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MINDFULNESS: COPING WITHOUT A SUBSTANCE

Mindfulness: Coping Without a Substance

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May 2020

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MINDFULNESS: COPING WITHOUT A SUBSTANCE

Abstract

This qualitative study explored the effects of mindfulness on individuals recovering from the use of mood-altering substances. Participants were voluntarily recruited from a recovery-themed meditation group at a mindfulness center. The participants responded to interview questions related to how mindfulness has impacted their recovery and experience of stress. Themes related to how mindfulness fostered cognitive and emotional changes, that helped participants cope with emotional distress without using mood altering substances were included in the responses. The results of this study indicate that mindfulness mitigates emotional distress among clients who struggle with using mood-altering substances. Given that emotional distress qualifies as the main cause of relapse for those who struggle with drug use, incorporating mindfulness into the recovery process should receive heightened consideration.

Keywords: mindfulness; mindfulness-based interventions; models of treating substance use; mood-altering substances; substance use disorders

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Mindfulness: Coping Without a Substance

Research on mindfulness and its utility in assisting individuals with substance use disorders has been gaining increased traction in the academic community. Early data indicate that mindfulness mitigates reliance on mood-altering substances for those in recovery. However, studies on the effects of mindfulness on substance use disorders are still in their preliminary stages, and as such no definite conclusions are currently available. This present qualitative study sought to explore relevant data on the topics of mindfulness and addiction. Specifically, since addiction's impact on the US contributes to societal problems, examining mindfulness effect on treating substance use disorders seem like a plausible option. The resulting evidence indicates that mindfulness assists clients who struggle with substance use disorders to develop their ability to cope with stress effectively, thereby mitigating the likelihood of relapse.

Substance use in the US continues to persist despite its substantial, detrimental impact on society. From 1999 to 2017, for instance more than 700,000 people died from drug overdose in the US (Centers for Disease Control and Prevention CDC, 2019). Also, in 2017, more than 20 million Americans aged 12 and over met the criteria for a substance use disorder based on their annual consumption of alcohol or illicit substances. Over 14 million people had an alcohol use disorder, while 7 million people had an illicit substance use disorder (Substance Abuse and Mental Health Services Administration, 2018).

In 2017, over 30 million Americans aged 12 and older were currently using illicit drugs, i.e., they had used illegal substances in the past month, constituting, 11 percent of this population. Put differently, in 2017, one in nine individuals aged 12 and older in the US had used illicit drugs in the previous month. More specifically, an estimated two million adolescents between the ages of 12 and 17 were current users of mood-altering substances in 2017,

comprising; eight percent of this age group (Substance Abuse and Mental Health Services Administration, 2018).

The financial burden caused by drug misuse continues to plague the criminal justice system. The total cost to federal, state, and local governments in the US for the prosecution, incarceration, and probation of chemically dependent adult and juvenile offenders in 2005 was 74 billion dollars (Center on Addiction and Substance Abuse, 2010). In addition, 85 percent of incarcerated individuals meet the clinical criteria for a substance use disorder or were abusing illicit substances at the time of their arrest (Center on Addiction and Substance Abuse, 2010).

The need for substance abuse treatment in the US remains high. In 2017, 20 million people aged 12 or older, required substance abuse treatment (i.e., 1 in 13 people). This figure increases for young adults between the ages of 18 and 25, with one in seven needing treatment. In the same year, 18 million people aged 12 and over who needed treatment did not participate in a treatment program that year. However, one million did acknowledge having a substance use problem. For those who were aware that they needed treatment, two out of five did not admit themselves to a specialty facility due to lack of interest in discontinuing substance use at that time (Substance Abuse and Mental Health Services Administration, 2018).

There are a considerable number of treatment programs available for chemically dependent clients. However, the successful completion of such programs by clients remains an area of concern. In 2005, the graduation rate of clients in publicly funded programs was 44 percent across treatment modalities, and 36 percent for those serviced by outpatient providers, the most common form of service delivery in the US (SAMHSA Treatment Episode Data Set 2005, 2008). A study conducted by Laudet et al. (2009) documented participants in two publicly funded, state-licensed, intensive outpatient treatment programs in New York City between

September 2003 and December 2004. Participants were members of underserved minorities and were recruited in inner-city neighborhoods. Laudet et al. stated that 60 percent of the clients left the program before completion, with two-thirds of the clients claiming that nothing could have been done by the program to prevent them from disengaging in treatment services.

