

June 15, 2016

Standards and Training Committee

EMDR International Association

Attn: Sarah Tolino ([stolino@emdria.org](mailto:stolino@emdria.org)); Mark Doherty ([mdoherty@EMDRIA.org](mailto:mdoherty@EMDRIA.org))

Cc:

Dear committee members,

I have received a copy of the letter that Dr. Knipe submitted to your committee. Under the guise of asking you to evaluate my work, he has described to you what my work is, why it is wrong, and why it disturbs him. However, he describes my work incorrectly. In fact, his letter's description of my work is often the exact opposite of what I actually teach.

Dr. Knipe has made clear, in both our conversation and in his letter to your committee, that he believes that there is no difference between his work and mine, only a different vocabulary. I disagree. To refute his allegations, I will lay out the crucial differences between Dr. Knipe's ideas and my own.

As part of my refutation of Dr. Knipe's false statements, I have uploaded a short video, a part of my workshop, on YouTube. The first part of the video focuses on my treatment of the avoidance dynamic of addiction (point 8). The second part of the video refutes Dr. Knipe's assertion described in point 4 about what I say about the euphoric sensation linked with addiction. I have also attached the article I wrote differentiating between Dr. Knipe's and my respective approaches, as well as attaching a copy of the complete Feeling-State Addiction Protocol (FSAP) that I teach in every workshop.

You can access the video by clicking on: <https://youtu.be/iff2lV29dpM>

What follows is a point-by-point refutation of his assertions.

1. Dr. Knipe states that, at the EMDR International Conference in 2011, I was at "a loss for words" when asked to differentiate between Feeling-State Theory (FST) and Dr. Knipe's work. My actual answer to that question was that I had not heard of him. At the time, I not heard of Dr. Knipe nor was I aware of having been exposed to any of his publications—nor did any of the peer reviewers, with whom I worked extensively and some of who were part of the *Journal of EMDR Practice and Research* (Miller, 2012) peer review process, mention Dr. Knipe's name, suggest that I read Dr. Knipe's work on addiction, or suggest that Dr. Knipe should be included in my literature review for either of my papers. My lack of knowledge of Dr. Knipe's work in the field of addictive/compulsive behaviors was apparently shared by the peer reviewers in the addiction field who reviewed my papers. I only became aware of his work when Susan Brown brought the question to my attention about one year after the conference.

This misrepresentation of my response as being that I was at “a loss for words” is minor; others of Dr. Knipe’s misrepresentations are more significant.

2. Dr. Knipe states that I told him that, during my preparation for my dissertation (Miller, 2004), I was not aware of any prior work of EMDR therapists related to addiction.

This is false. I did not make that statement. I was well aware of Dr. Popky’s and Dr. Hase’s work when I did the literature review for my dissertation. In fact, Dr. Popky’s work is cited and discussed in the literature review section of my dissertation. My dissertation was published and available for anyone to read.

That I would tell Dr. Knipe that I was not aware of Dr. Popky’s work makes no sense since my dissertation contains a review of Dr. Popky’s work in it. Dr. Knipe’s misstatement about my not reviewing any other EMDR practitioner’s work is in line with the many other false assertions that he makes about what I supposedly said.

3. Dr. Knipe states that, during a phone call, he attempted to persuade me that his work is the same as mine. (Actually, we had a videoconference, not a phone call.)

The reason that he did not convince me is that Feeling-State Theory and the Feeling-state Addiction Protocol are not the same as his work. I attempted to explain to him the differences between his work and mine, but his mind was already made up and, although he listened, he ignored what I said. Other EMDR trainers have told me that they have also expressed to him that these approaches are very different but that he has refused to listen, continuing to believe that he is the original developer of my work.

The reason that I do not give him credit for my work is because he does not deserve it. Dr. Knipe’s complete lack of understanding of the FST of behavioral and substance addictions will be made clear further in this letter.

4. Another false statement Dr. Knipe asserts about my work occurs in his book *The EMDR Toolbox*, (Knipe, 2014). Dr. Knipe asserts, without any citation, that I believe that eliminating the euphoric FS is sufficient to eliminate an addiction.

I have never stated that. What I have stated is that a substance addiction is often caused by FSs that may include one or more of the following: a Sensation-FS (which may be a euphoric FS), a psychologically induced FS (including a feeling such as belonging), and an avoidance behavior. I clearly state and discuss these dynamics in my workshops.

