May 16, 2016

Standards and Training Committee
EMDR International Association
Attn: Sarah Tolino (stolino@emdria.org); Mark Doherty (mdoherty@EMDRIA.org)
Cc:

Dear committee members,

I'm writing to request that the committee examine and evaluate the EMDRIA-approved workshops of Dr. Robert Miller (PSY20630 California) with regard to two issues, one involving potential harm to EMDR clients struggling with addictive disorders and the other involving inaccurate statements by Dr. Miller regarding the prior work of other EMDR therapists, including myself.

1. In his trainings Dr. Miller appears to state that psychological defenses (such as avoidance, idealization, and shame) and dissociative personality structure are relatively unimportant in the treatment of addictive individuals. I am sure that Dr. Miller's procedures – the procedures of Feeling State Therapy – are very effective with a portion of people with addictive disorders. Moreover, he has provided a valuable service to the EMDR community by making it widely known that EMDR-related methods can be useful in the treatment of addictions. However, this being said, it is also true that, for a large number of chronically addicted people who are entering therapy, it is important to acknowledge the importance of the traumatic origins of their addictive disorders, the importance of avoidance urges and wishes, and the importance of treating those urges, as part of a treatment plan. The feelings a person experiences when using often are an appropriate target for processing, but the urge to use, for some clients is a more available and preferable target. And for some clients, the feeling of helplessness and shame after using are the most accessible target for processing. It varies from client to client. It is true -- and Dr. Miller does state this --many addicted people have a very strong overvaluation or dysfunctional positive feeling investment (idealization) with regard to the addictive substance, image, or behavior, and the targeting and resolution of this type of idealization is very often important in the treatment of addiction. What Dr. Miller appears to discredit, though, is the post-traumatic origins, and defensive function of this type of idealization. He states instead that this type of idealization, in most cases, originates and occurs in a way that is separate from traumatic experience, not intrinsic to a dysfunctionally stored memory network. In contrast to his view, it is the opinion of many EMDR addiction specialists that urges to use and the idealization of addictive behaviors are very often intimately connected with dysfunctionally-stored memories of trauma. For many chronically addicted people, addictive behaviors function to regulate emotional disturbance (basically post-traumatic

affect). Comprehensive therapy frequently involves not just targeting inappropriate idealization, but also targeting avoidance and the traumatic experiences that were concurrent with, and frequently are driving these dysfunctional self-regulation actions. In his workshops, and in the phone conversation with me in 2013, Dr. Miller said that addictive behaviors generally do not function, within an individual's personality, as a means to contain and regulate troubling posttraumatic affect. He has said that the "Level of Urge – LOU" (Popky, 1995, 2005) for an addictive substance, in response to an addictive trigger, is “irrelevant” in treatment – a rather odd statement. In our conversation, he said that methods that target triggers and consequent urges are “obsolete.” He stated that the installation of positive resources (e.g. a “Positive Goal State,” Popky, 2005) is not necessary for these clients. He is also on record as repeatedly stating that avoidance issues are not important in the treatment of addictive disorders – which is astounding, given the frequency with which addicted clients report extreme reluctance to go to 12 step programs, or to access troubling memories.

I'm currently providing consultation to several consultants in training. Some of these, and some of their consultees, have attended Dr. Miller's workshop, and have reported that Dr. Miller appears to be unfamiliar with both the presenting issues and treatment procedures for clients who have a significant degree of dissociative personality structure. Work with the defenses and with issues of dissociation within the personality of an addicted client is often crucial in order for treatment to be effective and lasting. The personality “part” that has an urge for the addictive behavior may at times be relatively inaccessible to the “part” that is focused on appearing normal and feeling normal. There may be a dissociative disconnect between the “part “ that uses, and the “part” that feels ashamed the next morning. There is a danger to clients if issues of avoidance, idealization and dissociation are not addressed (i.e. these clients are treated only with the Feeling State Therapy methods, as Dr. Miller advocates) and then the addictive behaviors continue, or resume shortly after treatment. There may be triggers to use that only emerge after a period of sobriety (e.g. “I haven’t had a drink in 2 months. Maybe I can go back into that bar”). These clients may conclude, "This EMDR therapy doesn't work for me." This would be a significant negative outcome for these individuals, who may represent the great majority of clients seeking EMDR therapy to treat addictive disorders, especially chronic addictions. This unfortunate and preventable outcome would also be damaging to the reputation of EMDR as an effective treatment for addicted individuals.

In a larger sense, Dr. Miller makes claims for Feeling State Therapy that most therapists working with addictions would regard as absurd, and in this way, the entire EMDR community is somewhat discredited. For

example, he states that most addictive disorders that he treats require 4 to 6 sessions, with the rare case "needing more." My guess is that he has not had very much experience in providing psychotherapy treatment to chronically addicted individuals, but he claims that his methods are sufficient and appropriate for the full range of addicted clients.

