The MET(T)A Protocol: Mindfulness and EMDR Treatment Template for Agencies

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ABSTRACT: Evidence indicating the relationship between trauma and substance use disorders (SUDs), in addition to relapse and treatment retention rates for this population, suggests there is a need for a trauma-focused solution to treat SUDs. Eye movement desensitization and reprocessing (EMDR) therapy has been studied extensively as an effective approach for treating trauma and Posttraumatic Stress Disorder (PTSD). The research evaluating its treatment for other mental health disorders such as SUDs is promising. Merging mindfulness and ethical mindfulness practices with EMDR therapy lends additional evidence-based elements to make the case for this integrative system of treatment to be studied as a trauma-focused primary psychotherapy to treat SUDs. The resulting treatment, the MET(T)A Protocol (Mindfulness and EMDR Treatment Template for Agencies), has been created to address the need for a trauma-focused solution to treat SUDs. Procedures of the MET(T)A Protocol as applied in each of the 8 phases of EMDR therapy are described in detail. Clinical examples are provided to explain the application of the MET(T)A Protocol.

KEYWORDS: Substance use disorders, EMDR therapy, trauma, PTSD, mindfulness, Buddhist psychology, MET(T)A Protocol

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Individuals who enter treatment programs seeking help for substance use disorders (SUDs) often get discharged prematurely or leave against medical advice, consequently resulting in the lack of sufficient treatment needed to maintain recovery. The National Institute on Drug Abuse (NIDA)[1] highlighted that treatment dropout is a major challenge faced by addiction treatment programs. Treatment relapse rates are another barrier to successful addiction treatment. NIDA[1] reported that 40 to 60 percent of people with addiction relapse. Clinical treatment studies estimated that more than two-thirds of individuals relapse within weeks to months of beginning treatment and that 85 percent of individuals relapse and return to drug use within 1 year of treatment.[2]

The harrowing statistics of addiction treatment indicate a need for new interventions. If simply treating SUDs is the solution to long-term recovery, treatment centers would not continue to struggle with client retention, and relapse rates would not be as significant. So, what is the missing link? Trauma commonly co-occurs with SUDs.[3-9] Research indicates that experiencing trauma as a child or adolescent is strongly associated with adult substance use, and may contribute as a risk factor for addiction later in life.[10-14] While treating SUDs and their symptoms is necessary for recovery, treatment must also focus on the root of the pain driving the substance use. The role that trauma plays is commonly overlooked in addiction treatment and met with resistance from treatment providers who fear that addressing trauma will lead to relapse. However, there are some current behavioral treatments with empirical support that address both SUDs and Posttraumatic Stress Disorder (PTSD) such as Seeking Safety,[15] Integrated Cognitive Behavioral Therapy for PTSD and SUD,[16] Prolonged Exposure,[17] Concurrent Treatment of PTSD and Substance Use Disorder Using Prolonged Exposure (COPE),[18] and Cognitive Processing Therapy.[19] Unfortunately, these treatments are limiting due to their solely cognitive approaches which is insufficient, as addiction compromises the functioning of the prefrontal cortex,[20] the part of the brain responsible for cognitive behavior. The link between trauma and SUDs marks a need for a trauma-focused solution that not only addresses cognition but also the emotional-limbic system and the body.

Eye Movement Desensitization and Reprocessing (EMDR) Therapy

EMDR therapy is an 8-phase treatment approach which consists of standardized protocols and procedures to treat unprocessed memories of adverse life experiences.[21] Unlike other therapies that strictly focus on current issues, EMDR therapy approaches the treatment of the individual from 3 different avenues through a three-pronged protocol: it resolves past experiences, targets current triggers, and helps to build trauma resiliency for the future. Bilateral stimulation (BLS) in the form of eye movements, tactile taps, or auditory tones is one aspect of the procedures used to desensitize and reprocess these memories into an adaptive, functional form. Processing maladaptively stored memories to an adaptive resolution through EMDR therapy decreases subjective distress, ameliorates negative emotions, beliefs, and physical sensations caused by them, and strengthens adaptive cognitions.[21]

The premise of EMDR therapy is rooted in the Adaptive Information Processing (AIP) model which theorizes that the foundation of mental health disorders is maladaptively stored memories of earlier adverse life experiences.[21] This theoretical model postulates that EMDR therapy has the ability to treat a plethora of clinical symptoms. Guided by a

model (AIP), methodology (8 phases), a protocol (three-pronged: treating the past, present, and future), and addressing distressing cognitions, emotions, and physiological symptoms, EMDR therapy has the potential to serve as a complete system of psychotherapy.

EMDR therapy is an effective treatment for PTSD.[22-29] Additionally, EMDR therapy has been studied as a promising treatment for other mental health disorders such as anxiety disorders,[30,31] bipolar disorder,[32] obsessive compulsive disorder,[33,34] acute stress disorder,[35] depression,[36,37] psychosis,[38] and personality disorders.[39] The diverse range of clinical applications for EMDR therapy infers that this treatment is wide ranging in its healing, supporting the case for it to be implemented as a primary psychotherapy. This is further advocated by the fact that in 2014, the late creator of EMDR therapy, Dr. Francine Shapiro, requested that EMDR be referred to as EMDR therapy, acknowledging EMDR therapy as a complete system of healing.[40]

EMDR Therapy to Treat SUDs

While studies using EMDR therapy to treat SUDs have theoretically informed clinical practice,[41-52] a gap in research exists supporting its efficacy, considering that there have only been 3 randomized controlled trials (RCTs).[53-55] Nonetheless, the promising prospect of using EMDR therapy to treat SUDs has generated 4 different addiction-specific EMDR therapy protocols: the desensitization of triggers and urge reprocessing (DeTUR) protocol,[56,57] (an urge reduction protocol that targets the triggers that bring up uncomfortable feelings leading to urges), the craving extinguished (CravEx) approach,[58] (focuses on the reprocessing of the addiction memory leading to stabilization in the addiction), an approach on dysfunctional positive affect,[59] (targets the dysfunctional positive affect associated with a behavior or person that can block access to a traumatic memory), and the feeling-state addiction protocol (FSAP[60]) (a modified form of EMDR therapy that breaks the fixation of a positive feeling event associated with an addictive behavior).

From this platform, Markus and Hornsveld[20] developed a set of all resourcing, trauma, and addiction-focused EMDR therapy (AF-EMDR) interventions that can be used to treat addiction. Known as the palette of EMDR interventions in addiction (PEIA), this selection of 15 modules was identified based on existing protocols, theoretical considerations, and clinical experience. The premise behind the PEIA is that it provides a plethora of promising options for a clinician to choose from when focusing on EMDR therapy treatment for addiction, based on history taking and individual case conceptualization. However, these interventions are not to be used as a standalone treatment but rather in conjunction with established addiction treatment. Research supporting the use of standard EMDR therapy, AF-EMDR therapy, and combined standard and AF-EMDR therapy to treat SUDs will be reviewed.

The Use of Standard EMDR Therapy to Treat SUDs

Kullack and Laugharne[45] studied 4 participants who met the criteria for PTSD and SUDs and who each received a standard EMDR therapy session weekly with no modifications or adaptations with the total number of sessions ranging from 4 to 9. At a 12-month follow-up, this study concluded that 3 out of 4 participants no longer met the diagnostic criteria for current substance or alcohol dependence, and 3 participants experienced a decrease in cravings. Marich[46] presented a case study of a cross-addicted female diagnosed with substance dependence and PTSD to demonstrate the impact EMDR therapy has had on her recovery process. After receiving treatment in a 12-step facilitation program, the participant in this study received 15 sessions of EMDR therapy over a 9-month period. Following EMDR therapy, in a semi-standardized phenomenological interview, the individual in this study reported having achieved 18 months of sobriety. Prior to this, the participant had been treated 12 times with traditional approaches but had never achieved more than 4 months of continuous sobriety. Marich[47] also conducted a study of 10 women who had received EMDR therapy as part of their continuing care treatment, all of whom considered their EMDR therapy treatment to be a critical component of their recovery continuing-care process. Several other studies supported the use of standard EMDR therapy to treat SUDs and other addictions.[42,44,50,61]

Addiction-Focused EMDR Therapy

In addition to using standard EMDR therapy to treat SUDs, other studies have explored the use of adapted EMDR therapy to treat SUDs and other addictions. Markus and Hornsveld[20] described that AF-EMDR therapy is used to target non-trauma memory representations of addiction. They identified goals of AF-EMDR therapy to include decreasing the fears or beliefs that paralyze an individual from changing, reducing the intensity of cravings and urges to use substances, and desensitizing triggers. They also suggested that AF-EMDR therapy protocols focus on reducing the attractiveness of the addictive behavior by emphasizing positive non-use memories as well as augmenting the stabilization of treatment effects.

