TREATING TRAUMA WITH MINDFULNESS APPROACHES

The world of addiction treatment is going through a great deal of change, in order to meet a world that has gone through immeasurable change. This is not only a reference to the opioid epidemic and all that it entails, but also the ongoing and deepening dialogue about what represents effective treatment in general. Two of the most formidable developments are 1) the growing agreement about the role of trauma in addiction and addiction recovery, and 2) the advent of mindfulness based approaches as a front line treatment for addiction.

My own personal recovery journey has formed my relationship with Buddhist mindfulness and with EMDR (eye movement desensitization reprocessing) therapy, and trauma treatment in general. My introduction to recovery came from my first AA meetings in New York City in 1989, which launched my still continuous recovery. Those meetings introduced me to the idea of inviting spirituality back into my life after a long absence. Very early on, a new friend in the program invited me to an AA retreat with a Big Book Promises focus, at a Zen Buddhist monastery in upstate New York. There I received my first mindfulness meditation lesson, and I have never really stopped practicing meditation over these last 28 years.

My sitting practice led me to explore the other facets of Buddhist psychology, and they lined up with my recovery path. The idea that life contains suffering and unsatisfactoriness was not hard to see as true, and the idea that the cause of the suffering was because of craving and clinging, also resonated with my experience both in my active addiction and in early recovery. Over the years, this has led to an approach, where I have not found it difficult to fold in all the paths I have encountered: my Jewish upbringing, all that I discovered in my Interfaith Ministry training from the various faiths of the world, the 12 step program, and Buddhist psychology.

As I studied trauma as a therapist, and then studied it through the lens and practice of EMDR therapy, I saw that EMDR was a mindfulness based therapy at its core. The first two phases require the development of a mindfulness practice in order to find enough of a ground to do this difficult work. The reprocessing phases of the therapy are built on the foundation of the development of mindfulness of what had been relegated to the unconscious, the body, or the non-cognitive areas of the brain. Through mindfulness and through the mindful attention instigated by the 8 phase protocol of EMDR, clients are able to achieve the beneficial effects of EMDR therapy described thoroughly and widely in the extensive research literature. As Dr. Francine Shapiro (the creator and developer of EMDR therapy) has said, we are able to bring maladaptively processed traumatic memories to adaptive resolution, and then we are able to live a more adaptive life.

How does this impact the entire milieu of a treatment center, and non-clinical staff? In the not-so-old days, the belief was that in order to treat the trauma you have to encourage, or even force a person to face the worst of the worst and to work through it by talking. We now know that since the majority of traumatic material is not stored in the part of the brain that can make sense of it, and talk its way through it, that we need to find ways to engage the more primitive parts of the brain, and the body. This new knowledge allows all staff, clinical and otherwise, to back up a few steps and not believe they need to engage the client in constant conversation about their traumatic background. The opposite is true in fact. The client really needs to have a space for healing held for them, a feeling of safety whether it is offered by a counselor, a tech, the housekeeping staff, or the kitchen staff. If we can maintain that safety for the client, their central nervous system will start to regulate properly, and they will gain access to the ability to the hard work in therapy, with steps, with all the thought based modalities.

What happens when you take these principles, ideas and practices, and place them at the center of the work of an addictions treatment agency? At the moment I am working with a couple of agencies using this as a foundational model for treatment. I have come to these conclusions: That EMDR therapy and mindfulness should go hand in hand; that mindfulness is not just a technique, and neither is EMDR therapy; that if we are to truly make a difference in clients' lives when providing addiction treatment, we need to find a way to genuinely help them through their trauma work; and that this will occur best using an agency wide and community based model that rests on the foundation of mindfulness, EMDR therapy, and trauma informed practice. More practice and research will reveal whether this approach will be successful. The initial findings are very promising.

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