

Drug addiction treatment is rarely effective when it treats substance use as a single, isolated behavior. People do not arrive in treatment as diagnoses on paper. They arrive with cravings, medical needs, strained relationships, anxiety, trauma histories, shame, legal pressure, work problems, sleep disruption, grief, and sometimes a deep uncertainty about whether recovery is possible at all.

That is why strong drug addiction treatment programs usually rely on more than one clinical approach. Medication may be appropriate for some people. Detox may be necessary before deeper therapeutic work can begin. Residential care may provide the structure a person needs early on, while outpatient treatment may help them practice recovery skills in daily life. Peer support, family work, recovery housing, and multiple pathways to recovery can all have a place, depending on the person.

Within that broader continuum, three therapies often stand out: cognitive behavioral therapy, dialectical behavior therapy, and eye movement desensitization and reprocessing. Most people know them by their initials: CBT, DBT, and EMDR. Each has a different purpose. Each asks something different of the client. Each can be valuable in drug addiction treatment when used thoughtfully, not as a slogan on a brochure, but as part of a carefully matched treatment plan.

Recreate Behavioral Health of Ohio, also known as Recreate Ohio, identifies CBT, DBT, and EMDR among the therapies that may be included in care at its Gahanna location near Columbus. The same Ohio facility describes services that include detox, residential or inpatient rehab, and outpatient treatment, along with medication-assisted treatment and individual, group, family, and couples therapy. That range matters because therapy is not a single appointment. In addiction treatment, the setting, timing, readiness, and clinical fit can determine whether a therapy helps a person move forward or overwhelms them before they are ready.

Why these therapies matter in addiction care

Drug addiction changes patterns. It changes how a person responds to stress, how they manage discomfort, how they connect with other people, and how they interpret risk. Over time, substance use can become the default response to emotions that feel too large, memories that feel too close, or situations that feel impossible to tolerate.

CBT, DBT, and EMDR address different parts of that pattern. CBT focuses heavily on the relationship between thoughts, feelings, behaviors, and consequences. DBT adds practical skills for emotional regulation, distress tolerance, mindfulness, and relationships. EMDR is often associated with helping people process traumatic or distressing memories that remain active in the present.

In a drug addiction treatment setting, these therapies are not competing brands. They are tools. A clinician might use CBT to help someone identify the thinking that precedes relapse, DBT to help that same person survive a craving without acting on it, and EMDR later in care when trauma symptoms continue to drive anxiety, avoidance, or substance use urges. The sequencing matters. A person in acute withdrawal, for example, may need medical stabilization, sleep, nutrition, and safety before trauma processing is clinically appropriate.

This is one of the places where experienced treatment teams tend to be cautious. A therapy can be evidence-informed and still be poorly timed. A client can be motivated and still not ready for a particular intervention. Good treatment is not just about offering more services. It is about matching the service to the person in front of the clinician.

CBT: learning to interrupt the addiction cycle

Cognitive behavioral therapy is often one of the most familiar therapies in drug addiction treatment. Its basic premise is straightforward: thoughts, emotions, physical sensations, and behaviors influence one another. If a person can slow that chain down and examine it, they may gain more control over what happens next.

In practice, CBT is not simply “thinking positive.” That phrase undersells the work. Addiction often thrives on fast, automatic interpretations: “I already messed up, so it does not matter,” “I cannot handle this feeling,” “One time will not hurt,” “No one will know,” or “I am better now, so I do not need support.” These thoughts may appear and disappear in seconds. By the time the person notices them, they may already be driving to a familiar neighborhood, texting an old contact, or skipping a therapy session.

CBT helps people identify these thoughts earlier. It also helps them test whether the thought is accurate, useful, or dangerous. A clinician might ask a client to describe the last several hours before a relapse or near-relapse. The goal is not to shame the client. The goal is to map the sequence with enough detail to find choice points.

A common CBT session in addiction care may look at a specific event rather than addiction in the abstract. For example, a person might say they had a strong urge to use after receiving a stressful phone call from a family member. The therapist may help them examine what they felt physically, what they told themselves, what they did next, and what alternative actions were available. Over time, this becomes less theoretical. The client begins to recognize their own relapse signatures: isolation, anger, boredom, overconfidence, resentment, romanticizing past use, or avoiding accountability.

