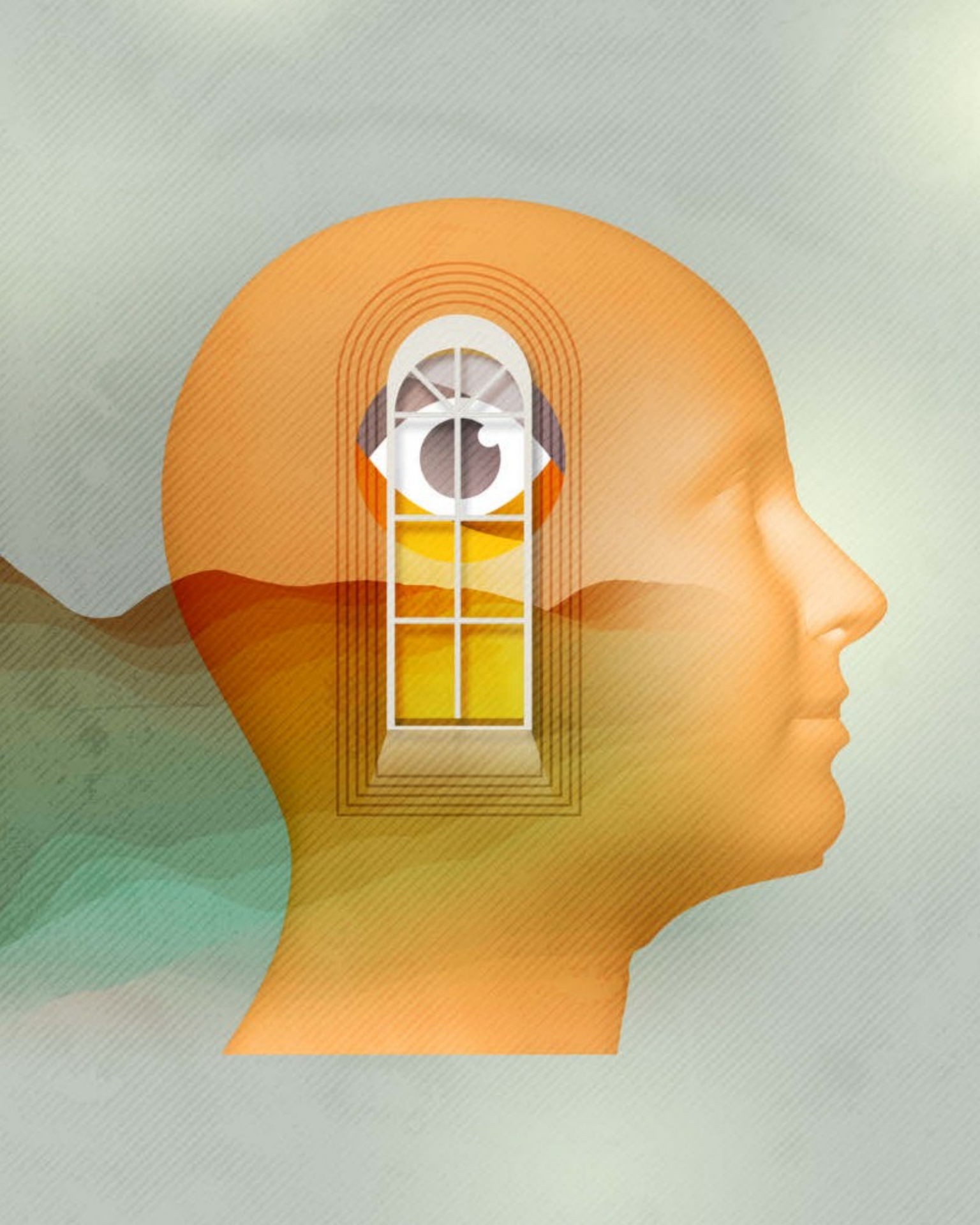


A DAY IN THE LIFE OF A MET(T)A PROTOCOL CENTER

By Stephen Dansiger, PsyD, MFT

Everyone has their unique EMDR training and practice journey. Mine has been intertwined with the world of addiction and recovery from the start.