In RCT, Hase et al.[53] used AF-EMDR therapy to reprocess the addiction memory, which is an episodic memory activated when experiencing craving or withdrawal symptoms, or thinking about relapse or the effects of drugs, in alcohol dependent participants. Compared to the treatment as usual (TAU) group, this study demonstrated that those who received AF-EMDR therapy reported a statistically significant decrease in craving at posttreatment and at one-month follow-up. At 6-month follow-up, this study concluded that the group that received AF-EMDR therapy had lower relapse rates than the TAU group. Other studies demonstrated the use of AF-EMDR therapy to treat SUDs and other addictions.[41,49,62-65]

Combined Standard and AF-EMDR Therapy

A quasi experimental study[43] assessed the effectiveness of combined standard EMDR therapy and AF-EMDR therapy in

treating posttraumatic and stress-related symptoms in 40 patients with SUDs. This study implemented the standard EMDR therapy protocol and AF-EMDR therapy protocols (CravEx,[58] an approach on dysfunctional positive affect,[59] FSAP,[60] and DeTUR[56,57]) in accordance with the PEIA. The TAU and EMDR therapy group in this study showed a significant reduction in posttraumatic, dissociative, psychiatric, and anxiety symptoms, whereas the TAU group showed a significant decrease in only posttraumatic symptoms. Although aspects related to characteristics of SUDs such as craving and abstinence were not investigated, this study has implications for promise in treating addiction, as a reduction in posttraumatic, dissociative, and psychiatric symptoms promotes addiction recovery by eliminating distressing states that might otherwise trigger an individual to use substances.

Wise and Marich[52] performed a qualitative phenomenological study in which the lived experience of 9 participants with co-occurring PTSD and addictive disorders was assessed after receiving both standard EMDR therapy and AF-EMDR therapy protocols. The AF-EMDR therapy protocols used in this study were DeTUR,[56,57] CravEx,[58] FSAP,[60] or a combination of the protocols. All participants in this study identified a remission in trauma and addictive disorder symptoms through standard EMDR therapy and AF-EMDR therapy and reported positive outcomes from the combined EMDR therapy approaches.

Safety Considerations for EMDR Therapy Reprocessing

While research indicates that EMDR therapy is a safe and effective treatment for PTSD and that it is a promising treatment for other mental health disorders, such as SUDs, client readiness and client safety factors must be assessed during phase one, client history, to determine which clients are ready for EMDR therapy reprocessing. Dissociated information, emotions, and physical sensations that were experienced at the time of the trauma can surface during or after reprocessing. As a result, if the client is not prepared properly, some of the risks associated with EMDR therapy reprocessing for individuals with SUDs are relapse and dissociation.

The emergence of disturbing material during or after EMDR therapy reprocessing can lead clients with SUDs to want to use substances to cope with this distressing experience.[21] It is critical that the EMDR clinician assess the client's capability to tolerate potentially distressing experiences that can arise from reprocessing.[21] It is through a thorough assessment during phase 1 that the EMDR clinician evaluates clients for distress tolerance skills and alternative coping strategies to implement instead of using substances to manage any disturbing psychological material that may surface during or after reprocessing.

Another potential risk of EMDR therapy reprocessing is dissociation, an initially adaptive response[66] of separating from parts of experience including somatic experience, consciousness, affects, perception, identity, and memory.[67] Dissociation is a freeze response that people use to cope with trauma.[66] If a client's system becomes overwhelmed by distressing psychological material, the client may dissociate to protect themselves from the unbearable experiences. During phase one, the client's ability to remain in the present moment while experiencing distress must be assessed and the EMDR clinician must ensure that the client has sufficient skills to ground themselves if they become emotionally dysregulated. Additionally, the client must be adequately monitored during reprocessing to ensure that they remain within their affective window of tolerance.

During phase one, if it is determined that the client is not able to withstand the experience of reprocessing a targeted traumatic memory, extended preparation (developing a safe therapeutic relationship, explaining EMDR therapy and its effects, addressing the client's concerns and needs, preparing the client to handle any disturbance that may arise in EMDR therapy reprocessing, and developing coping strategies such as a calm safe place and other affect regulation techniques) is needed before the client will be able to safely reprocess the memory.[21] Some of the client safety factors identified by Shapiro[21] to be critically assessed to determine which clients are ready for EMDR reprocessing are: level of rapport (the client feels comfortable to tell their clinician the truth about what they are experiencing), emotional disturbance (since the client should be able to withstand intense emotional disturbance that may emerge during or between EMDR reprocessing sessions, the clinician should test a variety of self-control and relaxation techniques to see if the client can successfully be alleviated from disturbance), stability (the client must be assessed for personal and environmental stability, including the client's capacity to ask for assistance if needed), life supports (the client must have a support system of people who can be there for them through disturbance in between sessions), and general physical health to endure the somatic sensations of memory reprocessing (for individuals with any physical problems, a physician should be consulted regarding any potential negative effects of intense emotional response; caution should be taken with women who are pregnant). EMDR therapy must be administered by a trained EMDR clinician and client readiness and safety factors must be assessed thoroughly during phase 1 to ensure the stabilization of the client during EMDR therapy reprocessing.

The Role of Mindfulness in Trauma-Focused Treatment for SUDs

In addition to EMDR therapy, mindfulness also plays a role in addressing SUDs and PTSD. Often, it is the symptoms of trauma that an individual is trying to cope with by using substances. Intrusion symptoms, avoidance of trauma-related stimuli, negative alterations in cognitions and mood, and alterations in arousal and reactivity can feel unendurable to the survivor of trauma and unsurprisingly result in the survivor using substances to manage them. The sequelae associated with surviving trauma are divorced from the experiencing of the present. The symptoms of trauma

can hijack the survivor from any chance at living in the moment. Accordingly, van der Kolk[68] refers to mindfulness practice as a cornerstone of recovery from trauma. Unresolved trauma results in symptoms that are too overwhelming for the prefrontal cortex to process, and as a result, it shuts down to protect conscious awareness from experiencing physical sensations, cognitions, and emotions related to the trauma, leaving the survivor without control over their experiences. Therefore, a main tenet of trauma recovery involves gaining mastery over internal sensations and emotions.[68]

Mindfulness, a purposeful, nonjudgmental awareness of the present moment,[69] provides the necessary self-empowerment and self-mastery that is needed to not only manage distress, but to change one's relationship with it. Mindfulness does this by strengthening the medial prefrontal cortex which allows for interoception, awareness of sensory, body-based feelings, an essential element of recovery from trauma.[68] In addition, van der Kolk[68] notes that mindfulness practices can help traumatized people by widening their tolerance of sensory experience, calming the sympathetic nervous system, lessening the destruction of fight/flight/freeze responses, and promoting distress tolerance. These benefits of mindfulness not only support trauma recovery, but they also promote recovery from SUDs.[70-72] Considering that substance use can be triggered by distressing mental and emotional states, maintaining self-awareness, possessing a widened ability to tolerate distress, and developing self-mastery may help to prevent individuals from using substances to cope with intolerable experiences.

Research supporting mindfulness-based treatment for symptoms of trauma is promising.[73-80] In their review, Boyd et al.[74] concluded that mindfulness-based treatments are effective in reducing symptoms of PTSD. Mindfulness-based approaches, such as Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT), are thought to address core components of PTSD symptoms such as avoidance, hyperarousal, emotional numbing, and negative emotions.[74] Boyd et al.[74] demonstrated hypothesized mechanisms by which mindfulness-based approaches may target symptoms of PTSD: Intrusion symptoms are thought to be addressed by the impact of mindfulness shifting attention to the present moment and providing reduced attentional bias to trauma stimuli. Avoidance is targeted by mindfulness through an increased openness to experience and willingness to approach fearful stimuli. Alterations in mood and cognition can be managed through nonjudgmental acceptance of trauma-related cognitions by an increase of self-compassion and a reduction of self-blame. Mindfulness targets alterations in arousal and reactivity through its potential to promote reduced attentional bias to trauma stimuli and a greater ability to remain in the present moment. Dissociative symptoms can be mitigated through the connection and awareness of somatic sensations and enduring aversive internal experiences brought on by mindfulness.

The Role of Mindfulness and Buddhist Psychology in EMDR Therapy

While research supporting the role of mindfulness in EMDR therapy is insufficient, EMDR therapy is still viewed by many clinicians in the trauma-focused field as a mindfulness-based therapy.[40] Mindfulness is inherent in EMDR therapy in phase 2, (preparing and stabilizing clients for EMDR reprocessing) phase 4, (desensitization, reducing the level of distress associated with the adverse life experience) and phase 5, (installation). Fundamental mindfulness components of phase 2 include: resourcing, which helps clients to regulate distress through accessing internal and external experiences and grounding, which unites clients to the present moment. In phase 4, paying attention to BLS in the form of eye movements, tapping, or tones is a form of mindful attention. Also during phase 4, well-established procedures of the EMDR clinician guiding the client to "just notice," "go with that," and "let whatever happens, happen" are rooted in nonjudgmental observation and awareness, key components of mindfulness.[21,81]

Logie[82] indicated that mindfulness can potentially serve as a mechanism of EMDR therapy, highlighting that phase 4 implements principles of mindfulness. Oren and Solomon[83] proposed that mindfulness is innately embedded within phase 4 and phase 5, (enhancing the client's positive cognition that replaces the original negative belief associated with the trauma) and concluded that mindfulness is a potential mechanism of action in EMDR therapy. Rozelle and Lewis[84] consider EMDR therapy to be a mindfulness-oriented intervention for trauma. They deduced that EMDR therapy has a meditative quality as a result of its resources, specifically the "safe place" technique, which helps clients to stay within their affective window of tolerance, when experiencing both hyperarousal and hypo-arousal as a response to processing traumatic material.

