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Mindfulness: The Missing Piece in Addiction Treatment

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MINDFULNESS: THE MISSING PIECE

Abstract

Mindfulness in addiction treatment is a young concept. Small samples of research and pilot programs show mindfulness is a positive approach to addiction treatment, but there is no concise theory as to how mindfulness should be implemented in addiction treatment. This research paper is designed to examine mindfulness in addiction treatment to aid in the success of sustained sobriety. Firsthand experience in addiction treatment as currently established, research of current mindfulness addiction treatment implementations, and qualitative interviews together suggest that mindfulness is a missing piece in addiction treatment.

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Mindfulness: The Missing Piece in Addiction Treatment

The research on the application of mindfulness treatment for addictions is in its infancy. Pilot programs and research studies have been surfacing in the addiction professional community over the last 10 years. Due to the infancy of the research and trial programs of implementing mindfulness in addiction treatment there are limitations. There is not enough longitudinal research or quantitative data to know whether mindfulness can serve as an effective complementary modality in addiction treatment. The purpose of this study is to examine the empirical gap in research concerning mindfulness, and to investigate whether adding mindfulness to conventional addiction treatment can foster sustained sobriety.

Many people suffering with addiction experience emotional and psychological difficulties which negatively impact their quality of life (Bayles, 2014). The goal in addiction treatment is recovery from the abuse of a substance or behavior leading to a life of sustained sobriety. However, sobriety from addiction can be difficult for an individual to obtain. While there are people with addiction who learn to live lives in sustained sobriety through programs such as 12-step, inpatient treatment, and outpatient treatment, in recovering from addiction and sustaining sobriety, much depends on the individual and his or her initial and aftercare treatment. Relapse, the return to abuse of a substance or behavior, can be part of the addiction cycle and can happen at any point in a person's recovery.

The role of addiction treatment is for a person to obtain the skills to live a life of sobriety. A tool that aids sobriety is a person with addiction learning how to change the mindset of his or her thoughts, resulting in the end of suffering in addiction. A change in mindset also teaches a person in treatment how to cope with thoughts and emotions without using a substance. One such application that would teach a person how to become aware of thoughts and emotions for

addiction treatment is mindfulness. The teachings the Buddha 2600 years ago are the foundation of mindfulness. Depending on particular beliefs, Buddhism may be viewed as a religion. The discussion of mindfulness in this paper is based on the secular applications of the Buddha's teachings. Mindfulness practice is a way of freeing oneself from suffering and learning how to quiet the craving voice, bringing forth the voice of compassion and self-love.

Mindfulness is a tool that brings awareness of one's emotions, cognitions, and mind state (Jazaieri McGonigal, Jinpa, Doty, Gross & Goldin, 2013). If mindfulness training were to be utilized in addiction treatment, individuals might become more aware of their habitual actions, allowing for better regulation of emotional triggers and addictive cravings. Through fostering individual's awareness of such emotions, and they are learning how to cope with them in a compassionate, nonjudgmental manner, mindfulness could be an effective support for sustaining sobriety (Garland, Froeliger, & Howard, 2014).

Addiction is a significant burden in terms of monetary loss and human suffering (Winger, Woods, Galuska, & Wade-Galuska, 2005). During the past 5 ½ years I have been working as an addiction counselor. Through my experience in treating addicts, I have formulated an experience-based perspective on addiction treatment. I have observed that many of the addiction treatment techniques used currently are not proving successful in supporting sustained sobriety. There is a cookie cutter format to addiction treatment that was implemented and adopted to become the standard operation of addiction treatment facilities: education about addiction, group therapy modalities, and individual counseling. The tools offered are all vital; however, increasing rates of relapse following addiction treatment highlight a need for additional therapeutic modalities. In recent years, empirical research exploring effects of mindfulness treatment for

addiction treatment has increased dramatically. Yet there is still a gap in knowledge of how mindfulness should be administered to be most effective for sustained sobriety.

In addiction treatment facilities, I have seen that people in treatment typically are not given sufficient time or education to learn about managing their emotions. Through my addiction counseling practice, I have observed that self-compassion and self-worth are emotions lost in a person in active addiction, while shame and guilt are prevalent. Once in addiction treatment, a client does not automatically redevelop positive emotions of self-regard. As a result, the need to soothe negative emotions re-emerges, and relapse to addictive behavior occurs.

Relapse from sobriety in addiction is defined as the return to substance use and abuse. In my experience, it is often due to the mental state of a person rather than to physical dependence on a substance. As Winger et al. (2013) have found, “behavioral scientists generally regard drug addiction as a behavioral disorder that results when drug reinforcers assume control over a substantial portion of an individual’s behavioral repertoire” (p. 673). Unfortunately, in addiction treatment, a client often does not learn how to become aware of his or her trigger behaviors leading to relapse. Once exiting addiction treatment, a client is left on his or her own to learn and deal with the emotions that arise when the supports of the treatment environment are withdrawn.

A component of mindfulness is the cultivation of nonjudgement of one’s inner experience (Schuman-Olivier, Hoepfner, Evins, & Brewer, 2014). The evidence in this study supports existing research showing that with self-compassion and nonjudgement, recovering addicts can learn to be comfortable within themselves. From a position of self-comfort, sober addicts can forgive themselves for the actions they took while active in addiction. It is to be hoped that through adopting mindfulness, addicts’ emotional suffering can end, leading the way to sustained sobriety.

This thesis, *Mindfulness: The Missing Piece in Addiction Treatment*, is designed to give firsthand experience in addiction treatment, as well as to provide qualitative research done via interviewing three individuals in sustained addiction sobriety. In the firsthand experience section, composite case studies are presented to paint a picture of the typical current addiction treatment process. The composite case studies represent firsthand observation as to how individuals relapse in the three addiction treatment modalities represented. The second section is a review of literature where addiction treatment modalities are examined. The literature review is broken into two sections with three different modalities examined in the afore-mentioned two sections; the current addiction treatment modalities and mindfulness intervention modalities. Qualitative research for this thesis is presented in the next section: methodology. The methodology of the research is discussed, presenting the rationale for the style of research, the protocol for participant recruitment, interview process and how data was analyzed. The findings and discussion section, the results of the participant interviews and break down of the findings are also discussed. Lastly, a conclusion of the thesis is made suggesting that mindfulness can be the missing piece in addiction treatment.

Firsthand Experience

As the researcher and author of this thesis, I also come with the expertise of addiction treatment, as I am licensed addiction counselor. Among the modalities used for such treatment, I have firsthand experience in three: Alcoholics Anonymous, inpatient treatment, and outpatient treatment. A common saying in the addiction community is that there is no one road to recovery. However, within the different avenues of the individual treatment modalities are standardized procedures that treatment facilities are required to follow to for accreditation. This makes for one road in the individual modalities.

In my work, I noticed relapse happening more often than sustained sobriety. I began to question why this was happening. I examined what was already implemented in the treatments as well as what was a common theme in the reasoning for the relapse. I began to identify missing pieces in the treatment modalities that could be contributing to the high relapse rates. For example, I noticed clients completing programs often felt scared, nervous, and not confident that they could live life in sustained sobriety. On the other hand, I have also seen clients who had action plans, confidence, and stable sobriety and relapsed anyway. It does not seem possible to predict who will relapse. This does not build confidence in me as a counselor that the treatment process currently in place is working. Something needs to change, or something additional needs to be implemented.

Although the foundation of Alcoholics Anonymous is an establishing a spiritual connection with a higher power, there are some downsides to AA treatment. AA is a peer to peer modality; there is no ability to identify comorbidity conditions. While inpatient and outpatient facilities provide these clinical advantages, they lack the spiritual connection of AA's foundation. Research is showing that sustained sobriety from addiction utilizing traditional modalities does not offer a guarantee of sustained recovery (Bergman, Hoepfner, Nelson, Slaymaker & Kelly, 2015).

In my personal life, I had learned mindfulness and meditation as way to help with suffering and struggles. In my counseling experience, I realized that mindfulness does not typically enter into addiction treatment modalities, and began to see the self-reflective and self-compassion components of mindfulness as a missing piece. I began to question why mindfulness is missing in addiction treatment, and whether mindfulness education might help with lowering

relapse rates. These questions led me to investigate the potential of utilizing mindfulness in addiction treatment.