You can view the video by clicking on: <https://youtu.be/iff2IV29dpM>

The discussion of substance addiction and FSs occurs near the end of the video.

5. I have recently written an article about the differences between FST and Dr. Knipe’s model that I have attached to this email. In his letter he states that I misrepresented his work.

I would be happy to address specifics, but I cannot because he doesn’t provide any; he does not cite specifically what I supposedly misrepresented. All my quotes of his work are accurate and in context. Since my article is available for him to demonstrate how I have “misrepresented” his work, I would have thought that he would point out my errors to the committee. In the context of seeking corrective action from the committee, a specific analysis of the article should be a requirement. He does not do so.

Throughout the letter, Dr. Knipe makes assertions about what I have stated without providing any citations or quotations. Even when he has the opportunity to specifically describe the errors in my article, he does not detail what work of his I have misrepresented. I can only surmise that he thinks that specifics are not important.

6. Dr. Knipe writes:

“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.”

This is a false statement on several levels. First, I have never used the words “overvaluation” or “idealization” in reference to FS treatment. Dr. Knipe’s statement “Dr. Miller does state this...” misleads the reader into thinking that I am using the same words that he does. His misleading statement must be deliberate since I have never stated what he asserts I have stated. He is, in effect, “putting words in my mouth.” That allows him to argue that the fundamentals of my work are the same as his, having attributed his words to me. Then Dr. Knipe explains how what I do is wrong, using the words he falsely attributes to me.

#### Definition of terms

**Idealization:** is defined as a mental mechanism, operating consciously or unconsciously in which one person overestimates an admired attribute of another.” (Underline is mine, Dictionary.com).

**A feeling-state:** is defined as a fixation of a feeling the person has about himself (self-referential) linked with a person, behavior, or object.

As is obvious from the above definitions, “idealization” and “feeling-state” are completely different concepts. Dr. Knipe obscures this difference between our respective approaches so that he can obscure the fact that these models of treatment are profoundly different. These differences are the result of totally different views about what “positive” means in the context of the positive feelings related to addictive/compulsive behavior. That is why I do not use the words “idealization” and “overvaluation” in regards to addictive/compulsive behavior. Dr. Knipe misstates the concept of feeling-state as if it is just another word for idealization. The concept of idealization and the concept of feeling-state are totally different concepts. By asserting “Dr. Miller does state this,” Dr. Knipe is able to obscure this difference.

The second level in which that statement is false is that I do not believe that idealization is even one cause of addiction; any overvaluation or idealization occurs after the feeling-state is formed. This difference in views is explained in understanding the differences between the FSAP's targeting of self-referential feelings versus Dr. Knipe's targeting feelings of idealization.

Dr. Knipe is very clear about his view of a self-referential feeling related to addictive behavior. Dr. Knipe states "However, I don't typically ask for a self-referencing cognition, since this is likely to bring up feelings of shame" (Knipe, 2005, pg. 191). Thus Dr. Knipe very clearly states that self-referential cognitions related to addictive behavior are negative.

FST, on the other hand, specifically chooses to identify self-referential positive cognitions/feelings because they are the cause of the positive-feeling-seeking dynamic in addictive/compulsive behavior. Dr. Knipe does not identify or appear to even recognize the existence of the positive self-referential cognitions that created the compulsion. That is the fundamental difference between the FST's model and Dr. Knipe's model. The only thing that the FST's model and Dr. Knipe's model have in common, regarding the identification of positive feelings, is the spelling of the word "positive."

The operational difference in these two concepts can be understood by examining the different approaches, utilizing Dr. Knipe's "Unrequited Love" script (Knipe, 2009). Both approaches would ask the question about what is the most positive moment the client has had with the person. From that point on, the treatment approaches are fundamentally different.

Dr. Knipe asks: "How much do you love or want to hang onto ... (the person)." In other words, Dr. Knipe is asking for the client's feelings (idealization) about the other person (other referential).

In FST what is important is not the feeling the client has about the other person (the idealization) but the positive feeling that the client has about himself (self-referential). In FST, the self-referential feeling is the feeling embedded in the FS—not the feeling towards the other person. Asking the client to specifically describe and focus on his feelings about the other person (the idealization) completely misses the fundamental psychological dynamic creating the addictive/compulsive behavior and leads the client off in the opposite direction because the cause of the addiction is never being specifically identified.