CBT also fits well into group therapy because participants often recognize themselves in one another’s patterns. One person talks about payday as a trigger. Another talks about driving past a certain exit. Someone else talks about guilt after speaking with a child or spouse. The group setting can make the work less lonely. It can also make denial harder to maintain, because peers may gently notice inconsistencies before the person sees them.

That said, CBT has limits. Some clients understand their patterns intellectually but still feel hijacked emotionally. They can describe the trigger, the thought, and the consequence, yet still cannot tolerate the distress long enough to choose differently. That is often where DBT skills become especially useful.

DBT: skills for emotions that do not respond to logic

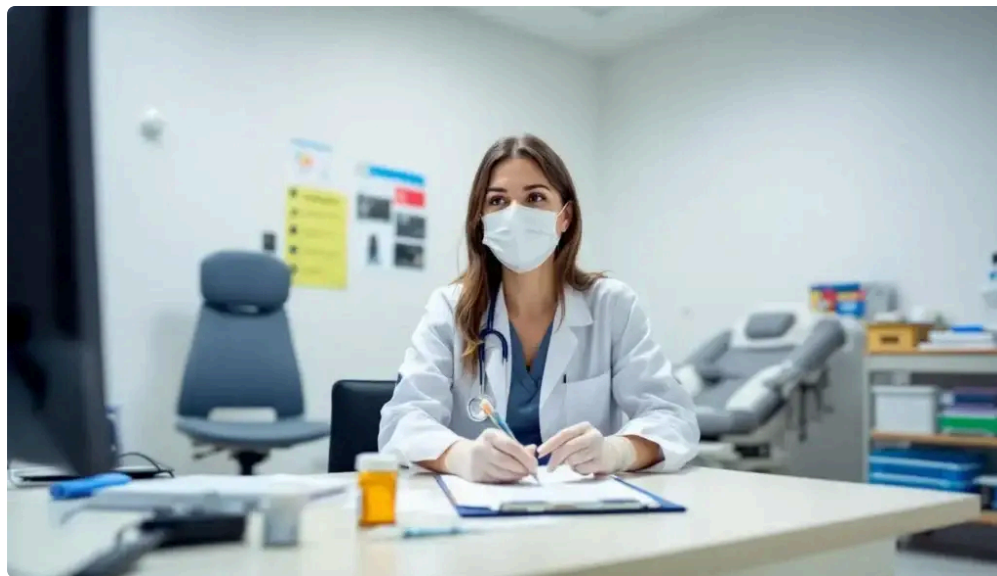
Dialectical behavior therapy was developed for people who experience emotions intensely and struggle with behaviors that can become harmful under stress. In addiction treatment, DBT can be highly practical because relapse risk often increases when a person feels flooded, rejected, panicked, ashamed, or trapped.

DBT does not ask clients to debate every thought. It often begins with a more immediate question: what can you do right now to get through this moment without making it worse?

That question has saved many recovery days. A craving may last longer than a few minutes, but it often changes shape when the person does not feed it. An angry text does not have to be sent. A drive to buy drugs can be interrupted. A conflict can be paused. A person can learn to breathe, call support, leave the room, take a shower, attend a meeting, tell staff, or sit with discomfort long enough for the nervous system to settle.

DBT is known for teaching skills, and that is one reason it works well in structured treatment environments. Skills can be practiced in residential care, reinforced in groups, discussed in individual sessions, and tested later in outpatient treatment when real-world pressure returns.

A practical DBT skill set in addiction treatment often includes:



- Mindfulness, so the person notices urges and emotions without immediately obeying them
- Distress tolerance, so a crisis does not automatically become a relapse
- Emotion regulation, so the person learns patterns that intensify or reduce emotional pain
- Interpersonal effectiveness, so conflict, boundaries, and requests become less destabilizing
- Acceptance strategies, so the person can face reality without giving up on change

The “dialectical” part of DBT refers to holding two truths at once. In addiction treatment, that often sounds like this: a person is responsible for their recovery, and they may need significant support to achieve it. A relapse may have consequences, and it can still be used as clinical information. A family member may be exhausted and angry, and they may still love the person deeply. The client may have done harmful things, and they still deserve care.