An individual's progress through addiction treatment and follow-up, as stated above, is a complex and often individualized journey, one that is best understood through a combination of anecdotal and empirical evidence. Accordingly, I begin examining the processes, successes, and failures of addiction treatment in two ways: through documenting my experiences as an addiction counselor, and through examining recent literature in the field. Following are three composite case studies constructed from the hundreds of patients I have treated or observed in the course of addiction treatment. These case studies illustrate typical patterns of treatment and relapse that I have observed in clients experiencing three treatment modalities: AA, inpatient treatment, and outpatient treatment.

Alcoholics Anonymous

Alcoholics Anonymous is a peer-run, 12-step process designed to help alcoholics achieve spiritual wholeness and complete abstinence from alcohol that was by Bill Wilson and Bob Smith in 1937 (Alcoholics Anonymous, 2001). Mr. Bill and Dr. Bob developed AA with the intention of building a community and process to build spirituality and character development. Bill and Bob's goal for AA was to help an alcoholic achieve sobriety and to help an alcoholic live a life of sustained sobriety. Hence their development of the twelve steps and twelve traditions practiced by AA members. Currently AA is an international organization. There are AA meetings run 24 hours a day, 7 days a week, 365 days a year. AA has telephone hotlines and online meetings. There is help through AA for anyone and everyone at any time of the day, any place in the world.

Currently in the US there is a growing epidemic of opioid addiction that is requiring a need for change in the way addiction treatment is administered. Alcoholics Anonymous was a common modality for alcoholics or persons with other substance addictions. Although originally designed for people (primarily men) addicted to alcohol (Alcoholics Anonymous, 2001), the Alcoholics Anonymous 12-step process has been shown to be effective for any type of addiction. Offshoots of AA include Al-anon, a 12-step process for family of alcoholics; Alateen, for children of alcoholics; and Narcotics Anonymous, for persons addicted to legal or illegal mood-altering substances. The groups such as Al-Anon and Alateen are groups to support family members improve their own lives; they are not to be used as an intervention with a person with addiction (Fernandez, Begley & Marlatt, 2006). Due to the success of the AA 12 step process, AA has been used as a standard model for a person of any type of addiction. The AA model is commonly introduced to a person in addiction treatment in every setting.

Composite case. Matt (composite case #1) was a 37-year-old man, married for 13 years, father of two daughters. Matt worked as a pharmaceutical sales representative. Matt was successful in his career, allowing for a home in the suburbs of Massachusetts and a comfortable life for his family. Matt started drinking in college, an age when excessive drinking did not appear unusual. After college Matt's drinking was excessive at times, but he believed he managed to keep his career and family life in order. However, Matt's drinking was causing him to have issues in his marriage, and legal issues. Matt had three drinking and driving arrests, each leaving him in jail for a night or two. After the third drinking and driving incident Matt's wife filed for separation and Matt had to move out of his house. Living in a hotel, facing extended jail time, Matt began to realize that his drinking was causing serious issues in his life. Under the advisement of his lawyer, Matt decided to go to an AA meeting. Matt's perception of AA had

been that it was a place for low- income people who drank bottles of vodka a day. At his first meeting, Matt did not talk to anyone, but he listened to members' stories, and heard similarities to his own life. Matt continued to go to meetings daily, listening. Out of fear of facing more jail time, Matt managed to stop his drinking. After a month of not drinking and attending daily meetings Matt took the first step of AA and surrendered himself to the idea that he was powerless over alcohol.

Emotionally desperate to repair his marriage and his everyday life, Matt dove head-first into the AA process. He found a sponsor and a home group which served as the base for his membership in the group. He attended meetings daily, and spoke with his sponsor daily, as well. Matt and his sponsor met weekly to work on the 12 steps of AA.

A 12-step sponsor is a peer who has achieved sustained sobriety, often of many years' duration. A sponsor has completed the 12 steps him- or herself for the knowledge to guide a sponsee through the process. Through his sponsor, Matt found inspiration and strength. He became active in his home group. After a few months of sobriety, Matt began to go with his home group on commitments—the AA equivalent of a guest speakership. Matt was able to maintain his job throughout the AA process; however, his wife remained unmoved, and she filed for divorce. With the help of Matt's sponsor Matt was able to accept the fact that his wife wanted a divorce, and to respect her wishes. Matt was able to work through the emotions of the decision and not relapse into drinking.

At the one-year mark of Matt's sobriety Matt celebrated with his home group and sponsor. Matt's relationship with his daughters stabilized; he visited with them a few nights a week and on weekends. Matt found an apartment where his daughters could visit. Matt learned to manage social engagements, especially those connected with work, without drinking. He

continued to attend meetings daily and to work with his sponsor. Matt learned to live a healthy, balanced life through the process of AA. He became successful at work, and achieved a promotion. It appeared that AA was successful in helping Matt achieve lasting sobriety.

However, the job promotion required Matt to have to travel more. His sponsor helped him navigate the traveling, by making sure Matt found a meeting in whatever location he traveled to. But after two months of continuous traveling, Matt's attendance at AA meetings dwindled to 3 – 4 times a week. Matt was still connected with his sponsor, but their contacts, too, decreased, to as little as once a week. Matt's traveling also meant that his visits with his daughters were fewer and farther between. One night, having lost a large standing contract with a hospital and exhausted after a long day at a conference, Matt attended a business party, reasoning that having some fun would relieve his accumulated stress. That night, among people he didn't know, Matt accepted a drink, and after three years of sobriety, quickly relapsed into regular alcohol abuse. A year later Matt found himself back at step one in an AA meeting. Matt felt guilty for relapsing--relapse was not what Matt believed would happen to him. In my professional experience, I have observed that relapse happens when a person stops or slows down in commitment to the 12-step program. Matt, like many others, stopped going to meetings and engaging in the fellowship of AA, resulting in disruption of Matt's sustained sobriety.

Inpatient Addiction Treatment

Inpatient treatment provides for a transition of a person with addiction immediately after hospital detoxification. Inpatient treatment is structured to teach an individual recently sober how to live a life in sobriety. Persons in active addiction become incapable of maintaining adult of activities of daily living. Inpatient treatment provides a safe, closed environment for clients learning how to live in recovery from addiction and to relearn life skills. Inpatient treatment

gives them the space and time to do this, in a structured manner. The most prominent feature of inpatient treatment is its safe, closed environment, and round-the-clock supervision.

Composite Case. Sarah (composite case #2) was an 18-year-old female. She started taking prescription drugs at parties with friends at the age of 15. Sarah drank alcohol, but preferred the high she got from Vicodin. Sarah lived with her mother, who is divorced from Sarah's father. She had no relationship with her father, and little closeness to her mother beginning at age 12, though her mother did her best to give Sarah a safe, supportive home environment. After two and a half years of Sarah's abusing prescription drugs and, eventually, heroin, Sarah's mother obtained a court order to have Sarah committed to a hospital for detoxification treatment. Sarah continued her addiction treatment process with after-care at an inpatient treatment facility.

Inpatient care involves a three- to nine-month process. Once admitted, Sarah was initiated into the routine of the inpatient facility. Upon admission, Sarah had been 30 days sober; however, her thinking was still governed by the disordered life she lived as an addict. Sarah did not like the requirement of having to get up early in the morning and having to eat the breakfast provided. Once the day's meetings began, Sarah became more involved in the treatment process. She attended several types of meetings daily. Education groups were facilitated by addiction counselors, educating clients about types of drugs and the effects of addiction. Group therapy, facilitated by an addiction counselor, allowed Sarah to share accounts of her struggles and receive feedback and support from peers in the group. AA meetings, held after lunch, also provided peer support, and led Sarah through the process of re-framing her past thoughts and behaviors, and envisioning new practices. In individual counseling Sarah worked on her treatment plan. In addition to these daily treatment-oriented activities, a few times per week

Sarah was brought to outside activities such as yoga, boxing, and indoor mountain climbing. Yoga resonated with Sarah, so she reached out to the teacher for advice about developing a yoga routine of her own. Afternoon also included an hour for assigned chores, after which Sarah enjoyed some relaxed down time before dinner. After dinner Sarah attended another AA meeting.