For example, the client may have the feeling that he (the client) has a feeling of "belonging" linked with the other person (OP)—an FS that was created during an intensified positive moment the client experienced with the OP. The result is that, once the FS is created, the client experiences the feeling of belonging whenever he is with the OP. Dr. Knipe completely misses the embedded positive feeling (the feeling of belonging) that the client is seeking because Dr. Knipe does not ask the client to identify a self-referential positive feeling. Without asking the client a self-referential question, Dr. Knipe misses identifying the feeling embedded in the FS. And Dr. Knipe states that he purposefully avoids asking about self-referential feelings because he thinks that those self-referential feelings that the client would describe would likely be negative. Instead, Dr. Knipe targets the feeling of "love" or "wanting to hang onto" that the client has toward the OP completely missing the real psychological dynamic creating the addictive behavior.

Using the above example, when the therapist using the FSAP asks the client to identify what his desired self-referential feeling is—in this case, “belonging”—the real psychological dynamic that drives the compulsive behavior that leads to the urge of “wanting to be with” the OP is identified. Once the client’s linkage between the feeling of belonging and the OP is processed with the FSAP, the FS is broken and any positive feelings driving the urge are eliminated. There is no need to target the idealization because, once the FS is eliminated, the idealization is also eliminated. The idealization is a consequence; the FS is the cause.

The FSAP targeting of the self-referential positive feeling is similar to the target selection of the EMDR standard protocol. In the EMDR protocol, when the client is asked about his negative cognition, the cognition identified is always self-referential, such as the answer to “What is the negative belief you have about yourself...?” You do not ask, “What is the negative belief you have about the other person?” (Other referential). In other words, FSAP follows the same basic target selection pattern as the standard EMDR protocol in order to get at the feeling embedded in the fixated memory, except that the feeling that the client is asked to identify is positive instead of negative. I do not think that Dr. Shapiro and EMDR trained practitioners would consider this difference in target selection to be a minor difference in treatment. I do not think that this difference between FST’s and Knipe’s target selection is minor when it comes to behavioral or substance addictions either.

The difference between the FST’s approach and Knipe’s approach to identifying targets also results in differences in the treatment of urges and cravings and in the necessity, in Knipe’s approach, for installing future templates for non-addictive behavior. In his letter to your committee, Dr. Knipe criticizes me for treating these dynamics differently from Dr. Popky. This criticism requires that he ignore that the difference in treatments arises from the difference in treatment models. Only by ignoring the difference in treatment models can he criticize the FS treatment for not doing the treatment that his model proposes.

