

## **DeTUR™**

### **(Desensitization of Triggers and Urge Reprocessing)**

#### ***A New Approach to Working with Addictions and Dysfunctional Behaviors***

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This eclectic treatment model and the theories involved are based solely on experience from *personal client observation and anecdotal reports* received from other therapists using this same protocol. It is an eclectic model and combines many methodologies, including but not limited to, cognitive-behavioral, solution focused, Ericksonian, narrative, object relations, NLP, The AIP model of EMDR, etc. The bi-lateral stimulation seems to form the catalyst for rapid processing and change, the turbo-charger that speeds the healing process.

Successful results have been reported across the spectrum of addictions and dysfunctional behaviors: chemical substances (nicotine, marijuana, alcohol, methamphetamine, cocaine, crack, heroin/methadone, etc.), eating disorders such as compulsive overeating, anorexia and bulimia, along with other behaviors such as sex, gambling, shoplifting, anger outbursts, and trichotillomania, etc. As new information becomes available, it is incorporated into the protocol.

*This protocol only represents a small part of a complete treatment model.* The therapist role is that of a case manager, orchestrating any/all resources necessary to aid the patient through recovery to a successful and healthy state of functioning and coping. The therapist must be able to assess severity of the addiction and determine any other diagnosis associated with the case. This model includes referrals for, medication, and testing for physical or neurological problems. Also included is consideration regarding detox, either in or out patient. Other outside resources include support groups, such as 12 step groups, education, skills training, couples, group, or family therapy. Many in this addictive population are dual diagnosed and can therefore run the full dimensional spectrum of disorders as called out in the DSM-IV. There are comorbidity issues, day-to-day stressors and survival issues that need to be addressed along with other problems such as the need for food and shelter.

There is no “one size fits all” solutions exists for these problems, therefore this protocol is flexible in order to be tailored to each individual client’s needs, goals and values. The therapeutic process is necessary in order to address client core traumatic events/issues underlying their psychological addiction. Since each therapist operates differently, the therapeutic interweave and interventions utilize the therapist’s training and style, evolving continual client feedback, thus aiding clients in the processing of each step through completion of any/all core or causal issue. The bi-lateral stimulation in the

accelerated information processing model is the catalyst and accelerator for uncovering and processing of core events/issues through to completion in order to prevent relapse.

There are several significant differences in this treatment approach:

- (1) Client's attention is directed towards a positive, attractive, achievable, compelling goal of coping and functioning, **NOT**, *away from a negative behavior*.
- (2) Abstinence, though highly recommended is not required in the definition of the treatment goal; coping and functioning in a positive manner as described by the client is the treatment goal. It is their therapy.
- (3) Relapse is reframed from failure to new *targets of opportunity* to be addressed in following sessions.
- (4) Chemical withdrawal and anxiety *appear* to be addressed since the process seems to take place out of the client's conscious level of awareness, not requiring constant attention on the part of the client. Clients often report surprise that at the end of the day they had not engaged in the negative behavior, had--but not as often, or had noticed urges to engage and could put them aside.
- (5) Targeting the individual triggers for desensitization allows this model to be used with clients early in recovery.

There are similarities and differences between this treatment protocol and the EMDR protocol. The EMDR protocol addresses affect and known traumatic issues. It utilizes positive and negative cognitions. The DeTUR protocol addresses triggers and uses positive body states. Where EMDR uses SUDs and VoC this model uses only Level of Urge (LOU) as measurement. Both use bi-lateral stimulation and installation of the positive, and require a thorough history taking, assessment and diagnosis for insuring client safety before starting treatment. This protocol addresses present and future and addresses past as it opens up. The EMDR protocol addresses past, present and future.

Initially, it was not considered advisable to use EMDR, or any type of therapy on addicts early in recovery. Work on any traumatic issues was not done until they were stable and had a long period of abstinence. The concern was that an emerging traumatic event might be too overwhelming for the client to handle and cause the client to relapse, binge or over-indulge.