Through this inpatient routine, Sarah was educated about characteristics of addiction, reflected on her own experiences with addiction, and learned tools for coping with addiction. While in the inpatient treatment Sarah was subject to random breathalyzer and urine drug testing. The random testing held Sarah accountable for her recovery; she knew that if she failed, she would be discharged from the program.

During her first months of inpatient treatment, Sarah showed progress in her recovery. After three months, she was dedicated to sobriety and depended on the inpatient process to guide her. She continued to work on her sobriety, learning about herself, improving her self-image and increasing her self-esteem. Since during the third month of treatment, clients were required to seek employment, Sarah obtained a job working in a store at the local shopping mall. At the same time, she became romantically involved with her roommate at the inpatient facility. Thanks to the balance between the treatment, her job, and her relationship, Sarah experienced a newfound confidence.

But in her fourth month of inpatient treatment, the relationship between Sarah and her roommate was discovered by the staff. Romantic involvement between clients was forbidden by the program's house rules; Sarah and her partner were discharged. After some searching, Sarah moved into a sobriety house. A sobriety house is often a rooming-house style arrangement, with staff to supervise the tenants. A person must stay sober to live in the house, routine drug and

breathalyzer tests are done to ensure the rules of that house. Sarah failed to complete this program, too. Nevertheless, with 4 months of sobriety experience and continuing attendance at AA meetings four days a week, Sarah was confident that she would remain sober. She did so for another year, despite daily cravings that she felt too guilty and ashamed to share with her partner or her AA sponsor. Despite her success in maintaining sobriety, the cravings made Sarah feel like a failure in sobriety; her emotions became overwhelming, and Sarah knew only one way to relieve her suffering. She took a bus to a place she had frequented when she was using, buying her old favorite prescription drugs. Her relapse began.

The drawback inherent in inpatient treatment paradoxically lies in its strength: its safe, closed environment frees clients from external distractions, allowing them to work intensively on recovery. But upon leaving the controlled treatment setting, clients are vulnerable once more to the stresses and temptations of life in the unpredictability of the real world. This vulnerability leaves them open to relapse. Another downside to inpatient addiction care is that the standardization of the treatment curriculum allows some clients to fall through the cracks. The clients who fall through the cracks are the clients for whom the treatment process does not resonate. The treatment is not effective for them. In my six years as an addiction counselor, I have observed that there is no single road to recovery. What works for one person may not always work for another. Accreditation standards for inpatient treatment programs, while necessary to safeguard quality, result in a cookie-cutter curriculum that may not resonate with every client. Although addiction counselors work hard to administer the curriculum and keep up with patients' progress and needs, they can become bogged down by the required paperwork, and not having enough staff, leaving staff over worked, causing counselors to be less able to deliver the optimum service they would like to provide.

Outpatient Treatment Process

Intensive outpatient treatment is commonly called IOP in the addiction treatment field. IOP is the treatment process for people who cannot attend inpatient treatment due to restrictions such as not being able to take time away from work or other family obligations. IOPs are often administered in a half-day time frame of 3-4 hours, 4 days a week, allowing people to continue living at home. People entering an IOP are at the same early recovery as someone entering inpatient treatment; often they enter IOP care coming out of detoxification or newly sober. IOP is not appropriate for some clients, ethically and from a clinical standpoint. My fellow addiction counselors and I refer clients to inpatient care when they are assessed as needing more intensive care than the IOP offers. The following composite case study tells the story of a woman who went through IOP treatment.

Composite Case. Carla (composite case #3) was 36 years old, and married for 10 years with two children ages 6 and 8. She had been abusing substances since the age of 14. Carla's addiction manifested first with opioids, then progressed to heroin use. The longest sobriety Carla had sustained was while she was pregnant. Carla had drifted in and out of treatment programs to address her addiction for 7 years. She attended intensive outpatient treatment (IOP) because it allowed her to work during the day and receive treatment in the evening. Carla attended the IOP on Monday, Tuesday, Thursday, and Friday nights from 5:30 – 8:30pm.

Carla participated in an education group from 5:30 – 6:30 pm, where she and the others in the IOP program were educated by an addiction counselor about drugs, addiction, and recovery. In the education group Carla learned about stress, relationships, boundaries, and living a life of sobriety. She was required to be tested randomly approximately once a week via urine sample and breathalyzer. From 6:45 – 8:30 pm, Carla participated in group therapy with a

counselor, which was focused on processing (sharing and reflecting upon) anything that may be going for a person in his or her life that was impairing his or her sobriety. In the processing group, members “checked in” about their current state of emotion; the counselor asked the group if anyone would like to share something that he or she was going through. Carla enjoyed participating in these processes groups because she was able to contribute and often to offer guidance to others in the group. Unlike self-reflection in mindfulness where a person becomes aware of themselves, in group processing the person is receiving guidance from peers and counselors.

Carla also met once a week with a counselor for individual counseling and with a doctor affiliated with the IOP program for medication to help with Carla’s opioid withdrawal symptoms. Carla was scheduled to be in the IOP program for 8 weeks. However, in the sixth week Carla was not showing the progress that counselors hoped for. They recommended that Carla remain in the program beyond the 8 weeks. Carla accepted this recommendation and committed to extending her treatment.

But the cost of IOP treatment caused financial strain for Carla and her husband, a stress that caused her to struggle in her sobriety. Although she regularly attended AA meetings, worked with her sponsor, and attended the IOP protocol as required, Carla stated that she did not see the use in staying sober when things in her life were still not better. The counselors worked with Carla to help her see the positive changes she was making in her life while sober. Carla took comfort in the support of the counselors and peers in the IOP group. However, although her husband also supported her sobriety, he was holding on to his resentment about the past loss of their money to drugs and alcohol. The couple began fighting more often about money. Stressed exhausted, and angry with her husband, Carla concluded that sobriety was not worth the struggle

and suffering it entailed. Because she had not mastered the skills to tolerate these emotions, Carla decided to have a drink at a bar where she also knew she could buy some prescription drugs. Thus, Carla relapsed. Carla's relapse lasted for 7 months. One day, embarrassed and feeling as though if she did not get sober she would die. Carla called for help from the IOP she had previously attended. Carla was referred to a detoxification facility. The IOP facility assured Carla that there would be a place for her in IOP when she was ready to start the process again. Having the support and encouragement of the counselors at the IOP gave Carla the courage to start over. But her journey of recovery and relapse was not atypical. As with clients who transition from inpatient programs to independent living, those who experience IOP care often find that the stresses of life outside intensive treatment become overwhelming. Despite intensive re-education and the ongoing structure of AA membership, they find themselves unable to manage the type of powerful emotions that led them to seek relief in substance abuse in the first place.

Matt, Sarah, and Carla's journeys through recovery and relapse are typical of many going through the process of obtaining sustained sobriety. The journey to recovery can take many attempts, and persons seeking sobriety often try a number of different treatment modalities. The three modalities discussed here have benefits and downfalls. I see a commonality of downfall in the three modalities. All are predicated upon external supports, whether in the form of clinical care or support from peers in recovery. While self-awareness is present to some extent as part of AA's Twelve Steps, the program is short on self-compassion and the avoidance of judgement of self or others. This missing piece in AA, inpatient, and IOP treatment means that recovering addicts tend not to internalize a continuous practice of self-awareness that can help them manage cravings and powerful emotions.

Addiction Treatment Modalities

The addiction treatment modalities section is the literature review section of this research paper. The literature review is broken down into two categories, the first section is review of three current addiction treatment modalities. The second category is mindful approaches to addiction treatment, with three subcategories of mindful modalities. The mindfulness subcategories are the review of research in the secular training, with focus on the physiological effects of mindfulness. The purpose of the literature review is to examine the research on the addiction modalities with which I have first-hand experience to as the effectiveness of the modalities. The objective of the literature review of mindfulness modalities is to review these current modalities, examine the studies on them, and investigate their effectiveness. .

Alcoholics Anonymous

Alcoholic Anonymous (AA) was founded in 1935 when Bill Wilson, a self-proclaimed alcoholic found reprieve in speaking to another alcoholic. Wilson formed regular meetings with other alcoholics for mutual-aid in stop drinking. Soon Wilson with the help of others in the group developed the 12 steps and the program became AA (Adams, 2015). The success of AA has intrigued researches to investigate what makes AA a successful addiction process. The perception of what is addiction is indefinable. Medical professions advocate the notion of addiction as a disease. Others endorse the spiritual lack in a person with addiction and how AA counteract the deficit (Adams, 2015). The wide difference of opinions as to why AA has been successful for individuals was the catalyst for the investigation. In the research, there appears to be a correlation of AA being successful for individuals to sustain sobriety because of the spiritual and community aspects.