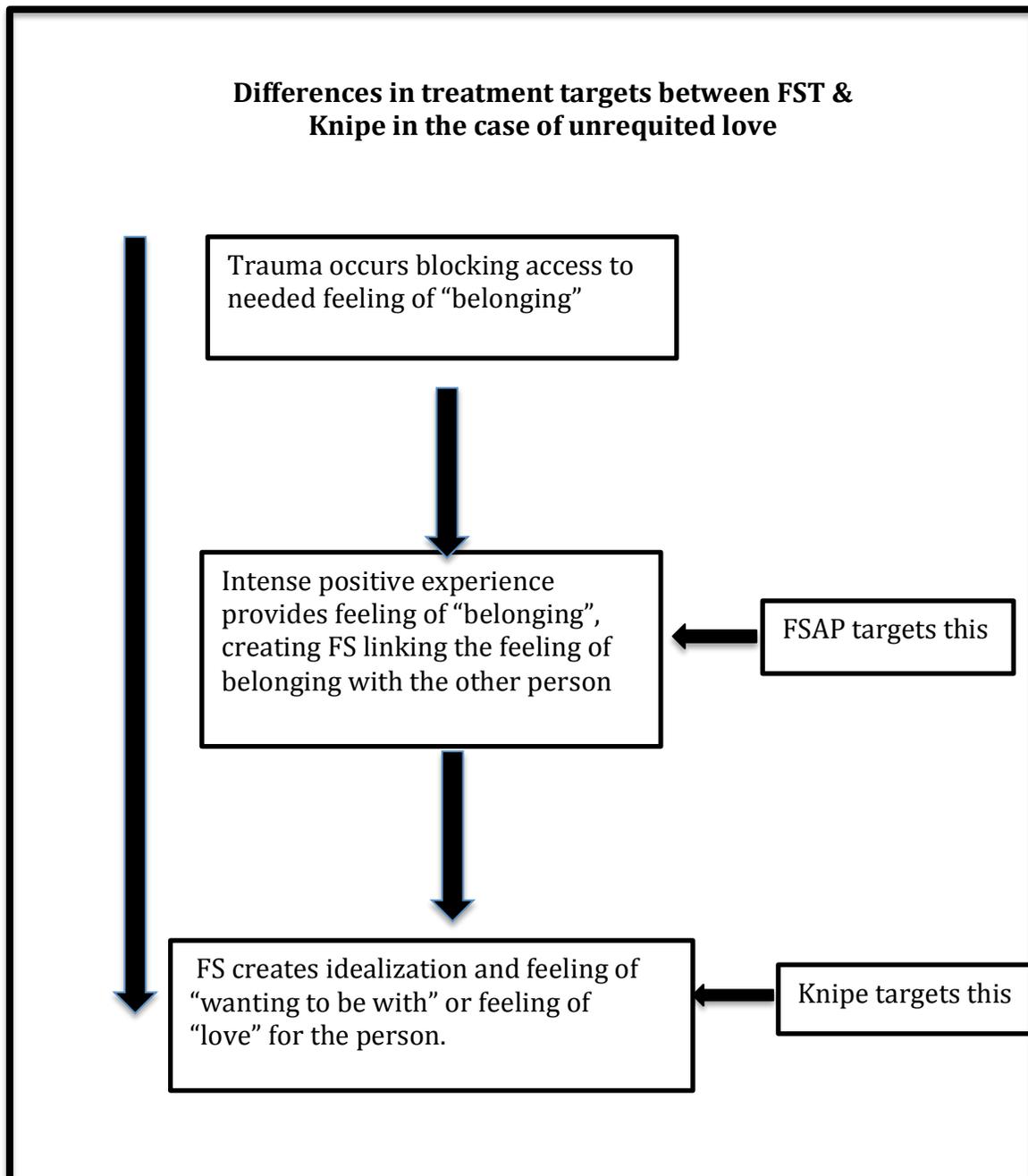
In summary, Knipe’s approach and the FST approach target two totally different feelings. Knipe targets the feeling the client has toward the other person (other referential). The FST targets the feeling that the person has about himself (self-referential).

Returning to the discussion of overvaluation and idealization, FST views the client’s overvaluation or idealization to be the consequence of the creation of an FS. In other words, first, an FS is formed and then, second, later in time, the overvaluation or idealization occurs. In other words, the idealization is actually a rationalization of the compulsion “to be with” a person toward whom, without the FS, the client would have different behavior. Using the above example, when the client’s FS links the feeling of belonging with the OP, the client has the urge “to be with” the OP because the client experiences the feeling of belonging when he is with the OP. That urge “to be with” is sometimes labeled as “love” (the rationalization.) Knipe’s treatment targets the overvaluation or idealization that played no part in the development of the

compulsion/addiction. In other words, when the psychological dynamic is a result of positive feelings, Dr. Knipe treats the symptom, not the cause.

The previous discussion illustrates why I would never state that addictions are the result of overvaluation or idealization and why his statement that “Dr. Miller does state this...” is totally and completely false. My published articles (Miller, 2010, 2012) describe the creation of an FS. I could understand if Dr. Knipe just doesn’t comprehend my work. But by using the words “Dr. Miller does state this...,” he is leading the reader to believe that I use the words that he says I use so that he can “prove” that he is the true developer of this model of treatment. Dr. Knipe’s having written in his letter to your committee that I stated something that I have never stated and that is contrary to the content of my published work has stunned me. And it is unethical.

The following graphic illustrates the difference in target selection between FST’s and Knipe’s models of treatment:



7. Dr. Knipe states that I do not believe that addictions have any connection with traumatic memories.

That statement is false. Phase 4 of the FSAP focuses on the traumatic memories that underlie the feeling-state. I explicitly state in my workshops that FSs often develop because of a traumatic experience that blocks the person from experiencing a needed feeling, which over time leads to a pent-up desire for the feeling. When an event occurs that finally allows the person to experience the needed feeling, the intensity of the event creates an FS. How can this be interpreted as meaning that I don't recognize that traumas are associated with addiction?

In fact, trauma treatment is Phase 4 of the FSAP. What follows below is copied from the FSAP workshop manual, the beginning of Phase 4 of the FSAP.