In 2005, I started my pre-licensed training as a therapist at an addiction treatment center. The Clinical Director, also my clinical supervisor, was an EMDRIA Certified EMDR therapist. She used EMDR therapy as frontline therapy in the treatment process. One client in particular struggled. My role on his treatment team was delivering individual and group sessions on mindfulness skills and anger management. My supervisor reached out for EMDR consultation from Dr. Andrew Leeds, and they invited me to listen in on the phone calls. I recognized some of the terminology, but it sounded different than treatment as usual.

And the client started to improve.I was fascinated. I saw a connection between my then 15 year-long mindfulness practice and this therapy. And as someone in a 12-step recovery since 1989, I intuited that this could be the future approach for treating addiction. Dr. Andrew Leeds was conducting an EMDR Therapy Basic Training a month later, and my EMDR therapy journey began. The beginning of my path came complete with ongoing occasional in-person support from Andrew, and from the late Dr. A.J. Popky, the creator of the DeTur (Desensitization of Triggers and Urge Reduction) Protocol (Popky, 2005; 2010). A.J. happened to live just miles from the treatment center. He relished the opportunity to work with a team excited about EMDR therapy and addiction. Both Andrew and A.J. encouraged me to see EMDR therapy as the present and future of addiction care.

However, in 2014, I was ready to leave the addiction treatment field for good. I had seen too many things that I could not unsee. There were many bad actors in the business's financial sector, inequities were everywhere in the ability to access treatment, and turf wars had left the treatment world stuck in some part of the past that was no longer helpful. Everything seemed to be a "versus" situation: harm reduction vs. abstinence, therapy vs. medicine, 12 step vs. non- 12 step, and so on.

In 2015, I met with Dr. Jamie Marich at the EMDRIA Annual Conference in Philadelphia. She offered me the opportunity to become faculty

with her Institute for Creative Mindfulness and teach her EMDR training curriculum that was perfectly aligned with my mindfulness and EMDR therapy experience. Shortly before that meeting, I was offered the chance to be the Clinical Director at a Buddhist addiction rehab center. I was to design the program and staff it as well. Buddhist mindfulness brought me back to the idea of working in addiction, but I needed an additional antidote to the "versus" mentality. A possible answer presented itself: Trauma-focused care. What if EMDR therapy left the realm of ancillary or specialty treatment and became the primary clinical practice? And what would the impact be on other clinical and non-clinical aspects of addiction treatment? Would there be an impact on operations and systems? Could trauma-focused care be the bridge between all of the "versus" and lead us to an integrative "both/and?"

I went to the CEO and said, "Obviously, I agree with you that Buddhist psychology is going to change the world of treatment; that's why I'm here. But I think the other thing we need to do is train every clinician in EMDR therapy and have it as the primary clinical tool. Everything else will fold into the 8-phase protocol and the Adaptive Information Processing Model. Whaddya think?" Fortunately, he just smiled and said, "I trust you. Go for it."

In the Basics of Buddhist Psychology and Addiction, clients learn the Five Hindrances to mindfulness practice can become portals into mindfulness: As soon as we become mindfully aware of sense desires, anger, sloth and torpor, restlessness and worry, and doubt, then we are no longer being led around by them, but instead they are now objects of meditation.

MINDFULNESS, EMDR THERAPY AND ADDICTION

When I went on an Alcoholics Anonymous (AA) retreat at a Zen Buddhist monastery with only four months of recovery under my belt, I had no idea that I was going to meditate in this fashion for the rest of my life, let alone that I would live at that monastery for a year. I noticed early on that Buddha's fundamental teaching, the Four Noble Truths, read as a diagnostic, and it also sounded like it was describing addiction. The diagnosis: Life contains suffering, and at the very least, can be highly unsatisfactory. Causes and symptoms: What causes the experience of suffering or dissatisfaction? It is the craving and the aversion of the fight or flight mind. The cure: Somehow, we must end this cycle of craving and aversion. The prescription: essentially rewiring the mind and body so that we can engage our wisdom, set an intention, speak/act/work in the world, and make an effort to cultivate mindfulness and concentration to build more mind and heart wisdom. This conceptualization of the heart and mind was already coursing through me when I met EMDR therapy. There seemed to be a connection.