Mindfulness is just 1 component of a larger teaching known as Buddhist psychology. Buddhist psychology, which is rooted in Buddhist teachings, is a radical and positive approach to psychology and human life that focuses on how individuals think about their thoughts and experiences and their relationships with them rather than focusing on the contents of consciousness.[85] Rozelle and Lewis[84] proposed that a close connection exists between EMDR therapy and Buddhist practices through the fostering of concentrated attention and transformative insight. Concentrated attention is inherent in EMDR therapy in phase 4, in which the client pictures the targeted traumatic memory and focuses on a form of BLS at the same time. In parallel, mindfulness and meditation, 2 practices of Buddhist psychology, implement the use of concentrated attention to ease suffering. EMDR therapy promotes insight through the client developing a positive cognition that replaces the negative cognition associated with a traumatic memory, which represents the belief that the client can heal. Similarly, Buddhist psychology describes a process of enlightenment where positive cognitions and feeling states, such as lovingkindness,

compassion, sympathetic joy, and equanimity arise through the processing and transformation of suffering. EMDR therapy invokes realizations within clients such as acknowledging that the trauma that is causing them suffering is a memory in the past and that the threat is no longer present. Buddhist psychology promotes the realization that suffering can be healed innately through enlightenment, allowing the survivor to more easily arrive in the present moment without continuing ruminations on past traumas and future fears. Additionally, both EMDR therapy and Buddhist psychology are based on the premise that the mind has the innate capacity to heal itself.

Mindfulness as a Treatment for SUDs

Mindfulness has been identified as delivering several treatment mechanisms for behavioral addictions such as a decrease in reactivity, a reduction in relapse and withdrawal symptoms by substituting maladaptive addictive behaviors for a positive relationship with mindfulness/meditation, the ability to regulate dysphoric mood states, adapting the concept of urge surfing, (allowing urges to pass without acting on them by simply observing them), and reduced autonomic and psychological arousal as a result of conscious breathing.[86] In their systematic review and meta-analysis, Li et al.[87] concluded that mindfulness training shows promise in the treatment of substance misuse. They found that compared to TAU, mindfulness treatment was more effective in reducing the amount and frequency of substance misuse in addition to deducing that mindfulness training resulted in positive findings in the treatment of alcohol and other drug misuse in adults.

In a systematic literature review of mindfulness-based interventions (MBIs) for the treatment of substance and behavioral addictions, Sancho et al.[72] concluded that MBIs reduce symptoms of addiction such as dependence and craving and result in the improvement of depression, anxiety, and emotion regulation challenges. There are several studies that demonstrated the capacity that MBIs have for reducing cravings.[88-92] In addition to reducing cravings, applying the components of mindfulness fully into one's life may lead to sustainable recovery by solidifying treatment gains.[93]

Garland et al.[94] determined that MBIs demonstrate the potential to benefit individuals with SUDs by promoting recovery and positive behavior change. This is evidenced by their study showing that MBIs reduce drug cue reactivity, improve natural reward processing, disengage emotional reactivity from subsequent moods and behaviors, increase positive affect, alter cognitive control networks and reward circuits, interrupt drug-use action schemas, regulate addictive automaticity, and increase control over attentional bias. Their study also concluded that MBIs exercise, strengthen, and remediate the cognitive control networks and natural reward circuits that have been hijacked by chronic drug use.

Witkiewitz et al.[95] highlighted similarities between mindfulness-based approaches and already established treatments for SUDs such as cognitive-behavioral therapy, behavior therapy, and 12-step programs. Mindfulness-based treatments, similar to the cognitive-behavioral approach to treating SUDs, focus on the examination of thoughts as they relate to cravings, triggers, and urges.[95] Observing thoughts as pleasant, unpleasant or neutral, leaning into the acceptance of them, and reevaluating them from seemingly unbearable to tolerable and expected aligns with cognitive restructuring and reframing.[95]

Mindfulness-based approaches also share similarities with behavior therapies, such as exposure therapy.[95] While exposure therapy gradually exposes the individual to their triggers and uses the process of habituation to produce more adaptive behavioral responses, mindfulness-based approaches use a similar concept of urge surfing, in which the individual non-judgmentally observes a distressing thought or experience, acknowledges its presence, does not fight it, and allows it to pass without acting on it.[95] Additionally, the 12-step treatment model for SUDs highlights in its 11th step for individuals to use the practice of meditation to improve their relationship with their higher power and to maintain spiritual fitness. An important element of MBIs and one of its most effective practices is meditation. Mindfulness-based approaches can widen individuals' experiences with the 11th step with the use of various teachings of meditation and mindfulness techniques that can target relapse prevention by providing avenues for affect regulation.

Safety Considerations for Mindfulness

While there is a strong body of research that demonstrates the wide-ranging benefits of mindfulness,[96-100] there is also literature that indicates potential risks of mindfulness. Van Gordon et al.[101] reviewed studies reporting adverse effects associated with mindfulness: mindfulness meditation increased false memory recall,[102] meditation reportedly exacerbated mental health issues and led to troubling thoughts and feelings,[103] participants developed an addiction to mindfulness,[104] MBIs increased awareness of psychological issues that had priorly remained latent,[105] and meditation induced psychotic symptoms.[106] Van Gordon et al.[101] concluded that due to the small number of studies investigating the adverse effects of mindfulness, it is not clear whether mindfulness can lead to negative health outcomes. Additionally, they argued that it is the lack of understanding the nuances of mindfulness by instructors and poor teaching of mindfulness rather than mindfulness itself that leads to the greatest risk.[101]

Creswell[107] reviewed the risks of participating in mindfulness interventions. He reported that unpleasant experiences such as agitation, anxiety, discomfort, or confusion are not uncommon reactions to mindfulness training and that they are viewed as an important characteristic of the psychotherapeutic change process in mindfulness interventions. Lustyk et al.[108] summarized potential adverse effects of mindfulness meditation into 3 categories: mental, physical, and spiritual health considerations. Adverse effects on mental health, which were the most

frequently reported negative consequences of meditation included depersonalization, psychosis, depression, and anxiety. Adverse effects on physical health involved neurological and somatic problems. Regarding negative consequences related to spiritual health, some studies reported cases of religious delusions. Most of the studies reviewed by Lustyk et al.[108] reporting adverse effects were case studies. While case studies are helpful in identifying adverse effects, more rigorous study designs such as RCTs would provide more conclusive evidence.[109]

There are also specific risks of mindfulness for individuals with SUDs with a history of trauma. Mindfulness can intensify symptoms of traumatic stress such as flashbacks, dissociation, and heightened emotional arousal.[110,111] When this population is asked to purposefully pay close attention to their internal world, they can become overwhelmed with the unbearable sensations, increasing cravings and the desire to find relief in maladaptive ways. In order for mindfulness to be a safer and more effective practice, it must be practiced with an understanding of trauma.[110] A trauma-sensitive approach to mindfulness is necessary to gradually open the client up to connecting with their internal experiences that they have worked so hard to shut down. Trauma-sensitive mindfulness aims to minimize the possible risks of mindfulness while catalyzing the potential benefits at the same time.[110] Treleaven[110] proposed 5 principles of trauma-sensitive mindfulness: stay within the window of tolerance, shift attention to support stability, keep the body in mind, practice in relationships to support safety and stability in survivors of trauma, and understand social context.

Buddhist Psychology as a Treatment for SUDs

Buddhist psychology uses mindfulness to investigate mental states, to release those states that cause suffering, and foster those that bring peace.[85] Buddhist psychology consists of philosophy practices, community life, meditations, cognitive strategies, and ethical trainings that foster inner transformation.[85] Kornfield[85] identified 26 principles of Buddhist psychology encompassing components that result in freedom from suffering such as mindfulness, compassion, wisdom, concentration, the middle path, and the causes of suffering, including clinging, delusion, and ideas of self. These principles highlight the well-developed and time-tested healing system of Buddhist psychology that redefines how mental health disorders are viewed and how treatment is implemented.