#### **Phase 4: Process the NC underlying the FS**

15. Identify the NC that underlies the feeling. (*What's the negative belief you have about yourself that makes you feel you can't belong? can't connect? aren't important? et cetera.*)

16. Use the float-back method to identify an event related to that feeling. If no event is identified, target the NC. (*Can you remember an event that made you feel that way?*) Process with the standard EMDR protocol.

The FSAP not only recognizes the importance of traumatic memories in the formation of addictive/compulsive behavior but actually identifies the specific trauma associated with the behavior. Once an FS is eliminated, a common occurrence is that a traumatic memory surfaces. This traumatic memory appears to be specifically related to the feeling that has been identified as embedded in the FS. In the above example of the feeling of belonging linked with the OP, the specific traumatic memory may surface that blocked the client from experiencing the feeling of belonging.

In other words, the FSAP not only targets the real desired feeling driving the compulsive behavior, but targets the specific trauma related to the compulsive behavior. Dr. Knipe's targeting the "positive" feeling toward the other person misses both.

The FSAP protocol has been in every manual in every FSAP workshop I have taught. The FSAP protocol has also been available for download from my website since I began teaching workshops. After all this time, how can Dr. Knipe not be aware of the complete protocol? Dr. Knipe's assertion that I am not aware of the connection between addiction and trauma is just one more example in which he makes a false statement about what I teach and then proceeds to explain how what he incorrectly says I say is wrong.

Dr. Knipe continues this pattern of first, misstating what I teach and then second, describing how what he says I say is wrong in his discussion of avoidance issues.

8. Dr. Knipe's statement:

"He (Dr. Miller) is also on record as repeatedly stating that avoidance issues are not important in the treatment of addictive disorders."

Since I am supposedly "repeatedly" "on record," where are the citations of my statements?

Dr. Knipe's statement is completely and utterly false. In my workshops, I discuss how addictive behavior can be a method of avoiding feelings and memories. In fact, at the beginning of every workshop—within the first 15 minutes of the presentation—I spend a significant amount of time on the concept that addictive behavior can be the result of either or both of two separate dynamics—avoiding a feeling and seeking a feeling (the feeling embedded in the FS). I explain to the workshop participants that I am discussing these two dynamics in detail because the most common mistake therapists make in using the FSAP is attempting to identify an FS when there is not one.

I explain that, when the therapist determines that the avoidance dynamic is present, it is safe to assume that the compulsive behavior is being used to avoid feelings. I suggest that the most useful attitude for the therapist to adopt at the beginning of treatment is a more neutral listening approach in order to determine which dynamic is likely present—the avoidance of a feeling or the seeking of a feeling. I continue to discuss the avoidant dynamic throughout the workshop, illustrating how a compulsive behavior may appear to be the result of an FS but that the behavior may actually be a form of avoidance behavior. I also emphasize that both dynamics may be present in any addictive/compulsive behavior.

In all, I devote about 20 percent of my workshop to the avoidant dynamic underlying behavioral and substance addictions. I devote 80 percent of my time to teaching feeling-state treatment. My focus is more on teaching feeling-state treatment, not trauma treatment, because that is the focus of the workshop.

Dr. Knipe makes his assertion about my lack of understanding of the avoidant aspect of addictive behavior not only without any evidence, but contrary to my specific instructions in the workshops. As evidence of this, I have uploaded on YouTube a video of this part of my workshop. The video begins immediately after introducing myself and the agenda for the workshop. The video clearly illustrates Dr. Knipe's lack of concern for the truth. The avoidance discussion begins about 6 minutes 48 seconds into the video.

You can access the video by clicking on: <https://youtu.be/ifF2lV29dpM>

9. Dr. Knipe is correct in stating that I say that processing triggers is not relevant to FS treatment and that it is not necessary to install positive resources, as is done in Dr. Popky's DeTur treatment.

What Dr. Knipe does not understand is that, in FS treatment, triggers are only relevant when all the FSs and/or avoidance issues have not been processed. Once the FSs are eliminated, there is nothing to trigger. FS treatment does not install positive resources because clinical experience indicates that, once both the FS and avoidance issues are resolved, the person will automatically find other, more appropriate ways to experience the feelings he needs to experience.

Dr. Knipe's arguments concerning triggers and installing positive resources indicate that he does not understand FS treatment. The FSAP approach to both triggers and positive resources is a consequence of FST. The difference between the FSAP approach and the DeTur approach to triggers and positive installation of resources should be an indication to Dr. Knipe that these approaches are different, arising from different theoretical constructs about addiction. Dr. Knipe ignores the theoretical implications of these differences.