With the desensitization of each triggers and the installation of the positive treatment goal the client's ego strength **seems** to grow to a point where threads open leading back to core issues (if they arise) but only after sufficient ego strength is built. Once desensitized triggers are no longer the stimuli for using. Instead the triggers are connected to the new response, that of the treatment goal.

- **NOTE! DESIRE & COMMITMENT TO TREATMENT PLAN**

It is important that the client be committed to complete the therapy. He/she should be made aware that rapid improvements, though satisfying, do not mean that the treatment is complete. These fast results sometime lead the client to believe they have been "cured" and prematurely to drop out of treatment. For treatment to be successful

triggers that bring up urges must be desensitized and core events/issues reprocessed to completion. Consider the stories of individuals diagnosed with bipolar disorders, that, when feeling good decide that they no longer need medication and discontinue using it thus obstructing their progress.

**As in any therapeutic process, all standard client cautions and safety issues should be addressed.** Most of the addictive population have dual diagnoses. One should have competence working in these areas. Before attempting the use this protocol the therapist should advise the client of the process and the possibility of strong emotional issues that might emerge, introduce them to the stop signal and all other precautions as explained in detail during the level I and level II EMDR trainings and in Dr. Shapiro's book (*Eye Movement Desensitization and Reprocessing, Basic Principles, Protocols, and Procedures*). My clients report that the train metaphor to be very helpful, that they can sit back and just notice scenes, memories, etc. flash by, letting whatever happens happen without holding on to anything, without trying, analyzing, or judging. They also report that the onion metaphor, peeling away of layers helps them to understand the process. Several California clients have suggested that the onion be replaced by an artichoke in order to get to the heart of the matter.

## **PROTOCOL STEPS**

- 1. RAPPORT**
- 2. HISTORY, ASSESSMENT, DIAGNOSIS**
- 3. SUPPORT RESOURCES**
- 4. ACCESSING INTERNAL RESOURCE STATE**
- 5. POSITIVE TREATMENT GOAL**
- 6. ASSOCIATED POSITIVE STATE**
- 7. IDENTIFY URGE TRIGGERS**
- 8. DESENSITIZE TRIGGERS**
- 9. INSTALL POSITIVE STATE TO EACH TRIGGER**
- 10. TEST & FUTURE CHECK**
- 11. CLOSURE & SELF WORK**
- 12. FOLLOW ON SESSIONS**

### **1. RAPPORT:**

The foundation for trust in any relationship is rapport. It is the high level of trust the client feels with the therapist causing the safe therapeutic relationship. One of the most important characteristics of a therapist is the ability to gain the trust rapidly with the client, and to maintain it throughout the therapeutic process. Rapport allows the therapist the right to ask questions and to elicit appropriate answers. This is crucial for the following steps in this model.

## **2. HISTORY:**

As in any therapeutic setting a detailed history is mandatory. Testing for dissociative disorders and or any other DSM-IV disorders insures that the therapists know what problems might arise and have the necessary skills, competencies and/or referral base to handle situations that might arise. I have clients complete the DES, Beck depression inventory, and the Lazarus Multi-modal forms and review them before the history taking session. I find a genogram useful to detail information about family of origin, relationships issues, their present status, previous problems, and previous therapeutic relationships, state of health, medications, and then their drug or addiction history. When did they start, why, acceleration of use, what do they get out of it, single or multiple use, problems it causes, reasons for quitting, (they or others), how motivated are they to quit, what will it get them, and how else can they get the same results. How many times have they quit, what worked and what didn't. Look for possible secondary gain issues that might have to be addressed.