This balance is not just philosophical. It affects treatment culture. Programs that lean only on confrontation can increase shame and defensiveness. Programs that lean only on reassurance can avoid the hard behavioral changes recovery requires. DBT gives clinicians and clients a language for both accountability and compassion.

DBT can be especially helpful when drug addiction co-occurs with self-harming behavior, intense relationship instability, impulsivity, or chronic emotional overwhelm. It is not a quick fix. Skills have to be practiced repeatedly, especially when the person is not in crisis, so they are available when the crisis comes. The client who only opens the workbook during a craving is working at a disadvantage. The client who practices daily, even awkwardly, is building muscle memory.

EMDR: when trauma keeps pulling the past into the present

EMDR, or eye movement desensitization and reprocessing, is different from CBT and DBT in both feel and focus. It is most often discussed in relation to trauma and distressing memories. In addiction treatment, EMDR may be considered when unresolved trauma, panic, shame, or intrusive memories appear connected to substance use.

Many people in treatment have learned to use substances as a way to blunt memory, reduce hypervigilance, fall asleep, tolerate touch, quiet nightmares, or stop feeling detached from their own bodies. If those symptoms remain untreated, sobriety can feel unbearable. **Addiction Treatment in Ohio** The person may not be chasing euphoria. They may be trying to escape a nervous system that never stands down.

EMDR is not simply talking about trauma. It uses a structured process that may include bilateral stimulation while the person brings up elements of a distressing memory in a clinically guided way. The goal is not to erase the

past. It is to reduce the intensity and present-day grip of memories that continue to feel dangerous, humiliating, or unfinished.

In addiction care, timing is critical. Trauma processing can stir powerful emotions. If a person has no ability to tolerate distress without using, EMDR may need to wait while stabilization work happens first. That stabilization may include detox when needed, medical and psychiatric assessment, DBT skills, relapse prevention planning, sleep support, and enough therapeutic trust for the person to remain engaged.

There is also an important distinction between trauma-informed care and trauma processing. A program can be trauma-informed from the first phone call by emphasizing safety, consent, emotional regulation, and respect. EMDR, however, is a specific clinical intervention. Not every client needs it. Not every client is ready for it. When it is appropriate, it should be delivered by a properly trained clinician within a treatment plan that accounts for relapse risk and emotional safety.

A person might enter treatment believing the main problem is the drug use, only to discover that substance use was one part of a much older survival strategy. That discovery can be painful, but it can also be clarifying. If the therapy helps reduce the need to escape, recovery may become less about white-knuckling and more about building a life that no longer requires constant numbing.

The role of level of care

CBT, DBT, and EMDR do not happen in a vacuum. They sit inside a level of care. The same therapy can feel very different in detox, residential treatment, intensive outpatient care, or standard outpatient sessions.

Ohio law recognizes the importance of a community-based continuum of care for opioid and co-occurring drug addiction. That continuum includes services such as ambulatory and sub-acute detoxification, non-intensive and intensive outpatient services, medication-assisted treatment, peer support, residential services, recovery housing, and multiple pathways to recovery. The point is practical: people need different intensities of care at different moments.

Someone in detox may be physically and emotionally raw. The body is adjusting. Sleep may be poor. Concentration may come and go. In that setting, therapy often needs to be brief, supportive, and focused on stabilization, motivation, safety, and transition to the next appropriate service. Pushing too hard for deep insight during acute withdrawal can be counterproductive.

Residential or inpatient rehab gives more room for repetition and structure. A client can attend groups, meet individually with clinicians, receive support during difficult hours, and practice coping strategies in a contained environment. For someone whose home environment is unstable or saturated with triggers, this can create enough distance to begin learning new patterns.

Outpatient treatment asks the person to apply skills while living more of ordinary life. That can be both valuable and difficult. A person may leave a strong therapy session and then face an unpaid bill, a tense partner, a familiar street, or an old friend who still uses. Outpatient work often reveals whether the recovery plan can survive contact with reality. When it cannot, that is not a moral failure. It may mean the level of support needs adjustment.

Recreate Ohio describes a continuum that includes detox, residential or inpatient rehab, and outpatient treatment. That kind of range can matter because progress is rarely linear. Some people step down smoothly. Others need more time. Some do well in outpatient care after detox. Others need residential structure first. The right plan depends on clinical assessment, substance use history, co-occurring mental health concerns, safety, support systems, and how the person responds once treatment begins.