While Dr. Knipe denigrates the FSAP for not treating triggers and not doing a positive installation, neither Dr. Popky nor Dr. Knipe have published any research on their approaches. On the other hand, research on the FSAP was published in the *Journal of EMDR Research and Practice* (Miller, 2012). The research involved four participants with multiple compulsions. The results indicated that the FSAP may be useful in the treatment of behavioral compulsions. Another research study was published by Tsoutsas, et al. (2013) comparing the FSAP with Cognitive Behavioral Therapy (CBT) in the treatment of smoking addiction. The results indicated that the FSAP was superior to CBT.

Dr. Knipe developed his approach in 1998; and since that time, he has not subjected his ideas, either about my work or his, to the scrutiny of a peer review process conducted by a peer-reviewed journal. Dr. Knipe's negative attitude toward the FSAP's treatment of behavioral and substance addictions is not supported by any research.

10. Dr. Knipe states that he is concerned that my statements and methods will create a bad reputation for EMDR.

Over the last four years, I have taught over 1,300 EMDR practitioners in the United States, Canada, and Europe to use the FSAP. Many practitioners have reported successful treatment with patients who have a wide variety of compulsive and addictive behaviors. As with the EMDR standard protocol, learning to utilize the FSAP does require significant effort, but those therapists who have made the effort report that the FSAP has resulted in a positive change in their practice. Far from undermining EMDR's reputation, FSAP practitioners report a significant improvement in their ability to understand and treat compulsive and addictive disorders. As a result, since their clients have often been through multiple unsuccessful treatments, the clients are often surprised at the unexpected positive effects on their lives. Clearly, the reputation of EMDR has not been injured by therapists utilizing the FSAP that they have learned in my trainings.

11. Dr. Knipe states:

“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.”

Dr. Knipe’s statement is a clear indication that he doesn’t understand the crucial role that self-referential positive feelings play in addictive/compulsive behavior. The fact that targeting the “urge to use” because the “urge to use” is more available does not mean that the “urge to use” is a preferable target for treatment. In the FST, the “urge to use” is only relevant as an indicator that there are either more FSs or avoidance issues to work through. Targeting the “urge to use” is like targeting the urge to eat when you’re hungry. What the person wants is food, not the urge. The FSAP targets the feeling the person wants to experience, not the urge to experience it. The urge does not create the addictive/compulsive behavior. Rather, the urge is a consequence of the FS. That is why the FSAP never targets urges.

The client’s feelings of helplessness and shame about his addictive/compulsive behavior that Dr. Knipe refers to are certainly accessible targets for processing. However, they are not the cause of the problem, but the consequence of the problem. FS treatment is a model for treating the cause. As with the “urge to use,” Dr. Knipe treats the consequence of the FS. In the FSAP, the feelings of helplessness and shame are treated in Phase 5, after the FSs and traumas are processed. The FSAP does not confuse causes and consequences. Dr. Knipe targets what is easily “accessible” instead of the cause—the FS.

12. Dr. Knipe states that, because some of his workshop participants have accused him of stealing my ideas, that I must have provided them with misleading ideas about his work. Since I do not know which ideas of mine he has been accused of stealing, I do not know what he is referring to. Again, he accuses me of unethical behavior (misleading people about his work) with no evidence or even a full explanation of what his workshop participants said to him.

13. Dr. Knipe asserts that I am making a false distinction between my work and the work of others including Dr. Popky and Dr. Hase. Dr. Knipe’s inability to understand the difference between FST and Popky and Hase’s work is incomprehensible. In the DeTur, the triggers of the urges and cravings are processed. In the FSAP, the triggers are specifically not targeted. Instead, the FSs that the triggers are activating are targeted. In the DeTur, a positive future template is installed. In the FSAP, no future template is installed regarding how the person will behave without the addictive behavior. The targeting of the triggers and the installation of the positive template are the two major parts of the DeTur protocol. The FSAP specifically does not do either of them. I don’t know how the FSAP could be any more different from the DeTur.

Hase's treatment targets the Addiction Memory (AM). The AM is composed of the memory of craving and the memory of loss of control. Neither of those memories are FSs. If the targets are not FSs, then these protocols are not the same. The distinction between FST and Dr. Hase's work is obvious and clear.