Early in my mindfulness practice, a teacher said to me, "This sitting practice is not so much a practice of the mind. It is a practice of the body." It seemed counterintuitive since we spent so much time sitting still while working on our relationship to the mind while in that state of stillness. But that was the point. How do we find ways to settle the body and mind? How do we essentially grow in distress tolerance and then find resilience for the experience of each day, each moment? This was another thread that brought Jamie Marich and I together. She had been deeply exploring the relationship of movement-based mindfulness to the process of EMDR therapy and its impact on addiction. In stillness, in motion, mindfulness practices could be at the heart of Phase 2 resourcing and Phase 7 closure and the foundation of the remainder of the protocol. We explored this together in our 2018 book, "EMDR Therapy and Mindfulness for Trauma Focused Care," with many of our assessments and interventions coming from experience with addiction and rooted in the treatment of addiction.

EMDR AS A COMPLETE PSYCHOTHERAPY

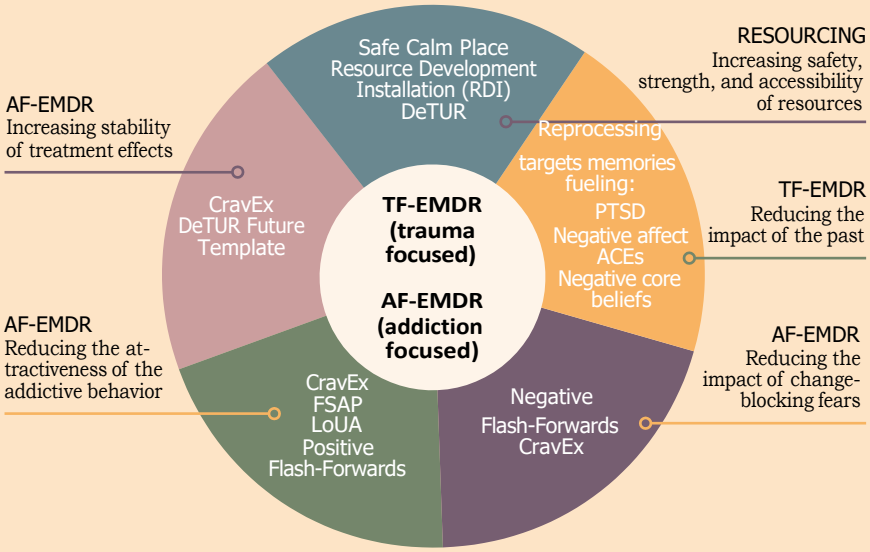
When I trained in EMDR at first, it was suggested to me that this could be my one and only psychotherapy. I could move from being an eclectic practitioner to becoming an EMDR therapist who worked eclectically within the 8-phase protocol and the AIP model. My conception at the time was completed by noticing that I could also work within Janet's Three Stage Model as a guide, as well as the Four Noble Truths of the historical Buddha and other teachings from that and other ancient and modern canons. This gave shape to the MET(T)A Protocol (Mindfulness and EMDR Treatment Template for Addictions). The MET(T)A name refers to the "Meta" use of the 8-phase protocol and the Adaptive Information Processing model to run all clinical and non-clinical operations, and "Metta," which translates as "loving-kindness," a key teaching in Buddhist mindfulness that also guides the work of the agency.

GETTING THE FIRST MET(T)A CENTER ROLLING

The first EMDR Basic training at the first MET(T)A center was held with ten clinicians, including the Medical Director, a psychiatrist. Three clinicians were pre-licensed working toward their hours, and two were still in their graduate school program. The center became an approved practicum training site for multiple graduate schools in the area, allowing us to bring EMDR therapy to the heart of their clinical training. Our clinicians also had the opportunity to train in and deliver mindfulness to the clients and families enrolled in the program and their own self-care.