Where medication-assisted treatment fits

Medication-assisted treatment can be part of drug addiction treatment, particularly for opioid use disorder and in other clinically appropriate situations. It should not be viewed as separate from therapy or as a lesser form of recovery. For many people, medication can reduce cravings, improve stability, and lower the chaos that makes therapeutic work harder to access.

Therapy and medication often address different parts of the problem. Medication may help quiet the biological drive to use. CBT may help the person recognize relapse thinking. DBT may help them survive emotional spikes. EMDR may help address trauma that keeps the nervous system on alert. Peer support may reduce isolation. Family therapy may address patterns at home. None of these automatically replaces the others.

Ohio's OARRS system, the statewide electronic database for controlled-substance dispensing information, is one example of how safe prescribing and monitoring are built into the broader treatment environment. Systems like this are intended to support safer clinical decisions and help connect people at risk of substance use disorder with resources.

Medication decisions should be individualized. Some clients feel relief when medication-assisted treatment is discussed openly and without stigma. Others carry shame because they have heard inaccurate claims that medication means they are "not really sober." Clinicians have a responsibility to handle that conversation carefully. The relevant question is not whether a treatment fits someone else's ideology. The relevant question is whether it is clinically appropriate, safe, and helpful for the person's recovery.

Individual, group, family, and couples therapy are not interchangeable

CBT, DBT, and EMDR may be delivered in different formats, and the format changes the work. Individual therapy allows privacy, depth, and personalization. Group therapy creates feedback, accountability, and shared learning. Family and couples therapy address the relationship systems that addiction often damages.

A person may make real progress in individual sessions, then freeze when asked to speak honestly with a parent or spouse. Another person may perform well in group but avoid the vulnerability of one-on-one work. A couple may need help discussing trust, money, medication, boundaries, parenting, or living arrangements after treatment. Family members may need education on support versus enabling, but they may also need space for their own anger and grief.

In strong programs, these formats are coordinated rather than scattered. If a client is using DBT skills to pause before reacting, family sessions can reinforce that. If CBT work identifies a pattern of secrecy before relapse, couples therapy can address what transparency might look like at home. If EMDR is underway, the treatment team should understand that trauma processing may temporarily affect mood, sleep, or emotional sensitivity.

Not every family relationship is safe or useful in treatment. That is an important edge case. Some families are supportive but uninformed. Others are chaotic, abusive, actively using substances, or invested in old roles that keep the client unwell. Family involvement should be clinically guided, not automatic. The same is true for couples therapy. It can be powerful when both people can participate safely and honestly. It can be harmful when coercion, violence, or severe manipulation is present.

Holistic supports can help, but they are not substitutes for clinical care

Some addiction treatment programs include holistic or experiential supports alongside clinical therapy. Recreate Ohio identifies options that may include yoga and mindfulness, art therapy, adventure therapy, equine therapy,

Reiki, acupuncture, chiropractic care, fitness and wellness activities, and nutrition education. These services can support recovery when they are integrated responsibly.

A person coming off substances may have ignored their body for years. Hunger cues, sleep rhythms, movement, and basic self-care can feel unfamiliar. Fitness and nutrition education can help rebuild routine. Mindfulness may help someone notice cravings before they escalate. Art therapy can give form to experiences that are hard to verbalize. Outdoor or adventure-based work can help people practice trust, frustration tolerance, and problem-solving in a nontraditional setting.

The trade-off is that holistic supports should not be oversold. Yoga does not replace detox. Nutrition education does not replace medication-assisted treatment when medication is indicated. Equine therapy does not replace trauma therapy. These services are best understood as complementary. They may improve engagement, reduce stress, and help clients experience recovery as more than symptom management.

For some clients, holistic options become the first place they feel present without substances. For others, they may feel uncomfortable or irrelevant. A professional program should allow room for both responses. Personalization matters here, too.

Certification, safety, and clinical responsibility

Drug addiction treatment is healthcare. It involves vulnerable people, high-risk transitions, complex medications, psychiatric symptoms, family strain, and relapse risk. Credentials and oversight matter.