The fact that Dr. Knipe is unable to comprehend the difference between FST and Dr. Popky's and Dr. Hase's work illustrates the intellectual blindness he demonstrates throughout his letter.

#### Final statement:

In his closing statement, Dr. Knipe appears to be reasonably asking for an objective evaluation and admits that his views may be "distorted." His numerous lies and false statements belie that seeming "reasonableness." When he says that I have "stated" things that I have never stated, his behavior is not a misunderstanding, but a lie—not a "distortion," but an outright fabrication. There is no middle ground here—either I stated something or I didn't. I find it shocking that Dr. Knipe would impugn my professional integrity without providing one shred of evidence. In addition to wholeheartedly rejecting his assertions, I have provided what I think are good examples of evidence—the video, protocol, and the conceptual basis of FST as described in my published articles—of a clear and convincing case that it is against reason to think that I would make the statements he "stated" that I made. Dr. Knipe's "reasonable" tone is just a façade. I suspect that his letter is the result of his grievance over my not giving him credit for my work. That is the only thing that makes sense to me that explains why the letter he sent to you is so devoid of evidence or intellectual integrity.

Dr. Knipe's letter focuses on two themes: 1) that Dr. Knipe is the originator of the ideas forming the foundation of Feeling-State treatment and 2) that what I do is wrong and dangerous. I can understand that he refuses to understand that the two approaches are different. In seeking "authorship," he attempts to obscure the differences between our approaches. I can excuse that.

What I cannot excuse is that Dr. Knipe has repeatedly made false statements about what I have said. The video clearly demonstrates the inaccuracy of his statements concerning what I teach about avoidance and the euphoric feeling. In addition, in order to criticize my understanding of trauma, he has had to ignore my complete protocol, which is and has been on my website for anyone to download. In the book that Dr. Knipe did author, the *EMDR Toolbox: Theory and Treatment of Complex PTSD and Dissociation* book, he has made false statements about what I teach.

Let me be very clear. Dr. Knipe's false statements are not the result of a lack of understanding or "distortion." Dr. Knipe attributes statements to me that I have never said. I have provided to the committee evidence (video and FSA protocol) to support my allegation that what Dr. Knipe said in his letter to your committee about what I teach are made up out of whole cloth—i.e., lies and false statements. Clearly, for someone to seek the committee's judgment on the basis of lies and false statements is unethical.

I am aware that Dr. Knipe has standing in the EMDR community and that, because of that standing, the committee may find it difficult to believe the level of mendacity in his letter. I was totally stunned. I expected a level of disagreement and argument over our different models of treatment. What I did not expect is for Dr. Knipe to literally make up statements about what I have said. Therefore, in response to his letter, I am recommending to the committee that Dr. Knipe be evaluated for his ethical fitness for training EMDR practitioners.

I appreciate your consideration in this matter.

Robert Miller, PhD

#### References

Knipe, J. (2009)., Dysfunctional positive affect: Methods to assist clients with unwanted avoidance defenses; Procrastination, Clearing the pain of unrequited love, and Codependence or obsession with self-defeating behavior. In M. Luber (Ed.), *EMDR scripted protocols: Special populations*. New York, NY: Springer.

Knipe, J. (2015). *EMDR Toolbox: Theory and Treatment of Complex PTSD and Dissociation*. New York, NY: Springer.

Miller, R. (2004). *The feeling-state theory of compulsions and cravings and decreasing compulsions and cravings using an eye movement protocol*. Pacifica Graduate Institute.

Miller, R. (2010). The feeling-state theory of impulse-control disorders and case: the impulse-control disorder protocol. *Traumatology*, 16(3), 2-10.

Miller, R. (2011). *Breaking impulse-control disorders: A new theory and protocol for compulsions*. EMDRIA annual conference, Anaheim.

Miller, R. M., (2012). Treatment of Behavioral Addictions utilizing the Feeling-State Addiction Protocol: A Multiple Baseline Study, *Journal of EMDR Practice and Research*, 6(4) pp. 159-169.

Tsoutsas, A., Fotopoulos, D., Zakyntinos, S., Katsaounou, P. (2013). *Treatment of tobacco addiction using the Feeling-State Addiction Protocol (FSAP) of the Eye Movement Desensitization and Reprocessing (EMDR) treatment*. 11th Annual Conference of the International Society for the Prevention of Tobacco Induced Diseases. Athens, Greece, December, 2013.