In addition to standard history and cautions, asking open-ended questions (how long, what made them start, what do they get out of it now, how often, earlier attempts, success and failures, secondary gain, blocking beliefs, and negative internal dialog regarding their unsuccessful attempts) will reveal client patterns, communication styles and decision-making criteria. Listening for key words, phrases, patterns, and belief systems reveals useful insight for metaphors, reframes, etc. for use in interventions in the therapeutic interweave, be it narrative, cognitive, psychodynamic, whatever the therapist's style. This is extremely useful for individual therapeutic interventions when nodes open to emerging events relating to core issues.

## **3. EXTERNAL SUPPORT RESOURCES:**

Clients need a safe environment to express their thoughts, feelings, fears, etc., a place where they can openly and freely speak their mind, be heard, and get feedback that is honest, supportive, non-judgmental and not critical. When things get tough, as before relapsing, they need someone to talk to, or even to be able to hear themselves speak their thoughts out loud.

12 step groups, AA, NA, CA, RR-Rational Recovery, MM-Managed Moderation religious organization, fraternal organization, women's or men's groups, family, friends. These groups should be supportive, non-judgmental, and flexible to clients needs, not the group process.

## **4. ACCESSING INTERNAL RESOURCE STATE:**

Most therapy sessions start with the therapist asking the client "What's your problem?" This seems to place the client into the problems and bring out the feelings of powerlessness that accompany their problems. Beginning each session by asking clients about their problems seems to focus their energy on the problem and place them into the physiology of powerlessness. I learned this procedure after watching Robbie Dunton work with children. I noticed that she always asked them what they liked and did best, and

then did eye movements with them. Their entire physiology shifted. They appeared more energized and were smiling.

I now have clients recall a time when they experienced feelings of being resourceful, powerful and in-control and direct them to those to notice the powerful feelings, and then use eye movements (EM) to strengthen these powerful feelings. This appears to empower clients and allows the process to move faster.

Clients might be only able to momentarily bring up something positive and then immediately the scene shifts to a negative component. The trick here is to have them freeze the experience and only focus on the positive element before doing eye movements. Some therapists report that their clients are not able to think of anything positive in their life to concentrate. Some examples you might try with them could be; participation in sports, any task accomplishment, even washing/shining a car, feelings when their favorite team won an event. Creativity and flexibility is the key in these difficult situations.

Problems: they can't identify a time.

Use someone else they respect, movie, TV, or book here

## **5. POSITIVE TREATMENT GOAL (PG):**

It is important that the treatment goal be defined and owned by the client. It is their therapy, therefore their goal. Abstinence, though highly desirable is not required as a necessity in the definition of the treatment goal. The positive treatment goal should be attractive and achievable, one that has a magnetic pull that they can easily maintain their focus on. I use their definition of how they would look coping and functioning successfully in a positive manner. There are many stories of women giving up smoking and drinking because the attraction of having a happy, healthy child was more appealing than the need or compulsion to use. Their goal was one they could maintain their focus. There are also stories of veterans that were shooting heroin while in Vietnam, and were able to walk away from the addictive component when they returned stateside. Other "things" became more important - enjoyment and functioning successfully became their focus.

Help clients identify their positive treatment goal.

What would it get them?

How they would know when they got it?

What would they be seeing, hearing feeling, tasting, smelling, etc.?

Guide them through the specifics until they can create a clear image of how they would look being successful and fully functional, having attained their goal. Their goal does not have to include abstinence. It will be implied. Although abstinence is requested, it should not be part of the goal. It is very difficult concentrating on NOT doing something. It is important that their goal must be achievable within a reasonable not too distant future, not a fantasy.

