment approaches, EMDR can enhance client stability, prevent relapse, and promote recovery (O'Brien & Abel 2011).

CONCLUSION

The use of EMDR in the presented case was effective in overcoming psychological, cognitive, and behavioral symptoms. The addicts may have multiple traumas due to their long-time addiction that makes the treatment very complex and requires longer therapeutic work. Also, there are traumatic experiences that preceded the addiction. EMDR helps in treating addiction also by using standard protocols and resolving previous traumatic memories. The application of addiction protocols is recommended in the treatment of opiate addicts, and then the use of the standard protocol for other targets.

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