Research of AA has established better outcomes on alcohol-related, psychological and social measures than other addiction treatment modalities (Humphreys, Blodgett & Wagner, 2014). The Humphreys, Blodgett, and Wagner (2014) study showed AA participants to have genuine benefits of being therapeutic, socially supportive of health behavior change, fostering sober friendships, making role models available, and instilling of hope. The hypothesis of the study was to explore the effectiveness of AA as to why AA is successful when it is a self-selection program. Humphreys, Blodgett and Wagner (2014) found there to be therapeutic values of AA, supporting in the success of the program, this should be a reassurance for clinicians, researchers, families and people with current drinking problems. Contradictory to Humphreys, Blodgett and Wagner (2014), Fiorentine (1999), found that AA may not be appropriate for those with major psychiatric disorders. The finds for Humphreys, Blodgett and Wagner (2014) research was done through randomized trials of AA facilitated interventions.

Frequent attendance at one or more meetings was found be the reason for sustained sobriety through AA in Fiorentine's (1999) study of AA success. The more frequent an individual attends AA meetings, the greater the likelihood of sustained sobriety (Fiorentine, 1999). Interestingly, it was not the 12-step process in AA as much as the regularity of meeting attendance. Could the success be due to the community and relationships built in AA that keeps an individual sober? The over-controlling mental desires of a substance is exchanged for the reliability on community support found in AA. (Adams, 2015).

It appears that the studies are inconclusive at best because there are many factors that cannot be controlled in an experiment. Mainly due to AA having a foundation of anonymity collection of data is difficult to obtain for statistic rates. People in AA live out their daily lives outside of meeting time – working, taking care of children, having hobbies, socializing, etc.

Therefore, it seems necessary for successful programs to give those who have or are struggling with addiction the tools to manage their addictions outside of the program. Whether this is through strong social networks or through individual techniques (or a combination of both), it seems the jury is still out.

Inpatient

Inpatient is a designed modality for addiction treatment which allows respite for an individual active in addiction time to heal and learn to live life not dependent on a substance. Inpatient removes an individual from environments that have been perpetuating his or her addiction. Inpatient allows efforts toward sobriety and provides a 24-hour treatment setting (Finney, Hahn & Moos, 1996). Clinical inpatient services offer adults and adolescents clinical staffing to incorporate treatment of mental health issues that could be an individual underlying issue with substance use. (Bergman, Hoepfner, Nelson, Slaymaker, & Kelly, 2015). Inpatient treatment normally is 3 – 9 months in duration. An individual's insurance may pay for inpatient, with varying state to state coverage, or an individual will pay out of pocket for inpatient treatment. Through assessing adults over a year after residential treatment, the combination of 12 step and professional services enhances the outcomes of sustained sobriety after residential treatment. This shows the importance of community-based resources. (Bergman et al., 2015). Inpatient provides a communal style living environment teaching individuals the power of community. Through community individuals learn to think outside of themselves, be of service to others and learn how to be supported.

Outpatient

Intensive outpatient (IOP) was developed due to in the rise of stimulate substance addiction in the 1980's (Substance Abuse and Mental Health Services Administration

[SAMSHA], 2006). At the time the treatment models in place were to mainly treat alcohol dependency. The treatment model was showing to be ineffective for treating other stimulant substances dependency (Obert et. al., 2000). The foundation of an IOP was to administer elements of relapse prevention, cognitive-behavioral, psychoeducation, family genogram, and 12-step program supplementation. Depending on the agency IOP's typically run 8 – 16 weeks. In 1998 SAMSHA evaluated the effectiveness of IOP's and recommended implementation of teaching clients how to structure a substance free lifestyle, time management, as well as conducting regular drug and breath-alcohol testing.

While an individual is in IOP, he or she is requested to attend 12 step meetings outside of the IOP. If AA is the 12-step external support this allows for an individual to find a group in which he or she can be active in after the IOP, having the support set up upon completion of the IOP. A difficulty for inpatient individuals who may be attending AA meetings not located near where he or she lives or works (Finney et al., 1996). The ability to continue everyday life while receiving assistance for sobriety is a benefit with IOP.

IOP and inpatient both offer the stability of clinical support, accountability where AA does not. The research around the effectiveness of AA, inpatient and outpatient does not show a solid finding of one working better than another. The three addiction modalities examined each offer a different avenue for an individual to obtain sobriety in the hope for sustained sobriety. The benefit of having different options for addiction treatment allows for individuals to find what is the right one for them. The researchers are showing that the success of each modality is not the structured curriculum of the program but the benefits of community and relationships in aiding individuals for sustained sobriety. However, relapse is happening within the three modalities. There is something missing within the three modalities, and mindfulness could be what is

missing. The next section reviews three different mindfulness modalities that have been implemented in addiction treatment.

Mindfulness Modalities

Mindfulness training intervention approaches, often an approach stemmed from secular mindfulness practice, by way of bringing awareness to an individual's internal thoughts and behaviors. The skills cultivated through mindfulness can serve universally to be effective in a secular or traditional approach. Mindfulness training is the way to "ultimately reduce suffering by catalyzing a shift of rotation in one's relationship to aversive experience" (Black, 2014, p. 488). Utilizing mindfulness for addiction treatment is an incentive for the understanding of craving and suffering in the context of addiction.

A part of addiction is relapse, which is the "return to a previous behaviors or mental state" (Bayles, 2014, p. 23). Relapse is not a goal in addiction treatment and should be avoided. The arising of mindfulness integration in addiction treatment is being examined in hopes that with the addiction modality relapse can be avoided. A predictor of drug craving, continued drug use and relapse is the inability to effectively deal with stress (Garland, Gaylord, Boettiger, & Howard, 2010). Stress appears in different forms and manifests when there is an overall life pressure or a traumatic life experience (Young, de Armas DeLorenzi & Cunningham, 2011). The correlation between addiction and stress has fostered the examination of mindfulness-based stress reduction with addiction treatment.

Mindfulness-Based Stress Reduction Interventions

Research has shown that certain elements of stress reduces of addiction. Bowen et al., (2009) conducted a longitudinal randomized controlled trial intervention. Bowen et al., (2009) hypothesized "that participation in Mindfulness-Based Relapse Prevention (MBRP) would be

associated with greater reductions in substance use, and greater increases in mindfulness and acceptance in MBRP versus Treatment As Usual (TAU)” (p. 3). Participants participated in an 8 week 2-hour once a week MBRP session. The sessions had meditations practice and themes for discussion, relapse prevention education, assigned daily exercise for homework.

Bowen et al. (2009) study results showed improvement in days of not using substances, having cravings, awareness, and acceptance with using MBRP as an alternative form of treatment. However, the study also states that evidence showed no other differences between the two groups when it came to mindfulness aspects. Both groups showed a decrease in substance related issues, however not a significant amount. In conclusion, the study showed MBRP to be effective for aftercare relapse treatment for substance abuse. As well as the study provided evidence supporting mindfulness meditation to be useful as a therapy application for addictive behaviors.

A pilot program based on mindfulness-based stress reduction (MBSR) was done by Vallejo and Amaro, (2009) in a community-based addiction treatment setting. The goal of the pilot program was to utilize mindfulness meditation skills for relapse prevention. The initiative for the study was to increase awareness of the association between substance abuse and stress.

Vellejo and Amaroa’s pilot program was implemented with women attending treatment within a residential addiction treatment facility. The design and implementation of the program entailed 2 weekly MBRP-W classes, due to language barriers one class was presented in English and the other in Spanish. The biweekly classes were held in a 9-week cycle over a 4-year period. The weekly classes were broken down to five segments comprised of a welcome meditation, setting class objectives, brief didactic psychoeducation presentation based on each class theme,

experiential and formal mindfulness practices, and lastly a reading of recovery literature and poems by class participants and homework.