I have the client imagine seeing a picture of themselves having already achieved their

goal. Although initial descriptions are often stated in the negative, e.g., “I won’t be....,” or “I won’t have to....” My next question then becomes if you won’t be....., or won’t have to..... What will you be doing instead? This sometime takes considerable effort guiding them to the right path and maintaining them on track. Remember it is difficult to “not” do something (*don’t think of a pink elephant*). The challenge is to guide them to describe their positive goals in *positive, concrete, sensory-based* terms. After assisting them in building their picture, ask if this is really what they want? Does it have a strong pull to it? Make any adjustments to make it more appealing, does it feel better if they make the picture bigger, clearer, brighter, bring it closer, and add sounds? If the client is a smoker worried about gaining weight, be sure they see themselves looking the way they want to look, perhaps in a special outfit (the same for weight loss clients, inches are more important than pounds). When the picture has the strongest attraction and feels best to them use eye movements (EM) to make the goal more compelling and attractive. This positive goal is the treatment goal, the focal point of the treatment plan. Remember they are seeing themselves and are dissociated from the actual experience.

time related

reasonable

achievable

attractive, magnetic, compelling

## 6. POSITIVE STATE (PS):

The next step is to have them associate with their goal. Give them the experience of how it would feel to successfully achieve their goal, and then using associative representation, anchor the experience into their physiology. Visualization and concentration on positive feelings has been around for quite a while. Norman Vincent Peale, Bernie Shapiro, Deepak Chopra, Maharishi, has written up this philosophy.

**Anchoring or Conditioned Response:** is a process of being able to replicate the physiological experience associated with an emotion or state by linking it to a physical representation (slight finger pressure). I exert slight pressure on a knuckle as the representation (after obtaining permission). I chose the knuckle of the little finger since it seems to be the least intrusive.

The client is directed to step into their picture of their positive goal, into that body posture, (*as-if state*), breathe into the feeling, move around in it, experience being successful, associating with what they would see, hear, and feel, smell, and taste, functioning successfully (the physiology of success). The PS, through a technique anchoring it into their physiology.

### **Installation of the positive goal into the positive state.**

Have the client bring up a clear picture of their positive goal, notice what they would be seeing, and then step into the picture, into their body. Have them notice and experience the positive feelings and then apply slight finger pressure to the knuckle (anchor). Then lead them through picture-feeling changes to increase the good feelings.

Visual adjustments: I ask them to make adjustments to the visual components as; brightness, focus, contrast, tint, size, distance, etc. and report on the change in internal feelings, and increase pressure slightly to that same place on their knuckle as the feelings peak. While I am utilizing the anchor have them do eye movements. This strengthens the mind-body link through the representative touch.

Auditory adjustments: Repeat the same process except using sounds, listening to the positive words or sounds they would be saying to themselves and what others would be saying, and then adjusting the auditory components as, volume, tone, tempo, balance, etc. and as the association with success peaks, apply the anchor touch, and do eye movements to further anchor the feelings of success into their physiology. Test the positive state by having the client touch their knuckle and notice the results. They should report a pleasant experience.

**It is important for the client to have a strong, positive, sensory based experience of having successfully achieved their goal, set and anchored into their physiology.**

## **7. IDENTIFY THE KNOWN TRIGGERS:**

During this step we want to identify the triggers that bring up the urge to use. How do they know when to engage in the dysfunctional behavior? These triggers are learned adaptive responses that relieve the discomfort and anxiety associated with earlier traumatic episode(s) and allows them to cope with life. These triggers could be a *place, person, time, emotion, smell, taste, event, action or object* that are linked to the biological envelope surrounding the trauma(s). These triggers are associated with whatever they are noticing at those times they get the urge to use.

I will step the client through the process to pinpoint the specifics of each trigger and then label them for the next step in desensitization. For example if a smoking client reports that he/she gets the urge with morning coffee, after meals, and with drinks I will mark them with **t<sub>morning coffee</sub>** **t<sub>meals</sub>** and **t<sub>drinks</sub>** For those with weight problems the triggers should represent those times when they eat larger portions, wrong type of foods, unnecessary snacks, etc. After compiling the list of known triggers I prioritize them in the order of what seems to be important, weakest to strongest. My theory is that if I begin with the weakest client ego-strength will build as the triggers are desensitized and the positive state installed.