Buddhist psychology views addiction as a false refuge that is a form of attachment associated with a desire for pleasurable states, the resulting clinging and grasping to continuously experience them, and aversion to experiences that cause displeasure.[112] Addiction occurs when the desire that leads to grasping and clinging becomes insatiable. Relief is only experienced momentarily and is quickly followed by a craving for more. The state of addiction is referred to by Buddhist psychology as becoming a hungry ghost: satisfaction is unachievable.[85] While Buddhist psychology views pain as inevitable, it describes suffering, which includes addiction, as a reaction to pain. Within the Buddhist psychological system of human suffering exists a solution. One of the primary teachings of Buddhism, the Four Noble Truths, offers within it a medical model to treat addiction: The diagnosis is that suffering is the core problem of life; the symptoms and causes of suffering are craving, clinging, aversion, and unhealthy attachment; the cure to end suffering is to turn toward the causes and conditions that create suffering and heal them; the prescription to end suffering is the Eightfold Path, which is a guide to the path of liberation from suffering through following essential elements of Buddhist practice: moral conduct, mental discipline, and wisdom.[113]

While the history of the Eightfold Path and Buddhist psychology dates back 2600 years, only recently has there has been an increase in the evidence base for the implementation of "third-wave" cognitive behavioral approaches, which are rooted in Buddhist and other eastern philosophies, for the treatment of psychopathology.[86,114-116] Mindfulness and meditation are the most well established aspects of these cognitive behavioral approaches, but are only a small component of Buddhist psychology. Buddhist principles of compassion, lovingkindness, and non-self have also risen to areas of interest for research.[86] Shonin et al.[115] found that Buddhist-derived lovingkindness and compassion meditation can improve: psychological distress, levels of positive and negative affect, the frequency and intensity of positive thoughts and emotions, interpersonal skills, and empathic accuracy, all of which have implications for recovery from SUDs. However, considering that there has been no unified system for the effective clinical operationalization of Buddhist principles and practices within clinical settings,[116] it is challenging to measure Buddhist psychology as a treatment for SUDs. Further investigation is warranted to determine how to operationalize Buddhist principles and practices in a manner that will result in research validity.

The MET(T)A Protocol: Mindfulness and EMDR Treatment Template for Agencies

The MET(T)A Protocol is a trauma-focused solution in which trauma resolution and adaptive reprocessing are the focal points of treatment for SUDs. It is currently being implemented at 3 different SUDs treatment centers where research is in preliminary stages. The protocol is comprised of 4 elements: (1) Foundational training in the 8-phase protocol and AIP model of EMDR therapy and consultation for all clinicians at the agency; (2) Staff training in mindfulness, Buddhist psychology, and trauma-focused care; (3) Enhancing the mindfulness inherent in EMDR therapy and integrating Buddhist psychology into the 8 phases of EMDR therapy and Pierre Janet's Three Stage Model of Trauma Treatment; and (4) Supervision for clinical and organizational leaders in implementing the MET(T)A Protocol effectively. EMDR therapy, which is supported by over 30 years of research, and mindfulness and Buddhist psychology, which are rooted in 2600 years of application, are the guiding treatment components of the protocol. The protocol incorporates mindfulness techniques and practices to

provide stabilization and resourcing for clients and to help them increase their affective window of tolerance. Additionally, the protocol teaches clients a design for mindful living through guiding them along the Eightfold Path, which suggests building wisdom in order to set skillful intentions, living ethically in speech, action, and livelihood, and making the effort to develop mindfulness and concentration through meditation practice. It also implements Buddhist psychology as an empowerment-based approach to treating SUDs, guided by the philosophy that freedom is possible even in the midst of unendurable suffering, highlighting the innate resilience that exists within clients.

Designed for trauma-focused care and the therapeutic treatment of clients recovering from SUDs, the MET(T)A Protocol is a comprehensive treatment protocol directed by the model, methodology, and three-pronged protocol of EMDR therapy integrated with trauma-focused practices of mindfulness, a design for mindful living through the Eightfold Path, and Buddhist psychology. The AIP model, which proposes that unprocessed, maladaptively stored memories of adverse life experiences are often the primary source of SUDs, informs the premise of the protocol that trauma resolution serves as the main goal of treatment. The methodology (8-phase protocol) serves as the structure for the protocol, directing treatment planning and guiding the direction of treatment with a beginning, middle, and end. It also provides for the protocol to encompass a holistic treatment approach to SUDs, addressing and treating disturbing images, negative cognitions, and emotions, and distressing physiological components, all related to the unprocessed adverse life experiences. The MET(T)A Protocol uses the three-pronged protocol of EMDR therapy to provide 3 avenues of healing: a resolution of the past, treatment for the present, and a design for future healthy living.

Janet's Three Stage Model of Trauma Treatment, which was developed in 1889, also serves as a guiding theoretical foundation of the MET(T)A Protocol. This stage model provides a template for trauma-focused care that is considered in the literature as the consensus model of trauma treatment. The 3 stages originally proposed by Janet, as described by van der Hart, Brown, and van der Kolk[117] are Stage 1: stabilization, symptom-oriented treatment, and preparation for liquidation of traumatic memories; Stage 2: identification, exploration, and modification of traumatic memories; Stage 3: relapse prevention, relief of residual symptomatology, personality reintegration, and rehabilitation. The MET(T)A Protocol uses Janet's Three Stage Model as the operating framework for trauma-focused treatment. The first order of treatment is stabilization of symptoms and preparation for trauma work which is accomplished through establishing safety, building therapeutic rapport, and developing mindfulness skills within the client through phase 1 and phase 2 of EMDR therapy. The second stage is processing the traumatic memories into an adaptive resolution through EMDR phases 3-6 and implementing mindfulness to tolerate distress from reprocessing. The final stage, the prevention of relapse through managing residual symptoms and reintegrating the personality, is applied through EMDR phase 7 and phase 8. The MET(T)A Protocol applies this 3 stage model inside the therapy office, as well as throughout the process of treatment including intake and admission procedures, integration of other therapeutic modalities, general operations, administration, and discharge planning.

In addition, the MET(T)A Protocol enhances the implicit mindfulness in EMDR therapy. The protocol uses the mindfulness inherent in phase 4 of EMDR therapy to assist clients to nonjudgmentally observe their thoughts, emotions, and physical sensations to prevent such experiences from overwhelming their capacity to cope. Explicitly, the protocol teaches clients mindfulness practices and techniques to promote stabilization, resourcing, and to increase their affective window of tolerance.

The MET(T)A Protocol employs several traditional mindfulness practices, including but not limited to the Four Foundations of Mindfulness (Body, Feeling Tone, Mind, and Dharma). In Mindfulness of Body, the MET(T)A Protocol guides clients to use their awareness of their body or breath to help regulate their nervous system in order to widen their affective window of tolerance and to assist clients in recognizing what they are experiencing internally. Mindfulness of Feeling Tone helps clients to change their relationship with their experience, and instead of labeling it positively or negatively, guides clients to identify it as pleasant, unpleasant, or neutral. Mindfulness of Mind allows clients to notice the transient nature of thoughts, emotions, and experiences, helping them to neither cling to nor avert from them, but to detach with nonjudgmental attention. Mindfulness of Dharma assists clients to use larger truths, conceptual thought, the application of the previous 3 foundations of mindfulness, and the teachings of Buddhist psychology to gain insight for healing regarding the root of suffering, to identify what is skillful, and to detach from unpleasant states. Other mindfulness practices recommended by the MET(T)A Protocol include walking meditation and beginner's mind practice. Agencies using the protocol have the option of adding mindfulness techniques and programs of their choosing to enhance and customize for their population.

The MET(T)A Protocol integrates mindfulness practices throughout each of the 8 phases of EMDR therapy. In phase 1, history-taking and treatment planning, and phase 2, preparation, they are implemented to stabilize clients and build internal and external resources to increase coping and distress tolerance. In phase 3, assessment, mindfulness practices are used to help clients to access their target in a safe, contained, and effective manner. In phase 4, desensitization, mindfulness is utilized to assist clients to nonjudgmentally observe what they are noticing, to regulate distressing experiences that may result from reprocessing the traumatic material, and to desensitize their experiences. In phase 5, installation, Mindfulness of Mind is implemented to support clients to identify positive cognitions and integrate them into daily experiences. In phase 6, body scan, Mindfulness of Body is employed to assist clients in noticing distressing and pleasant body experiences and

linking them. In phase 7, closure, mindfulness practices are used by clients to return to a state of emotional equilibrium at the end of each session to ensure their safety and integrate gains and insights from the session. In phase 8, reevaluation, mindfulness practices are reevaluated to ensure their continued effectiveness. During reevaluation, the clinician can assess any potential abreactions, which occur when unconscious, emotionally charged material is brought to conscious awareness, activating an intense emotional release or a fight/flight/freeze response. The integration of mindfulness training in the early phases of EMDR therapy serves as the foundation of support for clients to observe heightened responses and abreactions without being incapacitated by them and provides the necessary scaffolding needed for future reprocessing sessions.

The MET(T)A Protocol uses the Buddhist psychology component of the Eightfold Path to provide a design for mindful living for individuals in recovery that consists of moral conduct, mental discipline, and wisdom. The design includes the following components of the Eightfold Path: wise understanding, wise intention, wise speech, wise action, wise livelihood, wise effort, wise mindfulness, and wise concentration. Wise understanding provides clients with the wisdom that beginning on the Eightfold Path, a new guide to living in recovery, might result in a positive outcome, different from past unsuccessful attempts at recovery. Through the teachings of the Four Noble Truths, wise understanding helps clients to accept the impermanence of life and that pain is inevitable. Through wise understanding, clients acknowledge that: there is suffering and unsatisfactoriness in life; craving, clinging, aversion, and unhealthy attachment are the cause; leaning into and healing the causes and conditions of suffering is the solution; and the solution exists in the Eightfold Path.