In the initial stages of the pilot program there was an uneducated assessment of the direct relevance to issues of addiction and relapse, early recovery, trauma, mental health, and literacy in the group of participants. Vallejo and Amaro (2009) had no experience working or administering MSBR to individuals in addiction treatment. Due to the lack of knowledge of the needs of individuals in early addiction treatment, the initial stages of the pilot program were not welcomed by individuals in the addiction treatment facility receiving treatment. Vallejo and Amaro (2009) redesigned and developed a new curriculum for the program, attending to the issues which arise in early recovery, the population of participants.

The authors wrote in the article that “the revised program focused on specific stressors faced by women in the program. A more didactic approach was followed to teach clients about the relationship of stress to relapse and how mindfulness could be useful as a relapse prevention tool” (Vallejo & Amaro, 2009, p. 199). The participants in the pilot program displayed issues of trauma, and short attention spans, often found in early recovery. The participants also faced stress around child custody cases against them, and individual counseling that caused inconsistent participation with the pilot program. The inconsistent participation was no fault of the participants, but not considered by Vallejo and Amaro (2009) when developing the pilot program. The authors aimed for the pilot program was to have participants develop awareness of cravings, “observing it with a certain spaciousness and affectionate curiosity instead of reacting to habitual ways” (Vallejo & Amaro, 2009, p. 197). Once the new curriculum was implemented, the now called MBSR-W program, showed substantial positive changes in attendance, attitudes, attention, and evaluations at the end of the MBSR-W cycles.

The outcome of the program was measured by structured interviews administered by research staff at three different phases; initial, 6-months, and 12-months. Participants also completed a satisfaction form at the last group session. There were also written observations done by instructors of the groups. The result of the study over the 4-year implementation results showed significant improvement after the adaptation of the curriculum (Vellajo & Amaro, 2009). Upon completion of the study the authors expressed three conclusive lessons learned from the program. The first lesson was the importance of reframing to focus on relapse prevention. The second lesson was the need for adaptations in regard to participants' trauma histories, short attention span, and life literacy. Lastly the third lesson was the need for flexibility for the participant's treatment schedule (Vellajo & Amaro, 2009).

There was a learning curve in the process both for Vellajo and Amaro (2009) and for the treatment center the program was administered in. Both sides were new to the delivery; the authors had no prior experience with the population. In addition, a mindfulness-based intervention had never been administered in the treatment facility. The study has a lot of limitations; due to the longevity of the study. The researchers had the time to address the limitations and re-access the pilot program to deliver the changes that were needed. The conclusion of the study showed that with professional trained facilitators mindfulness-based stress reduction can be beneficial in addiction treatment.

Brewer et al. (2009) published the results of a pilot trial that "compared mindfulness training (MT) to empirically-validated treatments for substance abuse disorders (SUDs) such as cognitive behavioral therapy" (Brewer et al., 2009 p.1). Brewer et al. (2009) hypothesized that conditions linked to stress are perilous in the formation of addictions and their dissemination as chronic disorders.

Participants for the trial study were recruited through an outpatient facility, resulting in 36 screened individuals eligible as well as agreeing to be a participant in the study. The trial consisted of weekly group therapy sessions as the participants' primary treatment. The participants were randomly assigned to groups based either in a Cognitive Behavior Therapy (CBT) or Mindfulness Training (MT) in the outpatient treatment setting. The participants were required to meet the requirements of the DSM-IV criteria for alcohol and/or cocaine abuse or dependence in the time frame of the past year. Participants were tested and assessed weekly for drug use. During the after treatment the measurement of personalized stress provocation was assessed (Brewer et al., 2009). The results of the pilot study showed no difference in treatment gratification of the fourteen individuals who completed the treatment. The data from the pilot programs laboratory paradigm suggested decreased psychological and physiological measurements of stress during incitement in the MT compared to CBT.

Brewer et al. (2009) study was much like Vallejo and Amaro (2009) study and used adaptations from the traditional mindfulness-based stress reduction program. The MT treatment sessions in Brewer et al. (2009) pilot program was shortened to accommodate participant retention and treatment compliance. The authors reported "data suggest that shorter-than-standard MT sessions may still provide sufficient training to establish efficacy" (Brewer et al. 2009, p. 6). In conclusion Brewer, et al. (2009) pilot study suggests MT to be a potential component to addiction treatment regarding stress activity.

The three mindfulness based programs reviewed showed slight changes in the outcomes for the participant for stress and cravings. However, the studies do not mention foundation mindfulness components, compassion and nonjudgement. Reviewing the studies, it appears mindfulness is beneficial for addiction treatment; however, is mindfulness based stress reduction

the proper standard to be using in addiction treatment? The studies were aiming to aid stress and cravings for people in addiction treatment. Perhaps there is more to aiding people in addiction than just stress and craving management? In the next section a different mindfulness approach is examined.

Mindfulness Training Interventions

Despite large efforts in addiction treatment process, treatment approaches have remained deficient in teaching individuals with addiction how to remain in sustained sobriety (Brewer, Elwafi & Davis, 2012). In the following articles from Brewer, Elwafi and Davis (2012), Himerlstein (2011) and Groves (2014) exploration of utilizing mindfulness training for addiction outside of the stress reduction modal. Emotional and physical suffering, craving, impulsiveness, and lack of self-regulation become part of an individual's life when suffering with addiction (Brewer, Elwafi & Davis, 2012). The Buddhist psychology assists in healing human suffering through mindfulness training (Brewer, Elwafi & Davis, 2012). Refuge is a word heard in the Buddha's teaching, a person must take refuge in the Buddha to be free of suffering and cravings. A person active in addiction may mistakenly have taken refuge in his or her substance of choice, the answer to a mind shift in where to take refuge may be mindfulness training. Mindfulness training, the path to awakening or enlightenment emulates a parallel course one takes in addiction treatment. The outcome to be to end suffering, craving, and to awaken to life. In the following studies, the approach of mindfulness training for addiction treatment in the Buddhist psychology model is presented.

Himelstein's (2011) pilot study was designed as a group-based therapeutic treatment, a mindfulness-based substance use intervention implemented on incarcerated youth. The pilot

study incorporates formal and informal mindfulness practices, didactic drug education, experiential exercises, and group discussions within each module of the 8-week program.

The pilot study was an hour and a half once a week, for 8 weeks. The study had two major components: drug education and development of self-awareness. In the sessions of self-awareness activities consisted of emotional awareness and regulation, empathy building, and informal and formal mindfulness practices (Himmelstein, 2011). The informal mindfulness practices were moments of guided awareness and check ins. The formal mindfulness practices consisted of mindfulness meditations within each session. The measurement of program completion rate, self-report impulsiveness, self-regulation and perceived risk of drug use were the primary position of the study.

Although the study did not find significant changes from pretest to posttest with self-regulation, the results did show a decrease in impulsiveness and perceived risk of drug use (Himmelstein, 2011). Addiction has a cycle of craving for the substance of choice, often resulting in impulsiveness, a possibility also presented to an individual in sustained sobriety, Brewer, Elwafi and Davis (2012) explain the cycle as “the addictive loop.” The addictive loop is the association of the substance of choice to be positive, and cravings or withdrawals to be negative (Brewer, Elwafi & Davis, 2012) resulting in wanting a more positive experience. The mindfulness training in Himmelstein’s (2011) study also showed positive learning experiences around drugs and the harmful habits drugs causes. Although Himmelstein (2011) study was limited only to youth in juvenile detention, the study presents how mindfulness training can be a vital implementation in addiction treatment. The study utilizes mindfulness training to educate and bring awareness to external behaviors, however there is no emphasis on how to live with the internal emotions that the individual will become aware of.

Fernandez, Wood, Stein and Rossi (2010) took a different approach to examining mindfulness and substance use. The study concentrated on alcohol use, and looking at the link of awareness and reduction of alcohol use (Fernandez, Wood, Stein & Rossi, 2010). The authors theorized that avoiding unwelcomed thoughts disseminates addictive behaviors, the link between the two being meditation. Supporting factors in the study suggested individuals who could focus on an activity with undivided attention may be less likely to engage in heavy alcohol consumption. The study measured mindfulness through the Five Facet Mindfulness Questionnaire (FFMQ) a 39-item designed to measure mindfulness through questions focusing on the ability to be witness experiences, or to ability to accept thoughts and feelings without judgement. The study used participants whom were already participating in a larger clinical trial on alcohol use and abuse.