## **8. DESENSITIZING EACH TRIGGER:**

The client identifies a picture representative of the trigger, along with any words, tastes, and smells etc. that go with it. I ask them to bring up the picture along with all it's associations and report the strength of the urge, Level of Urge (LOU), at the time, measured from 0 to 10, where 0 is nothing and 10 is the strongest. I then have them

associate the LOU with a body location (Where are you feeling that # in your body?) I then ask them to hold the picture along with all the associated words, tastes, smells, and to notice what and where they are feeling the urges in their body and begin the eye movements. After each set of EM I ask; *what are you getting now? Or what's coming up now? Or what are you noticing now?* I record their answer and reply; Go with that, or concentrate on that, or Think about that and have them do EM again. This is repeated until the desire drops to 0 (LOU=0). This can be thought of as cutting the wire between the stimulus and the learned dysfunctional response. If the client's answers seem to be looping or going off track I will return them to target trigger and ask for the new LOU. I then have them tie the number to a body location and begin EM again.

If the client reports no change between sets the therapist should try the following changes until the client again reports changes:

- a. Increase the width or distance of the eye movement
- b. Increase the speed (especially if they are intellectualizing)
- c. Increase the number of movements
- d. Change direction
- e. Change to taps or sounds

***Note: If another node opens up, I will follow it through to completion, sometimes switching to the more standard EMDR protocol if it leads back to core issues, as taught in the Level I and Level II training.***

When to go back to target triggers:

- After long conversations
- when lost or confused
- when you feel that the LOU=0 or close to 0

**The therapist's' style, training and experience should be used to create a therapeutic interweave for the client's situation at the appropriate time.**

It is during this desensitization process, where the therapists' individual style and skills are required, when the client get stuck, loops, abreacts, or other nodes open up. The cognitive or therapeutic interweave as taught in the level II training is the therapist's best tool to aid the client during this desensitization or reprocessing phase. It can be administered either between sets or during the set while the client does the eye movements. I find it to be more powerful when the client is doing the EM.

When the client reports a LOU=0 have him/her think about it and do another set of EM.

## **9. LINK AND INSTALL POSITIVE STATE**

This step installs the positive state to the triggering urge. Similar to the stimulus-response mechanism, this is replacing the using response with the positive response that has been anchored and set into the individual's physiology. Whenever the stimulus is activated the response of positive state of being comes up. It seems that this step allows

the process to take place out of the level of awareness and enables client to be more withdrawal free.

Have the client bring up the previous triggering incident again and apply slight pressure to the knuckle (♯) while doing a set of EM. Whatever positive feelings or statement the client reports after the set, have them hold it and do another set of EM. If the client's report is negative then most likely another channel has opened up and needs to be addressed.

#### **10. TEST & FUTURE CHECK**

To test the installation have the client bring up the trigger again and ask for the LOU. If there is any remaining urge repeat the desensitization process. If the LOU=0 have the client imagine a time in the future and check the LOU again. If the client reports LOU=0 have them think about it and with the anchor do another set of EM.

#### **11. REPEAT STEPS 7 & 8 FOR EACH TRIGGER:**

#### **12. CLOSURE & SELF WORK:**

Remind the client that the process continues after the session is over and that they may or may not experience new thoughts, memories or experiences, that they can contact you if necessary and if they notice anything unusual to make a note of it for the next session.

If they feel any urges, notice what and where they are feeling them. Pick a spot on the wall, and move their eyes rapidly back and forth until the desire fades; then think about the urge again, press their knuckle while doing the EM. If the urge continues have them contact their sponsor or support group. If they do use **remember this is not relapse**. It is new information emerging; make a note of it so it can be used to work on during the next visit. It is important that clients do not feel they failed.

#### **13. FOLLOW ON SESSIONS:**

At the beginning of each session check for:

- Any new information.
- Previously desensitized triggers.
- Relapse

If previous triggers have not brought on any urges do EM on any/all successes. This helps build ego strength on the successes noticed to date.

If client reports relapse begin work on the triggers causing the relapse. In cases where client has experienced new stressors these stressors may have to be targeted for EM.