Wise intention helps clients to live a life free from the intentions of ill will, desire, and harmfulness. It provides clients with a specific purpose and to focus on a foundational motivation to end suffering.[113] Wise speech assists clients in abstaining from words that promote harm and deceit, naturally guiding clients to speak the truth, especially in relation to their thoughts and feelings. Wise action promotes a moral and healthy lifestyle for clients including engaging in self-reflection, refraining from harmful behaviors to others and to oneself, and taking actions that foster self-esteem. Wise livelihood provides clients with direction towards working for the good of others and being of service to them, and through being true to oneself, by being honest, open, and willing. Wise effort encourages clients to make the conscious decision to direct their energy into being of service to others, abstaining from harmful behaviors, and engaging in healthy and adaptive behaviors. Wise mindfulness guides clients to develop a nonjudgmental mindfulness of their painful and pleasurable states, instead of escaping from them or clinging to them. Wise concentration helps clients to retrain their mind from being fixated on the past or future to focusing on nonjudgmental awareness of the present moment.

Buddhist psychology is woven into EMDR therapy through the MET(T)A Protocol as both share the same goals: to heal suffering and to foster a healthy and adaptive life. Buddhist psychology achieves this through teaching that freedom and joy are possible in the midst of suffering through letting go of the causes of suffering and returning to innate wisdom and compassion.[85] The mindful and ethical components of Buddhist psychology are implemented in phase 1, phase 2, phase 7, and phase 8. In phase 1 and phase 2, clients are taught to use mindfulness and ethical living skills (wise understanding, intention, effort, speech, livelihood, and action) as resources to access when they are feeling emotionally dysregulated and to increase distress tolerance. Resource building through mindfulness and psychoeducation of principles of the Four Noble Truths and Eightfold Path reduce shame and help to shift away from pathology to inherent truths and wisdom. For example, the first truth states that there is suffering; some days clients will be feeling mired in their suffering. When they are reminded that they are in the experience of the first truth, it helps to normalize their experience and reduce feelings of associated shame. The mindfulness and ethical living skills of Buddhist psychology are used to teach clients how not to attach to pleasurable experiences, to manage cravings by observing them without judgment, to let go of aversions to displeasure, and to detach from their stories of what happened and what is to happen. During phase 7 and phase 8, these skills are reinforced and reviewed with existing coping skills. The Buddhist psychology aspect of the MET(T)A Protocol highlights the innate wisdom within clients that is untouched by trauma and addiction and helps clients broaden this part within them.

Mindfulness is often practiced independent of the full application of Buddhist psychology. While mindfulness alone is greatly beneficial, it was initially intended to be practiced as only one aspect of the Eightfold Path. The clinical advantage of Buddhist psychology is that the Eightfold Path offers ethical, philosophical, community, and cognitive reprogramming components that augment the healing of SUDs. The ethical lifestyle considerations of the Eightfold Path support full lifestyle change and more robust relapse prevention. Traditional clinical mindfulness programs have extracted these components from the fullness of the Eightfold Path. Wisdom, insight, and skills are not enough for the application of mindfulness to sustain long-term recovery. Practicing the Eightfold Path offers a complete system for transforming suffering of which mindfulness is only 1 of 8 factors. It gives clients true agency to continually make healthy, life-affirming decisions in the face of craving, hardship, and setbacks.

Individual and Group Approaches in the MET(T)A Protocol

The framework of the MET(T)A Protocol guides both individual and group sessions. Characteristics of the application of the protocol that serve as the structure for all individual and

group sessions are: trauma-focused care (providing trauma education, assuming that unhealed trauma plays a role in presenting issues, greater action in delivery of treatment services, and proactive treatment planning[40]), the AIP model (awareness that presenting issues have a foundation in maladaptively stored memories), and Janet's Three Stage Model of Trauma Treatment (ensuring that Stage 1, stabilization of symptoms and preparation for trauma work, is always occurring). The protocol creates a cohesive narrative for clients to relate to one another during group sessions and fosters a unifying platform. Clients learn to share a MET(T)A Protocol language to include, discussing concepts of Buddhist principles, processing their EMDR therapy sessions with one another, and developing resources through the use of meditation practices, which allows them to feel supported and connected on a healing journey together.

Cultural, Religious, and Spiritual Considerations in the MET(T)A Protocol

Similar to any other guiding psychotherapy of a treatment center or agency, the MET(T)A Protocol is proposed to all clients as the primary treatment intervention. During a client's intake, the evidence base supporting its application and the integration of EMDR therapy, mindfulness, and Buddhist psychology is presented, along with addressing questions and concerns regarding the protocol. Cultural, religious, and spiritual beliefs that are assets to clients are not pushed aside; rather they are enhanced through the protocol as it affirms all practices that are healthy and adaptive for the client. The principles of Buddhist psychology overlap with many modern and classic religious and spiritual tenets. This allows for clients to have their spiritual beliefs reinforced through the principles of Buddhist psychology. The MET(T)A Protocol offers the strength of Buddhist psychology not as a religious device but as a secular path of behavioral health and well-being. It implements Buddhist psychology as a guiding philosophy, a lifestyle, and a path for recovery, not as a religion or spiritual belief system. Honoring that clients may face difficulties in adopting the role of Buddhist psychology in the MET(T)A Protocol due to their cultural, religious, or spiritual beliefs, the protocol adapts to the client rather than expecting the client to adapt to it. The client chooses for themself which principles or practices of Buddhist psychology they feel comfortable implementing. However, if the client feels uncomfortable applying the principles or practices of Buddhist psychology due to their cultural, religious, or spiritual beliefs, they receive the protocol in an adapted way, independent of any focus on Buddhist psychology.

Adaptations/Deviations from the Standard EMDR Therapy Protocol

The MET(T)A Protocol contains some adaptations from the standard EMDR therapy protocol. There is the "meta" use of the 8 phases, the three-pronged protocol, and the AIP model that is used as a template for the work of an agency as it is viewed through a new prism. Born out of the Buddhist mindfulness that infuses the treatment, this prism is also one filled with and guided by lovingkindness (i.e., "metta") thus the Mindfulness and EMDR Treatment Template for Agencies or MET(T)A. The "A" in MET(T)A has changed from Addictions to Agencies, as more mental health providers outside of the addiction world are beginning to adopt MET(T)A, including a treatment center for eating disorders.

Another adaptation to the standard EMDR therapy protocol is that under the application of the MET(T)A Protocol, every agency's job is to provide phase 1 and phase 2 for every client. The MET(T)A Protocol changes the implied treatment guideline from "is the client appropriate for EMDR therapy" to "every client is considered to be in phase 1 and/or 2 of EMDR therapy upon arrival." Additionally, the inherent mindfulness in EMDR therapy is made explicit and mindfulness practices are integrated throughout each of the 8 phases. Finally, Buddhist psychology is integrated into phase 1, phase 2, phase 7, and phase 8. These adaptations are explored in further detail in the description of the application of the MET(T)A Protocol.

Treatment Components of the MET(T)A Protocol

- Every client seeking treatment for SUDs is considered to be in phase 1 and/or phase 2 of EMDR therapy upon arrival at a MET(T)A agency. MET(T)A agencies provide phase 1 and phase 2 for every client.
- Employs trauma-focused mindfulness practices to provide stabilization, distress tolerance, and to foster individuals to adopt adaptive and mindful living patterns. The trauma-focused mindfulness practices implemented in the protocol are rooted in the Four Foundations of Mindfulness.
- Teaches ethical livelihood practices based on the Eightfold Path. The ethical livelihood practices are created for long-term, integrated lifestyle changes that are designed to increase cravings control and sustain relapse prevention.
- Implements long-term aftercare support in the form of providing every client that discharges from treatment a therapeutically aligned mindfulness coach in one of the following specializations: life coaching, recovery coaching, or trauma resilience coaching.
- Founded upon the clinical experience which suggests that integrating mindfulness and EMDR therapy represents an effective approach for providing trauma resolution, and trauma resolution represents the most promising outcome for people suffering from SUDs and other mental health issues.
- Based on the premise that mindfulness practice is the foundation for successful trauma resolution as it appears to desensitize and potentially ameliorate trauma and PTSD symptoms. This concept informs the use of mindfulness techniques and mindfulness lifestyle training throughout all 8 phases of EMDR therapy.
- The MET(T)A Protocol uses the AIP model as the core principle that informs treatment: maladaptively stored

memories become a primary focus of treatment and adaptive resolution of those memories is a primary goal.
- Clients are prepared to tolerate trauma resolution work through mindfulness practices, psychoeducation of Buddhist psychology, and the 4 major EMDR therapy related preparation (phase 2) skills: butterfly hug or monkey tap, light stream visualization, calm safe place, and simple container exercise.[118]
- All clinicians at a MET(T)A agency are trained in EMDR therapy, receive consultation, and are trained in mindfulness, Buddhist psychology, and trauma resolution. Clinical meetings are conducted in the fashion of EMDR therapy consultations.
- The MET(T)A Protocol can be implemented as an abstinence-based or harm reduction approach. The protocol honors that abstinence is not the sole, primary measure of recovery. Measurements of trauma resolution and PTSD symptom reduction are viewed by the MET(T)A Protocol as meaningful evidence of recovery. Relapse is perceived as a common part of the recovery process, even with excellent trauma treatment.
- Every session ends with resourcing to include mindfulness practices developed in phase 1 and phase 2.
- In the MET(T)A Protocol, all aspects of the agency are considered resources and are responsible for keeping clients safe. This includes the milieu, group therapy, and all employees, from the CEO to line staff to maintenance workers.