The study outcomes showed a reduction of alcohol use but not complete sobriety. The study is worth examining due to the finding that with administration of mindfulness meditation there are benefits in aiding addiction. The studies done by Fernandez, Wood, Stein and Rossi (2010), Himelstien (2011), Brewer, Elwafi and Davis (2012) continue to reinforce mindfulness in addiction treatment is not necessarily about reducing stress. The studies are presenting outcomes that using mindfulness meditation is more about an individual becoming aware of thoughts and behaviors.

Clinical symptoms of addiction are craving, impaired self-control, emotional dysregulation, and stress reactivity (Y.Tang; R.Tang, & Posner, 2015). In Tang, Tang, and Posner (2015) study the enlightening of emotion regulation is significant to the prevention and treatment of addiction. Tang, Tang and Posner (2015) suggest using emotion regulation and mindfulness meditation as the process of treatment of addiction. Tang, Tang and Posner (2015)

used the application of mindfulness meditation-integrated body-mind training (IBMT) as the only method of demonstration to support the author's hypothesis. IBMT is administered in a systematic training involving of meditation for attention and self-control.

Tang, Tang and Posner (2015), focused on measuring brain regions and the effects mindfulness has on the regions. The findings in Tang, Tang and Posner's (2015) research showed increased connectivity and activity in regions of the brain that involve emotion regulation through mindfulness meditation training. Emotion regulation and self-control can aid addiction prevention and treatment (Y.Tang; R.Tang & Posner, 2015).

The mindfulness training interventions reviewed investigate the emotional and behavior aspects of the benefits of mindfulness for addiction treatment. The studies' findings do not demonstrate significant differences in before mindfulness intervention from after. As mindfulness intervention for addiction treatment research continues, there is hope for longer studies to indicate the benefits of implementation of mindfulness in early recovery addiction treatment settings.

Spirituality Mindfulness Approaches

The research studies thus far have all looked at mindfulness training in addiction treatment. However, what has not been spoken about is employing mindfulness in sustained sobriety. Once an individual has obtained sobriety, the work has not ended there; an individual now has the work of sustaining sobriety. In recent years' programs, such as Refuge Recovery A Buddhist Path To Recovering From Addiction (Levin, 2014) and Eight Step Recovery (Mason-John & Groves, 2014) have become available as community based Buddhist teachings for people in sobriety from addictive behaviors to maintain sobriety.

The uniqueness of these two programs is that the programs utilize the Buddha's teaching of the four noble truths and eightfold path as the structure of the programs. The Refuge Recovery (Levine, 2014) program approaches addiction as the path to recovery enlisting the Buddha's four noble truths called the four truths of refuge recovery the first being, "addiction creates suffering", second, the cause of addiction is "repetitive craving", third, "recovery is possible" and fourth, "the path to recovery is available" (Levin, 2014 p. 4). Stepping into the Refuge Recovery eight-fold path to recovery; understanding, intention, communication/community, action, livelihood/service, effort, mindfulness/meditation, and concentration/meditations (Levine, 2014). There is a strong importance on the practice of meditation in Refuge Recovery. Exclusive to the other Buddhist teaching based recovery treatment programs, Refuge Recovery also has a treatment center providing detoxification, residential treatment, outpatient, and sober living housing.

In his book (2014) book *Refuge Recovery*, Levine encourages individuals to take refuge in their own potential, the four truths, and to build a network within the Refuge Recovery community for sustainable sobriety. Refuge Recovery has peer run meetings across the United States. Refuge Recovery has formatted scripts for meeting curriculum and readings. Currently anyone can set up a Refuge Recovery.

Like Refuge Recovery, *Eight Step Recovery* (Mason-John & Groves, 2013) has a designed meeting format, and a strong emphasis is placed on meditation. The work in *Eight Step Recovery* (Mason-John & Groves, 2013) is drawn from the four noble truths and taking refuge in the program. The eight-step recovery is designed to provide teaching of how the mind works, tools to aid a mind susceptible to addiction, and customs to overcome addictive behavior, fostering an easeful mind free of resentments (Mason-John & Groves, 2013). Through meetings,

community and mentorship, the goals of the program can be met by any individual willing to take the path of the program.

The two community based programs are too new for studies or research to have been done on them; however, they are worth reviewing. Sustained sobriety has been held through the Refuge Recovery processes (Levine, 2014). The Buddhist teaching may increase benefits such as evolving awareness through meditation, education of nonattachment to the ego, and linking to a collective spirituality (Groves, 2013) that other programs do not incorporate. There is something to be said about what draws people in sustained sobriety to programs based on mindfulness. Uniquely in these two programs, the individuals who find, attend, and become involved in them do so on their own, and are not being introduced to the interventions in an addiction treatment center.

Mindfulness for addiction treatment is relatively new in research and studies. The research that has been conducted relies a great deal on mindfulness-based stress reduction protocol. Pilot studies like Bowen et al. (2009), have been the style of mindfulness commonly excepted in addiction treatment facilities. In most recent years' programs, such as Refuge Recovery (Levin, 2014) have become another means for sustainable sobriety with addiction. The examination of mindfulness community programs needs to be brought to researches' attention. The programs could be a twofold resolution: the spiritual aspect of Buddhist philosophy as well as the community support to assist individuals for sustainable sobriety. Although there is not research to support the outcomes of the community based programs versus the more secular addiction treatment programs, there appears to be a growing rate need for mindfulness in addiction treatment for sustainable sobriety.

This literature review of addiction modalities was meant to lay a foundation of what research has been done, as well as what has been successful and why. There is not one road to sustained sobriety with addiction. What works for one person may not always work for another. The end goal is for sustainable sobriety. If mindfulness is a path to sustainable sobriety, how mindfulness is administered and where along a person's journey is what is vital to the process. More research needs to be done on mindfulness and addiction, hopefully with the growing population of mindfulness in the Western culture there will be continued research in addiction.

Methodology for a Small Study on Mindfulness and Sustained Sobriety

As part of this thesis, I wanted to take a qualitative approach to investigating how and why how and why mindfulness has been a part of sustained sobriety for some. Although the sample size was small, the findings of commonalities among the participants was significant enough to support further investigation of the benefit of mindfulness in addiction treatment.

Sample Selection

The sample selection was done by recruitment of professional and peer networks through social media. The sample size was three women ranging in age from 48 to 55 years old. The participant's sobriety length ranged from 4 to 15 years. The three women were Caucasian, all present day living and originally from the Northeast. Two of the participants has higher education, one a lawyer, one a mental health counselor, and one finished high school. The three participants identified being middle class economic status. Two of the participants were previously married and divorced, and one never married.

The three participants identified as alcoholics. Two participants also abused opioids and one in addition to opioids abused marijuana. One of the participants has been through repeated addiction treatment process of detoxification and inpatient before least treatment process. One

participant had been to addiction treatment of inpatient once before sustained sobriety. The participant stated that the last time she was in detoxification she realized she may die the next time she used a drug, this was the catalyst to her wanting to become sober. Another participant stated she went away to treatment and has been sober since she left the treatment center. The third participant obtained sobriety through AA.

Interview Protocol

The recruiting of individuals for participation for interviews had the requirement of individuals utilize mindfulness in sustained sobriety. The requirement was to have an active meditation practice and learned at some time about mindfulness concepts. Ideally the concepts would be rooted in the foundation of Buddhist teaching. Once the initial contact with participants was made, further explanation of the objectives of the research project was explained, as well as brief review of the consent form. I scheduled phone interviews with the participants, allotting for 1 – 2 hours per participant. A series of seven questions were developed with the expectation that the questions would serve as a platform for the participant to explain her experience with mindfulness and sustained sobriety (see Appendix A).

The questions were asked in a manner that led participants to speak of her journey in addiction treatment and what led to finding mindfulness. The interviews began with the participant's addiction treatment history and an inquiry of which addiction treatment modalities she experienced in the past. The importance of discussing what type of addiction treatment the interviewee had experienced in the past assisted in determining if the interviewee had experience in other forms of addiction treatment which did not utilize mindfulness or meditation. If a person had experienced previous addiction treatment and relapsed, investigation into what treatment modalities were learned and not learned in the treatment process is essential.