2. The second concern has to do with Dr. Miller's failure to give appropriate attribution to prior EMDR – related methods of treating addictive disorders. In his initial presentation of Feeling State Therapy, at the EMDRIA conference in 2011, Dr. Miller failed to mention the work of Popky (1995, 2005); Haas et al, 2008; Cox and Howard, 2007, Marich, 2009, Zweben and Yeary, 2006, or my work with targeting dysfunctional positive affect – Knipe, Manfield and Snyker, 1998, Knipe, 2005, 2009, 2010. When someone from the audience asked him to differentiate Feeling State Therapy from "the work of Jim Knipe," Dr. Miller appeared to be at a loss for words. This exchange at the 2010 conference is available on the MP3 recording of Dr. Miller's presentation.

   I did not attend Dr. Miller's 2011 presentation, but I listened to the recording of it, and shortly after that I attempted to contact him by phone in order to 1) complain about his lack of attribution, and 2) perhaps learn from a colleague -- learn something new which would be valuable and could be an important addition to the EMDR-related treatment of addictive disorders. Over the following months, I contacted him again four more times, offering either an email dialogue or a phone call, and he finally agreed to speak with me by phone. In this conversation, I described to him in detail the ways in which his procedures were the same as what I had previously described in workshops and book chapters, and he defended his behavior by simply stating unequivocally that his procedures were innovative and original. He also stated that he had not been aware, during preparation of his dissertation thesis, of the prior work of other EMDR therapists or my prior work. I replied that I was not accusing him of plagiarism, but that he should make an effort to provide appropriate attribution when he is presenting these concepts. We ended the conversation agreeing to disagree, with him saying that he continued to believe that his concepts were "completely different" from the ideas previously presented by myself and others.

   In spite of this conversation, and apparently many other instances of Dr. Miller receiving this feedback from EMDR clinicians who are also addiction specialists, Dr. Miller continues to insist in his writing and workshops that his methods are "completely different" from prior writings of others. In making this point, he makes statements about my work (i.e. see http://www.fsaprotocol.com/fsap-vs-dpa-4-13-16.pdf) in which he labels and defines my work inaccurately, and then claims that he is the originator of methods that I in fact began writing about in 1998. The inaccurate statements about my work are then used to draw

inaccurate contrasts with his writing. In my workshops, I have had many questions from participants – participants who have heard Dr. Miller speak or read what he has written -- asking about the difference between his approach and mine. One participant said to me, "You got these ideas from Miller and you should give him credit." I suspect, without direct evidence, that these responses are based on misleading information given by Dr. Miller in his workshops and writings.

I acknowledge that my motive in writing here is to protect the authorship of my work, as well as the authorship of others. But the primary impetus for this letter is to bring about a solution to the above-described problems, for EMDR clients, and for the reputation of EMDR. I am not requesting that Dr. Miller's status as an EMDRIA Approved Credit Provider be withdrawn, rather I'm requesting that committee members conduct an objective evaluation of these concerns, and that, if these concerns are found to justified, Dr. Miller be encouraged to take corrective action. Specifically, I would like to request that the Standards and Training Committee make the following requests of Dr. Miller.

1. That, in his trainings, he emphasize to participants that addictive behaviors often function within the individual as a way to contain and regulate post traumatic affect, and that this defensive function of addictive behaviors is, very frequently, a crucial element of that person's presenting problem. Moreover, it would be important that he also emphasize the ways in which elements of dissociation, lack of full awareness and access between personality parts, and conflicting agendas between separate and dissociated personality parts are often part of the clinical picture of an individual entering therapy for treatment of an addictive disorder. Also, Dr. Miller should also alert participants in his trainings that the 4-6 session full and permanent resolution of addictive disorders is extremely rare, except perhaps in cases of very mild addictive patterns. His strong claims with regard to addiction, particularly chronic addiction, require, at minimum, stronger empirical evidence.

2. That Dr. Miller stop making a false distinction between what he is proposing and the prior work of others, particularly Popky, Hase and myself.

3. That, in his trainings, he give appropriate attribution to others who have described EMDR-related procedures for targeting and resolving addictive disorders and dysfunctional positive affect.

I would be very happy to find a resolution to these concerns, and I am open to learning that my views, expressed above, are distorted, if that is the case. I believe

that an objective assessment of the situation by the committee would be helpful to all parties in finding a resolution.

Thank you very much for your consideration.

Sincerely,

James (Jim) Knipe PhD
Approved Consultant
EMDRIA Credit Provider

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