A main feature of working with the 8-phase protocol and AIP model as central to all aspects of treatment is that the protocol provides contain-

Palette of EMDR Interventions in Addiction (PEIA)



Markus and Hornsveld (2017) approached EMDR and Addictions research and practice through two lenses in this article. First, TF-EMDR (trauma-focused EMDR) and second, AF-EMDR (addiction-focused EMDR), which have been used separately or together in treatment. They defined TF-EMDR as "the use of standard EMDR therapy to assist recovery from addiction by treating underlying trauma and comorbid PTSD." AF-EMDR is defined as "the use of 'adapted' EMDR therapy to target non-trauma memory representations of addiction. Most [AF-EMDR] approaches are directed toward mitigating craving; craving defined as an intense desire to consume a substance or to perform a specific behavior" (Markus & Hornsveld, 2017, pp. 6, 12). Markus and Hornsveld (2017) further examined EMDR addictions interventions via the concept of the palette of EMDR interventions in addiction (PEIA). The PEIA framework articulates a way to place each of the different protocols into categories, identifying different treatment purposes:

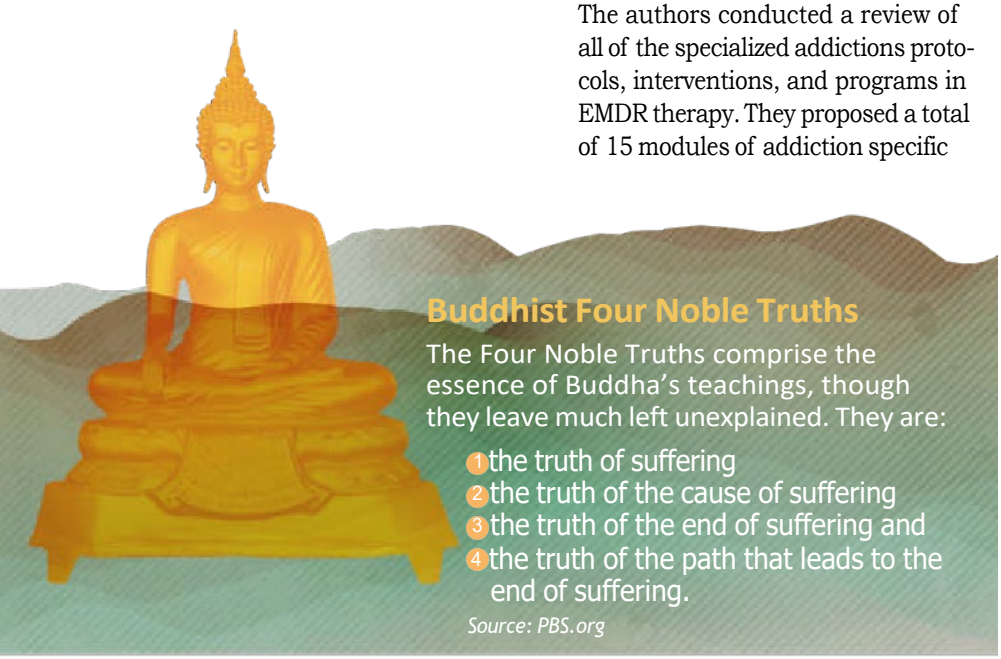
- **Resourcing:** Increasing safety, strength, and accessibility of resources.
- **TF-EMDR:** Reducing the impact of the past. Article highlights whether the reprocessing target is
  -memories associated with PTSD
  -memories fueling negative affect or diverse life experiences
  -memories fueling negative core beliefs.
- **AF-EMDR:** Reducing the impact of change-blocking fears.
- **AF-EMDR:** Reducing the attractiveness of the addictive behaviors.
- **AF-EMDR:** Increasing stability of treatment effects.

Reference

Markus, W. & Hornsveld, H. K. (2017). EMDR interventions in addiction. *Journal of EMDR Practice and Research*, 11(1), 3-29. Open access: https://doi.org/10.1891/1933-3196.11.1.3

ment both for the client and the clinician. A trauma-informed approach where we take time during Phase 2 preparation to widen the client's affective window of tolerance allows the clinician to hold the space without as much secondary trauma getting absorbed. Mindfulness practices also contribute to more general well-being for clinicians. The mindfulness practices being brought throughout the milieu calm the systems, the operations, the environment, and the relationships amongst staff, clients, and other stakeholders.

The training was provided for all staff in mindfulness for self and other care. Training was also provided for all staff in the fundamentals of trauma-informed care and trauma-focused care. The training and practice allowed staff to see the implications and manifestations of the work in formal and informal clinical engagements, group therapy, admissions, operations, and discharge planning. Manuals and protocols were developed to support the training and ongoing administration of MET(T)A.