The interview was then directed to how she utilized mindfulness in her life currently. A question was posed to determine if mindfulness was a new concept to the participant's or if she had prior a knowledge of meditation and mindfulness. The participants were then asked about how she was introduced to mindfulness and meditation. The interviews became a storytelling of the participant's journey. Each participant stated they were grateful to be able to be a part of the research.

Data Analysis

The three interviews were done through phone conversation and recorded on a recording device on a laptop. Assurance was made to the participants that I was the only person in the room during the conversation. The participants were informed they had the right to not answer any questions. The average interview was an hour long, with one interview being two hours in duration. On completion of the interviews the interviews were manually transcribed by me. I reviewed the transcripts tagging themes by color. Once themes were tagged by color a cross review of the three interviews for the common themes were examined to come up the data. The analysis was done by myself. Although there was room, great assurance was done to not have a bias role in the analysis.

Findings and Discussion

In the findings and discussion section the qualitative data analysis was broken down into three subsections. Each subsection was derived from three interview questions laying a foundation of the history and present day journey into mindfulness of the participants. After the subsections, discussion of the finds brings support to the participant's experience with utilizing mindfulness in sustained sobriety. The names of participants have been changed to pseudonyms for protection of participant's privacy.

Experience of Using Mindfulness with Addiction Treatment

Participant Donna was introduced to mindfulness and meditation in addiction treatment. Donna had never meditated until meditation was a part of the curriculum at the addiction treatment center she attended. Donna in present day meditates daily, teaches to children and attended meditation community events that she can find. Participant Serena learned of meditation through AA, Serna stated in step 11 of AA meditation is implemented. Serena had yoga practice and learned of mindfulness through her yoga practice. Present day Serena meditates on her own daily, works in a school teaching children mindfulness, and participates in mindfulness retreats. The third participant, Kelly was introduced to mindfulness and meditation while leaving detoxification as a suggestion as to a sober activity. Kelly was hesitant of sitting meditation but found participating in a mindfulness community of mantra and drumming aided in her sobriety. After a year of involvement in the community Kelly decided to sit in meditation. Kelly presently has a daily meditation practice.

Previous Knowledge or Practice of Mindfulness or Meditation

The three participants before embarking on an addiction treatment process had no previous knowledge or practice of mindfulness or meditation. Participants Donna and Serena had no previous history of addiction treatment process before the process that led to the current sobriety. Both stated she had tried to obtain sobriety on her own at different times (during two pregnancies each) only to return to using substances. Participant Kelly had attended detoxifications three times and tried obtaining sobriety own a few times only to find herself relapsing.

Mindfulness for Sobriety

The participants spoke of thoughts around using mindfulness for sobriety verses other processes they had used. The three participants stated that mindfulness was used in collaboration to other sobriety modalities. All three participants attend AA and attend individual mental health counseling. The commonality each participant stated was contributing factors to her sustained sobriety was mindfulness taught her compassion for herself and others, self-esteem, being part of a community outside off AA, and brought a spirituality component that was not experienced before.

Other Findings

There were negative emotions of shame and guilt as common theme among the women. The women each stated they had felt shame and guilt while active in sobriety as well as while in early recovery. The examination of the two negative emotions of shame and guilt will be examined in the discussion portion of this paper along with the four positive contributes mindfulness brought to the women.

Discussion

The results of the interviews showed positive and negative emotions as contributing factors to the participants sustained sobriety. The three participants each stated learning self-compassion, non-judgement, and compassion has been the take away from mindfulness to aid in her sustained sobriety. There was no mention by the participants of stress reduction, or physiologically reduction of cravings by utilizing mindfulness. In the literature review the most popular form to research and pilot programs for mindfulness in addiction treatment has been done with the foundation of mindfulness stress reduction. This is showing that the emphasis of using mindfulness in addiction treatment is on the physiologically reduction of addictive behaviors rather than examining the emotion factors which contribute to relapse in addiction.

The participants expressed the emotional effects of mindfulness in conjunction with another recovery modality as the reason for their sustained recovery. Participant Donna stated in her interview, “the combination of mindfulness and meditation with 12 steps meetings” is what has kept her in sustained sobriety. Mindfulness is not suggested as a standalone modality however it is suggested to be implemented in the inpatient and outpatient treatment process.

The results of the data analysis of the interviews showed commonalities of why mindfulness has been a part of each participant’s sustained sobriety. All three participants stated that mindfulness has helped them stay sober from addiction. All three have also stated that it was not mindfulness and meditation on its own but in conjunction with 12 steps programs and/or counseling. The initial commonalities in the interviewees is the demographics. Although the three participants found mindfulness and meditation at different points in her journey of sobriety each expressed having emotions of shame and guilt while active in addiction and in early recovery.

Shame and Guilt

Shame and guilt are a common emotion I have heard from clients, in my professional experience, and in the interviews of the three participants expressing how he or she feels in early recovery. The two emotions are identified as an essential part of moral motivation (Silfver-Kuhalampo, 2015). Shame is described as an undesirable self-evaluation people feel, when feeling insufficient and inferior and exposed to social criticism (Lynch, Hill, Nagoshi, & Nagoshi, 2012). Examples of shame I have heard from clients is shame of lying, stealing and manipulating others while active in addiction. Some extreme feelings of shame are from self-inflicted actions. Participant Donna expressed feeling shame for being intoxicated around her

children. Shame typically serves a toxic role in the setting of substance abuse (Luoma, Kohlenberg, Hayes & Fletcher, 2012).

Guilt can be aligned as a social cohesion, obeying to the unspoken agreed upon social and moral norms. When an individual is active in addiction actions are often not aligned with social agreements. Guilt plays an emotional role when the social agreements are broken. While active in addiction the substance of choice may be to suppress the feeling of guilt. In early recovery, the clarity of an individual's actions while actively using brings forth guilt. In my experience, I have not treated or spoken to a person in early recovery who did not have guilt or shame for his or her actions while actively using.

Mindfulness fosters positive emotions that aid in the quieting of focus of shame and guilt. This is not to say that shame and guilt will go away. Over time the development of positive emotions allows for an individual to emotional deal with the arising of shame and guilt. In the interviews with participants, the common positive emotions developed from mindfulness was self-compassion, compassion for others and non-judgement towards oneself and others. As well as a development of support through a community and spiritual connection.

Self-Esteem

Self-esteem per the psychology definition (Branden, 1969), is an individual's general logic of self-worth or personal value. Self-esteem pre-recovery, participants saw themselves as bad or good. Participant Donna stated "I never thought I had a problem with substances and alcohol. I was just seeing myself as being bad", in the bad vs, good, guilt and shame was her common feelings toward herself for being bad. Participant Kelly spoke "When I got sober I put my dresser in front of my closet and did not open my closet for a year. In the closet was all the liquor bottles I had stashed while I was drinking so my mother did not find them. I was ashamed

of her knowing how much I drank.” Self-esteem in sustained sobriety stated by participants as being a good person, kind, compassion person. Participant Donna is quoted as saying “I truly have found this to be beneficial and has made me a kinder, calmer person”, now that she has been practicing mindfulness and meditation.

Compassion and Non-Judgement

Self-compassion is comprised of a combination of affective, cognitive and motivational components, resulting in the enhancement of well-being (Jazaieri, et al., 2013). Self-Compassion is an outcome of mindfulness, through the process of learning to not judge yourself a person fosters an understanding of themselves. The participants brought up statements of feeling shame and guilt. Feeling wrong for the behaviors of lying, or manipulating others while active in addiction.

Compassion for others is a concept all three participants said was noticeable change in them. Participant Kelly spoke of her relationship with her sister that is nonexistent. Kelly stated “for years I felt anger at her for her not likening me. Today I can see that it must have been hard being my sister and having to always be the good one because I was always doing wrong.” The example also shows a nonjudgement towards Kelly’s sister. Kelly spoke of how she would judge her sister for having what Kelly thought the perfect life and not liking Kelly. Kelly judged herself for not having what her sister had in life. Kelly talked about while active in addiction the judgement fueled her addiction, “it was easy to blame my unhappiness on my sister because she did not like me and I was not like her” Kelly talked on judgment. Kelly continued to talk of how when she became mindful of how she was viewing herself and sister the compassion for both was easily to understand and accept.