In Ohio, treatment providers that deliver substance use disorder treatment must be certified by the Ohio Department of Mental Health and Addiction Services under state law. Certification does not guarantee that every client will have the same experience, but it establishes an important baseline of accountability. Families and clients should feel comfortable asking direct questions about licensure, clinical staffing, levels of care, medication services, emergency procedures, and how therapies such as CBT, DBT, and EMDR are delivered.

The phrase “full continuum of care” can sound reassuring, but it should lead to practical questions. What happens after detox? How is the decision made between residential and outpatient care? How are co-occurring mental health symptoms assessed? Who provides EMDR? How is medication-assisted treatment coordinated? What role do family sessions play? How does the program respond if a client relapses or wants to leave early?

Good providers do not treat these questions as disrespectful. They expect them. In addiction treatment, clarity can reduce fear. It can also prevent mismatches between what a family assumes is happening and what the program actually provides.

How clinicians decide which therapy to use first

The choice between CBT, DBT, and EMDR is rarely a simple either-or decision. Clinicians look at readiness, safety, symptoms, substance use patterns, trauma history, emotional regulation, medical needs, and the person’s current level of stability. A client who cannot sleep, is in withdrawal, and has severe cravings may need immediate stabilization before detailed cognitive work. A client with repeated relapses after conflict may need DBT skills before deeper trauma processing. A client with intrusive memories that repeatedly trigger use may benefit from EMDR once coping capacity is strong enough.

A simplified clinical sequence may look like this:

- Stabilize the person medically and emotionally, including detox when needed
- Build practical coping skills for cravings, conflict, and distress

- Identify relapse patterns through CBT and real-life behavior review
- Address trauma or distressing memories when the client has enough stability
- Step care down gradually while strengthening support outside treatment

Real care is messier than any sequence. Someone may need to return to stabilization after a setback. Someone else may be ready for trauma work sooner than expected because they already have strong coping skills. Another person may resist therapy entirely at first and engage through peer support, family pressure, or the relief of finally sleeping. Treatment teams have to keep reassessing rather than forcing the person through a preset path.

What progress often looks like

Progress in drug addiction treatment is not always dramatic. Sometimes it is quiet. A person tells staff about a craving instead of hiding it. They stay in group after receiving difficult feedback. They call a family member and tell the truth. They notice a trauma trigger and use a grounding skill. They challenge the thought that one mistake ruins everything. They agree to continue care after residential treatment instead of insisting they are finished.

CBT progress may show up as better pattern recognition. The client starts catching the thought before the behavior. DBT progress may show up as a longer pause between emotion and action. EMDR progress may show up as a memory that still exists but no longer floods the body with the same intensity. Medication-assisted treatment progress may show up as fewer cravings and more capacity to participate in therapy. Family progress may show up as firmer boundaries and less chaos.

Setbacks can also provide information. If someone relapses every time they return to an unsupportive living environment, the issue may not be motivation alone. Recovery housing or a different step-down plan may need consideration. If someone repeatedly leaves treatment when trauma material surfaces, pacing may need adjustment. If someone understands CBT concepts but cannot use them under stress, DBT practice may need more emphasis.

The best treatment plans are alive. They change as the person changes.

A realistic view of integrated care

CBT, DBT, and EMDR each bring something valuable to drug addiction treatment programs. CBT helps people understand and interrupt patterns. DBT helps them tolerate the emotional storms that **treating addiction counseling** often drive relapse. EMDR may help when traumatic memories continue to fuel distress and substance use. None of them works best as a standalone promise. They are strongest when integrated with the right level of care, medical support when appropriate, peer and family involvement, and careful attention to timing.

For people seeking treatment in Ohio, the broader care environment includes certified substance use disorder providers, a legally recognized continuum for opioid and co-occurring drug addiction, and systems intended to support safer prescribing and connection to resources. Recreate Behavioral Health of Ohio describes services in Gahanna that include detox, residential or inpatient rehab, outpatient treatment, medication-assisted treatment, and therapies such as CBT, DBT, and EMDR, along with additional clinical and holistic supports.

The central question is not which therapy has the most recognizable acronym. The better question is what the person needs now, what has kept them stuck, and what combination of supports gives them the best chance to stay engaged long enough for recovery to take hold. In well-run addiction treatment, therapy is not a

performance of insight. It is a practical, disciplined process of helping people survive urges, face pain, repair relationships where possible, and build a life that is no longer organized around drug use.