Treatment Goals and Interventions

Treatment goals for the MET(T)A Protocol, although uniquely tailored to every individual, are focused on stabilization, transforming traumatic material to an adaptive resolution, relapse prevention, and long-term sustainable recovery. Interventions to achieve these goals are centered within the following domains: preparation of the individual to be able to receive and sustain treatment, demonstration of the ability to maintain self-regulation through applying internal and external resources to stabilize, increased affective window of tolerance as evidenced by experiencing distressing emotions and not resorting to substances or other harmful behaviors to manage them, and trauma resolution as evidenced by the Subjective Units of Disturbance (SUDS) scale of EMDR therapy and completion of phase 1 targets.

Working within the MET(T)A Protocol treatment rubric, EMDR therapy is always occurring, inside and outside the clinician's office. Each clinician utilizes the 8 phases of the standard EMDR therapy protocol, trauma-focused mindfulness techniques, Buddhist psychology, and the application of mindful lifestyle training to meet the treatment goals. History taking will assist in identifying the root adverse life experience(s) connected to the client's presenting issue(s). An assessment of the client is conducted, which includes identification of strengths, assets, and resources, during which rapport building is fostered and mindfulness training and psychoeducation are implemented. MET(T)A Protocol resources of mindfulness training, guided meditations and EMDR therapy related preparation (phase 2) skills (butterfly hug or monkey tap, light stream visualization, calm safe place, and simple container exercise)[118] and the Resource Development and Installation (RDI) Protocol[119,120] will be established with clients. The RDI Protocol equips clients with a diverse range of skills and interventions to assist them with reprocessing traumatic material. Targets will be identified for reprocessing, a future template will be created, and positive treatment goals will be established, as directed by clients. The following contains aspects of a sample MET(T)A Protocol client's treatment plan:

Goal:	seek stabilization
Interventions:	psychoeducation on the effects of trauma and Buddhist psychology to reduce shame and guilt; reduce trauma related symptoms through practicing distress tolerance strategies established during phase 2; implement mindfulness practices based on the Four Foundations of Mindfulness.
Goal:	develop resources
Interventions:	identify existing strengths, assets, and recovery capital; engage in mindfulness practices based on the Four Foundations of Mindfulness; attend mindfulness meditation meetings and Dharma talks weekly; create an individualized support system comprised of people met through attending meditation and Dharma meetings, 12 step groups, or other self-help/spiritual groups; discover through self-reflection and mindfulness practices activities/hobbies that boost self-esteem and increase self-efficacy.
Goal:	build distress tolerance
Interventions:	continuously practice the Four Foundations of Mindfulness techniques while experiencing distress; practice strategies established during phase 2 such as meditation, butterfly hug or monkey tap, light stream visualization, calm safe place, or simple container exercise; practice acceptance through applying the Four Noble Truths to the current situation.
Goal:	transform traumatic material
Interventions:	develop and maintain stabilization through mindfulness practices learned during phase 1 and phase 2 or through other resourcing strategies; attend weekly EMDR therapy sessions; keep a journal to document any distress that comes up outside of the EMDR therapy sessions;

	engage in specific resources that have been identified to increase self-esteem and self-efficacy.
Goal:	cultivate relapse prevention skills
Interventions:	identify sensations, thoughts, emotions, and experiences that are triggers to use substances or engage in other harmful behaviors; engage in the Four Foundations of Mindfulness practices to increase mindfulness of the present moment; determine the most effective mindfulness practices or other resources that can be implemented during moments of feeling triggered and continuously practice these to strengthen them; engage in a support system daily.

Description of the Application of the MET(T)A Protocol

Phase 1: History taking

Phase 1 of EMDR therapy is the primary intake procedure. Exploration of the client's inner world occurs during phase 1, which includes history taking, assessment of strengths and resources, psychoeducation, introduction to the MET(T)A Protocol, discussion of client goals and desired outcomes, and treatment planning. The MET(T)A Protocol provides for a more mindful history taking by encouraging the clinician to maintain their own mindfulness practice to help them to respond with nonjudgmental awareness and engage in attunement with clients. The protocol is introduced during phase 1 to clients through the identification of resources and psychoeducation. Resources in the form of mindfulness practices and meditations are introduced during phase 1 and focus on directing clients to be aware of body sensations, thoughts, and feelings. Mindfulness practices and meditations are rooted in the Four Foundations of Mindfulness and also include walking meditation and beginner's mind practice. Mindfulness-based resources established during phase 1 will help to stabilize clients and prepare them for the reprocessing phases (3-6).

The MET(T)A Protocol honors comprehensive psychoeducation throughout individual therapy, case management sessions, group sessions, and during informal engagements as a critical aspect of effective treatment. It is crucial that clients be provided with the knowledge required to consent to treatment and direct their treatment. Clients are continually educated on the effects of trauma and the benefits of mindfulness practices in relation to recovery from trauma. This helps to buffer against the automatic pilot response, allows clients to observe intrusive thoughts/memories and let them pass, increases awareness of feelings stored in the body, and fosters the ability to use the breath and body as a reference point to regulate distress. Psychoeducation also focuses on Buddhist psychology to help clients change their relationship with their thoughts and emotions. Instead of strictly focusing on the content of thoughts and emotions, through Buddhist psychology, the MET(T)A Protocol teaches clients to develop an understanding of acceptance and compassion towards their experiences, and to let go of the clinging and aversion that perpetuates suffering. Psychoeducation is provided on the Eightfold Path, Four Noble Truths, Four Foundations of Mindfulness, impermanence, and lovingkindness.

A vital element of phase 1 in the MET(T)A Protocol is therapeutic rapport building. Considering that trauma ruptures trust, it is the responsibility of the clinician to explore ways to develop this critical component of treatment with clients. Without trust, the remaining 7 phases of EMDR therapy will be unsustainable. The MET(T)A Protocol uses the premise of EMDR therapy and Buddhist psychology to help clients to establish the ability to trust. Clients can begin with trusting the effectiveness of EMDR therapy and the 2600-year existence of Buddhist psychology, and then transfer this trust into their clinician.

A mindful approach to history taking

In the delivery of the MET(T)A Protocol, maintaining a mindful presence is a crucial skill to exercise throughout each of the 8 phases of EMDR therapy. It is especially critical in phase 1 while exploring the client's history when the therapeutic relationship is just beginning. A mindful presence consists of nonjudgmental awareness of the client, attunement with the client, and awareness of the clinician's own internal states. Research indicates that mindfulness for the clinician can lead to a more effective therapeutic relationship.[97,121-125] Marich and Dansiger[40] provide the following approaches to implement a mindful phase 1: be genuine and build rapport from the first greeting; do not retraumatize; ask open-ended questions; consider that getting an exact, chronological trauma history may be unsafe or impractical because of how the memories are stored in the limbic brain; be nonjudgmental; assure clients that they may not be alone in their experiences; do make use of the stop sign when appropriate; be mindful of how you give screening tools or devices to clients; have closure strategies ready; consider that evaluating a client is an ongoing process.

By taking the history mindfully in phase 1, it became apparent that the client, Keith, was more resourced than indicated by the severity of his most recent relapse. Keith's resources included: his sobriety on and off for over 20 years, a consistent mindfulness practice, and insight into his need for trauma-focused treatment. The reapplication of his resources allowed his PTSD symptoms to be abated more quickly and directly.

Phase 2: Preparation

Phase 2 involves preparing the client to effectively sustain treatment, through an explanation of the EMDR therapy process and its effects, the development of the therapeutic alliance, stabilization, and resourcing. Orienting clients to the theory and

procedures of EMDR therapy, answering their questions and addressing their concerns provides clients with the awareness needed to participate in therapy. The development of the therapeutic alliance which began in phase 1 is accomplished through forming a bond with clients and adopting a mindful stance with clients, which is critical for attunement, and maintaining mindful attention to one's own internal states. Stabilization, a major focus in phase 2, implements the development of affect-regulating techniques that foster safety, self-mastery, and control.[126] This critical step engenders readiness in clients, equips clients with resources to tolerate potential distress in the reprocessing phases (phases 3-6), and fosters empowerment.

In phase 2, the MET(T)A Protocol helps clients to relate to their experiences as unpleasant, pleasant, or neutral. This shift in relationship from judging experiences to observing them assists clients in self-regulation, an essential element for not only the reprocessing phases, but for relapse prevention. Phase 2 in the MET(T)A Protocol revisits the mindfulness practices introduced in phase 1 with clients and reinforces their application. Through practicing mindfulness techniques, clients develop the ability to gain a sense of self-mastery, and this confidence prepares them to tolerate distress that may arise during the reprocessing phases, in addition to equipping clients with self-efficacy for their recovery. A strengths-based approach, the MET(T)A Protocol teaches clients to turn inward to their innate resources that provided them with the resilience to survive their adverse life experience(s).