Buddhist Four Noble Truths

The Four Noble Truths comprise the essence of Buddha's teachings, though they leave much left unexplained. They are:

1. the truth of suffering
2. the truth of the cause of suffering
3. the truth of the end of suffering and
4. the truth of the path that leads to the end of suffering.

Source: PBS.org

History is taken with an eye on the complete clinical picture rather than focusing only on the addiction itself. They are looking for all the trauma and adverse life event-related material that brought them to a life of use of substances and behaviors in order to survive. In a trauma-focused model, we see the addictions as survival mechanisms, and so we need to treat the causes beneath the behaviors. The AIP model suggests that maladaptively stored memories brought to an adaptive resolution will bring sustainable, long-term recovery from the traumatic roots of addiction.

THE PEIA AND THE FURTHER DEVELOPMENT OF MET(T)A

Another turning point for EMDR therapy and addiction care came with Markus and Hornsveld's (2017) development of the Palette of EMDR Interventions in Addiction (PEIA). The authors conducted a review of all of the specialized addictions protocols, interventions, and programs in EMDR therapy. They proposed a total of 15 modules of addiction specific care using EMDR therapy. Of the most interest from our work with MET(T)A were the three trauma-focused modules. Trauma-focused EMDR for PTSD, Trauma-Focused EMDR for adverse life events and their triggering of addictive behaviors, and Trauma-Focused EMDR addressing the common negative beliefs about self often experienced by many people with addiction. The PEIA provided a boost to the idea that the 8-phase standard protocol could be at the center of addiction treatment. In contrast, the specialized protocols and other EMDR-related interventions could support those challenges specific to addiction, including urges and triggers, negative beliefs about self created by and driven by addiction, and future templates related to living differently post treatment.

A TYPICAL DAY IN THE LIFE OF A MET(T)A PROTOCOL CENTER

This is what a day might look, feel and sound like at a MET(T)A Protocol center:

Today, there are three groups: psychoeducation on trauma, mindfulness-based relapse prevention, and the basics of Buddhist Psychology and Addiction. All the groups begin and end with a brief mindfulness meditation that honors the ongoing commitment to trauma-informed mindfulness—eyes can remain open, you can opt-out of any and all instructions, we will use seated mindfulness but also be in movement at times. This makes for a more grounded presence in the group setting and helps everyone set intention to work together with the group leader to keep the group on track. Also, this guarantees each client in the milieu at least some mindfulness practice during the day. There is a discussion regarding the triune brain in the trauma psychoeducation group and the relationship between maladaptively processed memories and addictive triggers and behaviors. In Mindfulness Based Relapse Prevention, that knowledge along with mindfulness-driven exercises from the work of Marlatt and others (Bowen et al., 2021) leverages the psychoeducation and ongoing EMDR therapy to place the clients' attention on relapse prevention as a critical component of the third stage of trauma recovery.

In the Basics of Buddhist Psychology and Addiction, clients learn the Five Hindrances to mindfulness practice can become portals into mindfulness: when we become mindfully aware of sense desires, anger, sloth and torpor, restlessness and worry, and doubt, then we are no longer being led around by them but instead they are now objects of meditation. This increases distress tolerance and widens the affective window of tolerance, two keys to being able to tolerate and successfully navigate the reprocessing phases of EMDR therapy.

Today several clients are having their individual EMDR therapy sessions. In their group work, in session, and through informal conversations within the milieu, they have learned that everything that happens at the center is considered a potential resource. In their sessions, they work on additional resources, including those they might use in the office for Phase 7 closure. History is taken with an eye on the complete clinical picture rather than focusing only on the addiction itself. They are looking for all the trauma and adverse life event-related material that brought them to a life of use of substances and behaviors in order to survive. In a trauma-focused model, we see the addictions as survival mechanisms, and so we need to treat the causes beneath the behaviors. The AIP model suggests that maladaptively stored memories brought to an adaptive resolution will bring sustainable, long-term recovery from the traumatic roots of addiction.