## **RESEARCH** **Treating Sexual Compulsivity using EMDR and DeTUR**

Alex Spence, MA, CSAT

Recent research reports that approximately 3-6% of the population has some form of sexually compulsive behavior (Carnes, 2002). Often, those seeking treatment for sexual compulsivity experienced a variety of trauma in their formative years. Failing to recognize and treat trauma can often lead to relapse or an escalation in the compulsive behaviors. In addition, those reporting sexually compulsive behaviors report extreme difficulty in obtaining initial sexual sobriety due to a variety of relapse triggers. EMDR and A.J. Popky's DeTUR method provide specific methodologies in treating trauma and decreasing risk of relapse.

Currently, very little research exists in utilizing EMDR and DeTUR as clinical methodologies in treating sexual compulsivity. In this pilot study, the preliminary research appears to demonstrate that both EMDR and DeTUR provide a set of effective clinical interventions in treating sexual compulsivity.

This study examines the use of the DeTUR method utilized as the primary treatment modality with 24 clients who identified sexual compulsivity as their principal treatment issue. DeTUR was particularly effective in desensitizing sexually compulsive triggers. The subjects were selected from a client base of over 60 clients who self-reported sexually compulsivity and also met the clinical criterion for a diagnosis of sexual compulsivity. This was assessed using Dr. Patrick Carnes' Sexual Assessment Screening Test (SAST). If subjects score 13 or more out of a possible 25, they meet the criterion for sexual compulsivity. This screening tool can be found at [www.sexhelp.com](http://www.sexhelp.com).

Each subject completed a trauma screening to assess for the type and frequency of trauma experienced. In addition, each subject completed a healthful living scale. None of the subjects had experienced EMDR or DeTUR as a client in the past.

**Research Design**

Control Group	# of Subjects	# of Sessions	Tx Modality	Tx Modality	Tx Modality
Group A	6	10	Talk therapy		
Group B	6	10		EMDR	
Group C	6	10			DeTUR
Group D	6	10		EMDR	DeTUR

This study utilized a between subjects design model. Each subject was randomly assigned to a group and was exposed to only one level. Comparisons were made between subjects' reactions.

A pre-treatment assessment was made with each subject assessing for several measurable variables. These include Level of Urge (LOU), Subjective Units of Distress (SUDS), Validity of Cognition (VoC), as well as a trauma profile, healthful living scale, and client self-report. These evaluative measures were then administered at weeks 3, 6, 8 and 10 to assess for treatment effects.

The researchers used traditional EMDR to treat family of origin and other traumas that the patient experienced. EMDR was used to desensitize early trauma as well as associated blocking beliefs that prevent them from reaching their future positive resource state. EMDR was then used to aid the client in establishing a new sexual arousal template based upon previously unknown relational skills.

In addition, DeTUR was utilized to access an internal resource state, install their positive goal state, and anchor it in their physiology), to desensitize known triggers to decrease the risk of relapse behavior, and access these positive resources in the future.

The subjects in Group A-talk therapy only, reported a richer understanding of their sexually compulsive behaviors and also reported struggling with relapse issues due to no symptom relief.

The subjects in Group B-EMDR treatment, reported a significant decrease in their SUDS, VoC, trauma profile, and an increase in their healthful living scale. They also reported struggling with relapse issues.

The subjects in Group C-DeTUR treatment, reported a significant decrease in their LOU level, but did not report a significant decrease in their trauma profile or an increase in their healthful living scale.

The subjects in Group D-EMDR and DeTUR treatment reported a significant decrease in their SUDS, VoC, LOU, trauma profile, and an increase in their healthful living scale.

These preliminary findings appear to indicate that the use of EMDR and DeTUR are effective means in treating sexually compulsive behaviors. Further research studies are needed to examine the use and effectiveness of EMDR, DeTUR and traditional talk therapy in the treatment of sexual compulsivity.

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