Participant Donna spoke of a story of how she had judgement towards a woman at work and how once in sobriety she brought compassion to the woman in a business meeting.

I was extremely judgmental. I can remember one day sitting at a meeting, and a woman who often irritated me. She didn't do anything in the world to irritate me. It was me. I remember sitting looking at her thinking, the words that came to me were, she is a child of god just like you are. What are you doing? She was talking and I smiled and she went to stop. She was use to me cutting her off. And being able to say please continue to share. I want to hear what you have to say, I feel kinder.

Self-compassion can be the most difficult in early recovery because person is required to accept who he or she is. Self-compassion is learning to be satisfied in life, adapt optimism, happiness and wisdom. An individual must also accept self-criticism, depression, anxiety as human arising emotions (Jazaeri et al., 2014). In early recovery this can be challenging, but without learning this vital tool of self-compassion in my professional experience is what drives a person to relapse.

Community

Community is defined as “a feeling of fellowship with others, as a result of sharing common attitudes, interest and goals” (Community, 2017). A community is a place a person can communicate with likeminded people, and support others. In recovery, it is important to find a community that inspires a person and where a person can get help when stuck. Addiction programs such as 12 -step programs provide a community. However, 12-step communities can also be intimidating for individuals. In a meditation community, there is a large aspect of individual practice among others. A place where individual can conjugate to practice the commonality. Participant Serena began her sobriety by going to Alcoholics Anonymous, she

continues to attend meetings. In her interview, Serena spoke of how attending silent meditation retreats where a teacher gives a talk on mindfulness subjects was helpful and encouraging for her sobriety. Participant Donna spoke at length of how she searched out in the area she lives in for meditation classes, retreats or anything that involved mindfulness. Donna stated she found a monthly meditation group she would attend “I counted the days down for that hour. Some people would say to me, why do prefer going to this group. I said because the energy is good.” Noah Levine designed Refuge Recovery (2014) after he utilized mindfulness as a path to recovery from addiction. Levine writes about the Buddha teaching of taking refuge within a community. The coming together of likeminded individuals raises the energy often in a spiritual manner, allowing for support and guidance to sustained sobriety.

Spirituality

Spirituality is definition as “the quality of being concerned with the human spirit or soul as opposed to material or physical things” (Spirituality, 2017). My personal experience of mindfulness has opened my thoughts to seeing a world of freedom outside of my mind. Spirituality is a personal concept. In my professional teaching of spirituality in addiction treatment I teach spirituality as a relationship with ourselves, an energy outside of our self, and the world around us. I teach that a person can be spiritual without being religious. Spirituality encompasses our values, our priorities, and the way we interact with others. I invite the concept of a having a connection to high power within spirituality. A higher power being an energy greater than oneself assisting a person in life.

In the mist of addiction addicts often play the role of a higher power, feeling the power of how to control life. This is often done by a quest for power and control, lying and manipulating others to view or conform to the addict’s ideas or ways. The suffering a person with addiction

endures leads to a search of happiness, turning to and abusing substances at first appears to be answer. Looking for an answer outside of oneself in substances such as alcohol and drugs leads to feeling more invalid or spiritual emptiness. If a person in addiction realizes that abusing drugs and alcohol is not the solution to happiness, a realization or search for another solution can occur.

A spiritual awakening is the outcome of the search for another solution. A spiritual awakening is the change in behavior, attitude and thinking that there is a power greater than one self. I speak on spirituality from a firsthand experience of teaching spirituality in early recovery to clients. A personal story from *Refuge Recovery* (Levine, 2014) a woman Lynne's story is told as to how she embarked in AA for her sobriety. In her fourth year of sobriety Lynne went to a workshop where she was introduced to meditation. Lynne began a meditation practice, stating she felt a shift in a connection she had not felt before. Lynne had heard members in AA speak of a Higher Power but it did not resonate with her. In AA Step 11 is meditation, however it is connected to the Prayer of St. Francis. Lynne did not feel comfortable with that form of meditation. Finding mindfulness meditation was what helped her find connection. Lynne began attending meditation retreats at centers such as Spirit Rock Meditation Center in California. Meditation was the catalyst for Lynne of finding a connection greater than herself. Even though she has spent 4 years active in the AA program.

When an individual can set aside any prejudices against religion and open to the possibility of a spiritual connection outside of religion can be the shift needed for a spiritual awakening. The three participants and Lynne's story all contribute spirituality as a part of the success in sustained sobriety. Spirituality allowed the women to except life on life's terms and to stop trying to control life, they got out of the way and let a power greater than themselves

intervene. Meditation was the space needed to accomplish the connection to spirituality for the participants and Lynne.

The research done for this thesis does not come without limitations. There were limitations in the research. The sample size is small, and the interviews were from the perspective of the participant. Due to these limitation, there is encouragement for more research with a larger sample size to be conducted.

Conclusion

During the research for this paper the book *The Craving Mind*, Judson Brewer (2017) was published. Brewer (2017) wrote how he believes mindfulness aids a person with addiction is successful due to Brewer's teaching a person to become aware of his or her craving, habit mind. In the literature research reviewed in this paper, mindfulness has been looked at as a part of addiction treatment for stress and awareness of habits. The research of mindfulness and addiction is not showing what my human participant interviews found. Mindfulness brought about the development of compassion and non-judgment for one self and others. In the interviews for this research, as well as individual stories from resources of utilizing mindfulness in recovery, there was no mention of contributing the awareness of the habits or cravings as to why they have been able to have sustained sobriety.

In my experience as an addiction counselor there has been a missing piece in the treatment process. The addiction treatment process emphasis is on the physiological aspects of addiction. Minimal mental health counseling is given in treatment, while after care counseling is left up to the individual to seek. The missing piece is the processing of the day to day rise and fall of emotions in an individual and how to cope with his or her emotions. I witness clients relapse and return to treatment, the common theme with returning clients is a person not knowing

how to cope in daily life with the emotions that he or she has been numbing with substances once sober. An example of this is participant Kelly, who abused alcohol and prescriptions pills to suppress her mental health issues.

Through my research, it is apparent that mindfulness is emerging into therapeutic modalities in addiction treatment (Schuman-Olivier, 2014). However, the approach of how mindfulness should be administered is mainly focused on healing the physiological aspect of addiction by using science based methods (Bowen et al., 2009; Brewer et al., 2014; Garland, et al., 2014). My analysis of interviewed participants who have had sustained sobriety utilizing mindfulness show the success in sobriety is due to the emotional strength a person gains from the practice of mindfulness. There is room for mindfulness in addiction treatment. The three categories reviewed in the literature review are all gateways for individuals in treatment to learn mindfulness. Much like the current addiction treatment modalities, not one mindfulness addiction treatment application is better to administer than another. What is important is finding the application which resonates best for a person giving he or she the introduction to utilize mindfulness in sustained sobriety.

Research on mindfulness in addiction treatment is appearing in addiction peer journals and research is giving hope that mindfulness has a positive impact in addiction treatment. Mindfulness is still not an accepted modality to be formalized for implementation in a treatment process curriculum. I implement mindfulness in my work as an addiction counselor. A process that is encouraged by my employers and appreciated by clients. I teach mindfulness, as well as expose clients to meditation daily in the treatment process. There is still a long road and a lot of obstacles to overcome for mindfulness to become a requirement in addiction treatment curriculum. Insurance companies and accreditation companies who have not approved the

implementation requirement of mindfulness as a modality needs to get on board. Through my efforts and efforts of my peers, who have conducted mindfulness and addiction research, mindfulness can be a part of the addiction treatment process for everyone. One day, mindfulness the missing piece of addiction treatment will no longer be the missing piece.

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Appendix A

SEMI-STRUCTURED INTERVIEW GUIDE

1. Please explain your addiction treatment history
2. How long has your longest sobriety been?
3. Tell me your experience with using mindfulness with addiction treatment?
4. Did you meditate before embarking on a treatment process utilizing mindfulness and meditation?
5. Could you explain to me your thoughts around using mindfulness for your sobriety verses other processes you have used in the past?
6. Are there any differences between previous addiction treatment processes and the mindfulness process?
7. Have you utilized more than one addiction treatment process (a 12 step and mindfulness, cbt and mindfulness)?