Establishing clients with mindfulness practices in phase 2 provides the bedrock that fosters the healing that results from the reprocessing phases. Mindfulness training in phase 2 augments the client's coping skills, develops internal resources and self-efficacy, and expands their affective window of tolerance.[40] Mindfulness skills developed and practiced by clients can transform their capacity to heal by providing them with the capacity to tolerate distressing states. In phase 2, the MET(T)A Protocol assists clients with connecting to the present moment through Mindfulness of Body and Mindfulness of Mind practices, helps clients to balance and simplify extreme emotions by tolerating them as pleasant, unpleasant, or neutral, and provides access to resources such as lovingkindness, compassion, appreciative joy, and equanimity. Helping clients to build the internal resource of mindfulness not only provides them with an effective coping skill but reveals the self-efficacy that they possess by being able to activate this skill internally.

An additional benefit of mindfulness practice in relation to the MET(T)A Protocol is that mindfulness skills are implicit and explicit in the reprocessing phases of EMDR therapy. Dr. Shapiro's language of "what are you noticing now?" and "just notice that" points to her own mindfulness training and the case for the development of mindfulness skills for reprocessing in particular. MET(T)A Protocol clients are given psychoeducation as to how these skills will help them in the reprocessing phases, providing an understanding not only of the bridge from resourcing to reprocessing, but also providing a dedicated skill set for phases 3-6 that allows the client to reprocess more successfully, access and utilize resources and positive cognitions that arise during reprocessing, and take ownership of the overall therapeutic process.

Adaptations to mindfulness practices for survivors of trauma in the MET(T)A Protocol

Clinical judgement and a cautious approach to introducing mindfulness practices to survivors of trauma is a tenet of the MET(T)A Protocol. Mindfulness can cause distress for survivors of trauma because they can have reduced affect regulation and tolerance capacities. Suddenly exposing the disconnected survivor of trauma to their emotions and thoughts can have adverse effects on the survivor if they do not have the effective skills to self-regulate.[122] Therefore, exercising comprehensive stabilization during phase 2 is crucial. While introducing survivors of trauma to mindfulness training, the MET(T)A Protocol provides a series of options for mindfulness techniques rather than imposing a specific practice. This includes giving the client permission to keep their eyes open while they are practicing, allowing the client to scan the room and ground themselves instead of directing them to meditate, reminding clients that it is expected that their mind will wander while reassuring them that this is not a sign of failure, and not forcing breathing practices upon them. For example, with Sarah, a female who presented with opioid use disorder and PTSD, the MET(T)A Protocol was being utilized at her residential treatment center, so she was considered to be in phase 1 and phase 2 of EMDR upon arrival, and was introduced almost immediately to several mindfulness interventions. She reported that she did not like to do any breathing techniques because they increased her anxiety. Rather than force breathwork upon Sarah, the clinician explored other forms of mindfulness with her, such as guided meditations. Sarah discovered that body scan meditations were effective at keeping her in the present moment.

Phases 3-6: Trauma reprocessing

Mindfulness and Buddhist psychology practices of the MET(T)A Protocol introduced and practiced in phase 1 and phase 2 serve as stabilizing forces for phases 3-6: phase 3, assessment of the target to be reprocessed, phase 4, desensitization of disturbing emotions, cognitions, and sensations, phase 5, installation of the positive cognition identified by clients to replace the original negative cognition associated with the traumatic memory, and phase 6, body scan, to address residual body sensations. Throughout the reprocessing phases, the MET(T)A Protocol employs mindfulness training to encase the safety of clients.

In phase 3, all aspects of the adverse life experience(s) responsible for current disturbance are assessed, as adverse experiences are multi-faceted and their effects release incapacitating suffering over a broad range of human functioning. This is why it is

crucial to evaluate the psychological, physiological, and emotional components contributing to distress. Phase 3 provides this in depth, all-encompassing clinical picture of the adverse life experience(s) through eliciting the image to be targeted, the negative cognition associated with the image, a counteracting positive cognition, rating the validity of the positive cognition, naming the most significant emotion related to the image, and identifying physical sensations connected to the traumatic experience. A key element of a conceptualization of phase 3 according to the MET(T)A Protocol is providing clients with the mindfulness needed to tolerate discomfort long enough to identify the source of the image and the associated cognitions, emotions, and body sensations related to the traumatic memory. This mindfulness also equips clients with the affect-regulation skills needed to manage the potential distress resulting from phase 3.

By mindfully working phase 3 after a thorough phase 1 and 2, Sarah was able to safely activate her trauma, unlike during her previous treatment episodes, where her underlying trauma was not addressed with EMDR therapy or at all. Most treatment centers have historically been set up to address the top of the iceberg, what is observable in the client. This has served to help many people in treatment return to functionality in daily life. However, it typically does not get to the root of the addiction or the trauma that caused it in the first place, resulting in relapse. In using EMDR therapy as the primary therapy with Sarah and implementing the wraparound philosophy regarding resourcing, the MET(T)A Protocol allowed the clinician and Sarah to go right into the heart of her traumatic memory with increased confidence. Phase 3 can elicit abreaction as the trauma is activated through the senses in order to bring it to the surface to reprocess and desensitize. If there is a gap in time between phase 3 and phase 4 (due to logistics of the session) it can leave the client feeling like a live wire. The focus on Sarah's window of tolerance was clear and therefore using the MET(T)A approach with intensive resourcing prevented her from being stuck in a potential abreaction between phase 3 and phase 4.

Phase 4, desensitization, guides the processing of the adverse life experience(s) into an adaptive resolution, initiating the alleviation of current distress. Phase 4 provides the means to foster an adaptive response to a once debilitating experience through reducing the client's distress while enabling the development of new insights and adaptive associations of the experience. Inherent within phase 4 of EMDR therapy are 2 components that the MET(T)A Protocol makes explicit: mindfulness and nonjudgmental awareness. Guiding the client to "just notice" and "go with" their experience and not label it promotes the innate healing that EMDR therapy is accessing. Instilling mindfulness training and providing trauma psychoeducation systematically throughout all engagements of treatment including individual therapy, group therapy, case management, and informal interactions with staff and others in the milieu, helps the client establish a new relationship to their experience and beliefs, and fosters this innate process of healing. The clinician's own mindfulness practice helps them to more consistently "stay out of the way as much as possible" of the client's healing process, allowing them to provide nonjudgmental observation and genuine attunement to the client.

During phase 4, both Sarah and Keith were able to utilize the Four Foundations of Mindfulness learned through MET(T)A Protocol groups on Buddhist psychology to stay present with the feelings coming to the surface while experiencing activation. Due to the integration of this knowledge, the clinician was able to stay out of the way and only guide the reprocessing by mindfully instructing their clients on "what are you noticing now" and "notice that" so that reprocessing continued with very little need for other interventions.

Phase 5, installation, supplies clients with the positive cognitive networks necessary for optimal functioning. Phase 5 replaces the negative, maladaptive cognition that resulted from the adverse life experience(s) with a positive cognition that is strong enough to be a valid mechanism for future change. Through the installation and implementation of mindfulness training, the MET(T)A Protocol develops self-efficacy within clients that assists them in believing the potentiality of the positive cognition. The Buddhist psychology component of the MET(T)A Protocol helps clients in recognizing their innate strength and wisdom which allows them to develop and maintain a positive self-assessment of themselves. The shift from negative to positive is sustained and cemented with mindful attention to the new world that the clients have created within.[40] Installation for both Sarah and Keith took place organically, naturally, and also deeply due to their having mindfulness skills in place to increase their window of tolerance after reprocessing difficult memories. The results were evident in their maintaining long-term sobriety and trauma recovery.

Phase 6, body scan, fosters the reprocessing on a physiological level, as the dysfunctional material resulting in current disturbance is not only stored psychologically but has physical etiology and symptomatology as well.[21] This phase provides physiological healing, a component that generally only somatic therapies offer, revealing the multi-modal, integrative nature of EMDR therapy. Van der Kolk's[68] adage "the body keeps the score" holds true not only for traumatic material, but also for the positive effects of an adaptive resolution. The comprehensive attention to mindfulness in the MET(T)A Protocol throughout all aspects of treatment, including outside the individual therapy room, helps the client implement the practice of Mindfulness of Body in order to reveal any remaining distress that remains beneath their conscious awareness during phase 6 and to assist them in connecting with positive sensations and related cognitions that result from adaptive reprocessing. From a Buddhist psychology perspective, Mindfulness of Body practice on its own can serve as an avenue of awakening, a source of enlightenment, or the end of suffering.[127] From the MET(T)A Protocol perspective, this aligns with the successful reprocessing of a target in phases 3 through 6 of EMDR therapy. The

body scan in phase 6 is enhanced by mindfulness training in the earlier phases and through the mindfulness of the clinician. Sarah and Keith both noticed that their body sensations related to the trauma had subsided in session and that these effects were maintained after sessions.

Phase 7: Closure

Phase 7, closure, stresses the significance of continued stability and therapeutic progress throughout the healing process. It seeks to ensure safety and stability not only at the end of every session, but between sessions as well. This phase provides for treatment to occur in a safe, contained manner whether the clients are in the clinician's office or not. In addition, phase 7 allows clients to organically consolidate gains from the session in vivo while still in their session. In the MET(T)A Protocol, phase 7 is about deep resourcing that promotes safety for clients, honoring the mindfulness-based transitions clients have developed, and continuing to enhance them. It acknowledges the resources that clients have used throughout the first 6 phases and recognizes them as a new adaptive response to distressing experiences. It allows for greater integration of insights and new resources resulting from reprocessing. It highlights the client's transformation from resorting to harmful behaviors to cope with disturbance to implementing resilience-affirming skills that foster growth and hope for the future. Both Sarah and Keith chose mindfulness-based resourcing as their primary resourcing, which increased their connection to mindfulness skills, the mindfulness-based milieu of treatment, and the trust of their clinicians who modeled their own mindfulness practice.