In the clinical meeting, the language sounds much like an EMDR therapy consultation. Rather than asking whether EMDR therapy will be used, the conversation revolves around what resources are being built for the client and what additional preparation will be needed to begin reprocessing. "It's always EMDR therapy," (Dansiger, 2019) is the mantra. Many other therapies and modalities are being used, but they are being seen within the context of EMDR therapy. Everyone in the meeting has been trained in EMDR therapy. Most of them are on their way to EMDRIA Certified Status, and the Clinical Director has gone on to become a Consultant in Training well on their way to Approved Consultant status. The agency sponsors several Advanced Topics courses each year for their therapists. As a result, there is an advanced and deep commitment to addressing the clients' trauma and adverse life experiences. The team is constantly reevaluating the impact of the trauma-focused care on the addiction-related symptoms and adjusting the treatment plan accordingly.

Throughout the milieu, you hear clients, families, and staff using the language and practices of trauma-focused care and mindfulness. There is cohesion in purpose and direction. We reduced staff turnover, and there is consistency within the organization, and therefore more consistency in the treatment process. Instead of clients being in a rush to end treatment, they want to stay to continue

Some major tenets of MET(T)A Protocol

- A trauma-focused approach to addiction will result in long-term sustainable recovery.
- All clients are EMDR therapy clients from not only the moment they start intake but during the intervention, admissions, and even the detox process.
- Every client will receive Phases 1 and 2 of EMDR therapy, as well as Phases 7 and 8.
- Those who are prepared sufficiently for reprocessing during their stay will receive Phases 3 through 6.
- Those who need more preparation will either stay longer in treatment if possible and/or will have continued trauma treatment built into their discharge plan.
- For this approach to be fully effective, all stakeholders in treatment must receive training in trauma-focused care to support EMDR therapy. If the whole team has trauma-focused language and principles to work by, then treatment becomes truly trauma-focused.

their course of EMDR therapy. And those that are discharging wish to continue that journey. Clients and others have more hope, engendered by MET(T)A, providing a template for enacting thought leaders' clarion call over the last decades. To treat addiction, we need to treat the trauma.

FUTURE TEMPLATE: EMDR THERAPY AND ADDICTION

I am keenly aware that MET(T)A Protocol is only one way to frame the possibilities in treating addictions with EMDR therapy. For example, at this time, research is being conducted on using CravEx (Hase, 2010) at several treatment centers throughout Europe, and the PEIA has taken shape as a treatment approach with scripts and other guidance. As for MET(T)A protocol, two addiction centers, and one eating disorder clinic have finished all of the training in our accreditation model, which is designed to help agencies learn to run this system and then have it become self-sustaining. Other agencies are starting the process.

I hope that more practitioners and agencies will see how the Standard Protocol can drive addiction care, and there will be more conceptualizations, protocols, research, and action to continue this momentum. More than anything, I would love the addiction treatment community to see EMDR therapy as a complete psychotherapy, and more specifically, as a comprehensive primary psychotherapy for addiction treatment. All of the current and past models of treatment can fit within and be supported by this approach. There are also positive implications for helping underserved communities build this type of self-sustaining structure to increase access to trauma-focused addiction care at all levels of care. As is said in the 12-step groups I still return to after over 30 years of my recovery, "There is a solution." Now that solution can be trauma-informed, trauma-focused, and provide sustainable, long-term recovery.

More than anything, I would love the addiction treatment community to see EMDR therapy as a complete psychotherapy, and more specifically, as a comprehensive primary psychotherapy for addiction treatment.

Dr. Stephen Dansiger played CBGB and Max's Kansas City in the late 70s; drank, played drums in a toy rock band and then got into recovery in the late 80s; became an international social justice/diversity educator and rocker again in the 90s; and is now an EMDR therapist, Approved Consultant, trainer, writer and meditation teacher. As a diversity and inclusion educator for 15 years, he provided direct training services to groups from pre-K through universities and corporations and trained dozens of trainers throughout the U.S. He is a Founding Member of the Society for Health Care Innovation, an outgrowth of the Master of Health Care Innovation (MHCI) program at the University of Pennsylvania Perelman School of Medicine and Wharton School, where he is in the third cohort. His most recent upcoming book, coauthored with Jamie Marich, is Healing Addiction with EMDR Therapy: A Trauma Focused Guide *(Springer, September 2021).*

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