Phase 8: Reevaluation

Phase 8, reevaluation, which occurs in between sessions and then at the beginning of each new session, serves to reevaluate the treatment plan, check-in, and follow up with clients to assess treatment effects. Treatment is always in progress, even in between sessions for both the client and the clinician. This phase ensures that targets have been reprocessed and resolved, any activated material is addressed, and adequate assimilation of adaptive material has been achieved.[21] As a person-centered, agency based protocol, the MET(T)A Protocol uses phase 8 to continually assess whether or not the client's treatment goals are being achieved and to ensure that the client is leading the therapeutic process. This reevaluation is accomplished through all aspects of treatment, not just the in session EMDR therapy results. It includes all treatment planning documents and meetings, clinical meetings, group therapy, and notes on informal engagements of the client. It also allows line staff to receive notice of the client's state of mind between sessions and view it through a trauma-focused lens that they have been trained to understand. This helps line staff intervene appropriately within the construct of the 8-phase protocol, the AIP model, Janet's Three Stage Model of Trauma Treatment, and tenets of Buddhist psychology. Phase 8 in the MET(T)A Protocol stresses the importance of the clinician and all staff maintaining mindfulness throughout each of the 8 phases to be able to truly stay out of the way as much as possible and to let clients own the direction of their treatment.

One of the most important components of phase 8 in the MET(T)A protocol is evaluating the self-efficacy of clients. Without self-efficacy, clients will struggle with resourcing, not only a vital element of successful completion of phases 3-6, but crucial to maintaining recovery. The practice of clients confidently knowing that they can turn inward to manage distress and prevent it from overwhelming their capacity to cope is an invaluable asset and is necessary for adaptive functioning. It is the development of this self-efficacy that propels clients to be able to turn their future template into a reality. For example, Sarah reported that mindfulness practices empowered her with the courage to reprocess her traumas for the first time, despite being in various trauma-focused treatment programs since she was a child. She reported that since mindfulness practices supported her with a sense of safety and control, she finally felt comfortable to process her traumas. Additionally, Sarah claimed that her trusting relationship with mindfulness allowed her to sit through painful states without resorting to substances for relief for the first time since she began her recovery journey a decade earlier.

Discussion

The MET(T)A Protocol, which incorporates mindfulness techniques, mindful lifestyle training, and Buddhist psychology into EMDR therapy, and implements EMDR therapy as a complete system of healing, offers a trauma-focused solution to treat SUDs. With EMDR therapy, Buddhist psychology, and mindfulness at its core, the MET(T)A Protocol is guided by a structured framework. But the protocol is not rigid; it is inclusive to other therapies and is flexible in its implementation. The MET(T)A Protocol contains modifications within its framework. Other therapies or theoretical orientations can be folded into its structure. It is flipping the integration paradigm; rather than fitting EMDR therapy as a technique into other therapeutic modalities, it fits those therapies within the MET(T)A Protocol.

Informed by research demonstrating the relationship between trauma and SUDs, the MET(T)A Protocol redefines the main goal of treatment for SUDs as trauma resolution, by treating each client as being in phase 1 and/or 2 of EMDR therapy upon entering treatment. While clients are still responsible for directing their treatment, the goal of trauma resolution represents a united focus that all clients and staff use to inform treatment planning. Oftentimes in treatment programs for SUDs there are many co-occurring emotional and physical conditions that can impede the successful completion of treatment goals. When these co-occurring conditions become the main focus of treatment, the root of many of these conditions,

and a significant variable of recovery, healing the trauma, gets pushed aside. While the MET(T)A Protocol honors and addresses the co-occurring symptoms and disorders that accompany trauma, identifying trauma resolution as the main goal of treatment ensures that the healing of trauma remains the ultimate focus. By making trauma resolution the main goal of treatment for SUDs, co-occurring symptoms and conditions that appear to be primary issues and that can often mystify the impact of trauma, have the potential to be resolved as well.

EMDR therapy, the anchor of the MET(T)A Protocol, is implemented as a complete system of healing in the MET(T)A Protocol. It provides a biopsychosocial continuum of care for treatment, as outlined in each of the aforementioned 8 phases of EMDR therapy. Unlike therapies that focus on 1 aspect of an individual such as cognition, emotion, or behavior, EMDR therapy addresses psychological, emotional, and physiological dysfunctions throughout its 8 phases. In the MET(T)A Protocol, the 8 phases of EMDR therapy map out a treatment plan for the full continuum of care as they address all of the factors contributing to current, past, and future distress. Furthermore, EMDR therapy has components in almost all of the traditional psychotherapies[21] which allows for its 8 phases to be all encompassing and not restrictive in its treatment approach. This unique aspect of EMDR therapy makes it broadly adaptable and flexible to any treatment philosophy, which allows for the integration of mindfulness and Buddhist psychology.

The role of mindfulness in the MET(T)A Protocol moves beyond using it as an instrument to get through a difficult time. In phase 1 of EMDR therapy, the MET(T)A Protocol introduces mindfulness techniques to clients to use in times of distress and to stabilize them. In phase 2, the protocol evaluates the effectiveness of their use and reinforces their application. Throughout the rest of the phases of EMDR therapy, the protocol administers the continued use of mindfulness techniques to help keep clients mindful of the present moment, to maintain their connection with their body, to rely on them for self-efficacy, and to change their relationship with themselves and others. The MET(T)A Protocol teaches clients to apply mindfulness throughout the unfolding present moment through the application of the Four Foundations of Mindfulness.

Most significantly, mindfulness in the MET(T)A Protocol changes the client's relationship with their experiences, including how clients relate to their trauma. While the protocol does not demand that clients interpret their traumas in a specific way, it encourages them to view it from alternative perspectives that have the potential to shift their stances on healing. By guiding clients on how to interpret day to day occurrences as pleasant, unpleasant, or neutral, instead of labeling them as negative or positive, the protocol helps clients to reframe their thinking.

Another component of the mindfulness and Buddhist psychology application in the MET(T)A Protocol is that it provides clients with a structured blueprint for living in recovery: The Eightfold Path. Teaching clients to operate from their innate truth and intuition, set skillful intentions, live ethically in speech, action and livelihood, and make the effort to develop mindfulness and concentration throughout their daily life removes the guesswork that comes with embarking on a foreign journey void of substances. Equipping clients with the strategies of implementing mindfulness to stay in the present moment, to maintain connection with their body, as a distress tolerance intervention, as a technique to reestablish relationships with experiences that are more conducive to healing, and as a design for living, the MET(T)A Protocol uses mindfulness and Buddhist psychology as potent resources for recovery from SUDs.

Just as mindfulness sets the foundation to change the client's relationships with their experiences, the Buddhist psychology element of the MET(T)A Protocol creates a paradigm shift in how pathology is viewed and treated. In alignment with redefining the premise of treatment for SUDs to focus on trauma resolution as the main goal, Buddhist psychology reconceptualizes treatment for SUDs from focusing on what is wrong with clients to highlighting the innate resilience that exists within clients. While Western psychology views and treats SUDs through focusing primarily on pathology, the premise of Buddhist psychology centers around the strengths that are inherent in each individual. The MET(T)A Protocol uses this approach to help clients to identify the part of themselves that remains untainted by trauma, addiction, and any other adverse life experience(s). It uses the Buddhist psychology concept that there exists within everyone an innate wisdom, joy, and compassion that can direct clients towards freedom, even in the midst of suffering.

Limitations and Future Research

This article is not without its limitations. While the 3 treatment components of the MET(T)A protocol, EMDR therapy, mindfulness, and Buddhist psychology have individual evidence-based features, their integrative application as a primary therapy for SUDs warrants research. Initial research is needed to begin measuring the impact of the MET(T)A Protocol, using an RCT with a multiple baseline design and a large sample size. The anecdotal case examples do not support evidence that any perceived treatment outcomes result from the MET(T)A Protocol. Rather, they serve as supplementary material to assist understanding of the procedures of the protocol. At this time, there are no contraindications for the MET(T)A Protocol, as the MET(T)A Protocol can be implemented with any individual with a history of adverse life experiences.

Conclusion

Research demonstrates the need for a trauma-focused approach to treat SUDs. EMDR therapy has been established as an effective treatment for trauma and PTSD and its application as an effective treatment for a host of other clinical conditions such as SUDs is promising. Additionally, research indicates that mindfulness and Buddhist-derived interventions are

encouraging approaches to treating SUDs. Considering this, making the implicit mindfulness in EMDR therapy explicit, integrating Buddhist psychology into EMDR therapy and implementing EMDR therapy as a complete system of healing through the MET(T)A Protocol has the potential to serve as a primary treatment for SUDs.

Author Contribution

All authors made significant contributions to this work including manuscript preparation, writing, editing, and feedback.

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