For those clients who do complete their treatment programs, rates of relapse are substantially high. The current empirical evidence shows that relapse rates following the completion of traditional treatment programs are more than 60 percent (Bowen et al., 2009, United Nations Office of Drugs and Crime, 2007).

Models of Treating Substance Use

Due to the persistent challenges posed by substance use disorders throughout societies worldwide, it is essential to evaluate the theoretical models used to guide the treatment of individuals with such disorders.

The moral model is generally among the older treatment modalities, originating from religion. This model espouses the belief that those who struggle with addiction lack character and are weak. Advocates of the moral model reject any genetic basis for addiction. The lack of empathy inherent to this model is derived from the belief that if those who struggled with substance abuse displayed exceptional moral fortitude or had not lacked conviction from the outset, they would not have engaged in addictive behavior. This model seems to correspond to how illegal drugs are viewed in society, possibly due to political reasons but it does not have any therapeutic value. However, the notion of individual choice within the moral model remains a vital concept within other treatment modalities.

The temperance model developed in the mid-1840s was inspired by the writings of Dr. Benjamin Rush, an eighteenth-century physician (Levine, 1978). The model contends that

consuming alcohol moderately is not a reliable option. According to the model, total abstinence is the only way to overcome or prevent addiction. The core component of the philosophy upon which temperance model was built is that drugs, not people, are the problem. Further, this philosophical position argues that drugs are too powerful for any individual to control for an extended period of time. The ultimate result of the temperance model was the establishment of the prohibition movement, which sought to enact institutional and political solutions to substance misuse.

The disease model states that substance use is a chronic relapsing brain disease, one which develops due to a genetic predisposition or through excessive use (Russell et al., 2011). Initially, drug use occurs on a voluntary basis. Over time, however, continued substance use changes the neural pathways and processes of the brain. This leads to a gradual loss of behavioral control such that further use of mood-altering substances becomes an obsessive habitual response, not a choice (Ochoa, 1994). Therefore, convincing individuals with substance use disorders to receive treatment by medical personnel gives them the best opportunity to mitigate, if not eliminate their addiction (Russell et al., 2011). There exists substantial empirical evidence to challenge the notion that addiction is purely a genetic disorder and cannot be cured (Miller, 1993), with most treatment modalities acknowledging that addictions are maladaptive behaviors with some elements of cognitive or physical disease or dysfunction.

The spiritual model has had a significant impact on the US, mostly to 12 step programs such as Alcoholics Anonymous (AA), Cocaine Anonymous (CA), Narcotics Anonymous (NA), and Al-Anon (Substance Abuse and Mental Health Services Administration, 1999). This model is occasionally interpreted as a moral or medical model, yet there are specific differences between them (Miller & Kurtz, 1994). In the initial writings of AA, “defects of character” are

viewed as essential to comprehending alcoholism, with a definitive focus on concerns like pride versus humility and bitterness versus acceptance. From this viewpoint, using substances is thought to be a means of compensating for a lack of spirituality and for feelings of insignificance (Substance Abuse and Mental Health Services Administration, 1999).

In the spiritual model, understanding what causes addiction is deemed less important than following a spiritual path to recovery. Twelve-step programs greatly emphasize the acceptance of “higher power” (often viewed as God in AA), requesting change in one’s character, the maintenance of a relationship with a higher power through prayer and meditation, and the surrendering of one’s life to the will of that higher power. A 12 step fellowship is not entirely a self-help program since it relies, however slightly on help from a higher power. The first of the 12 steps is to acknowledge that one does not have the ability to recover on one’s own accord. Therefore, the way to develop a healthy lifestyle is to open oneself to the spiritual realm and thereby submit to the will of a higher power (Substance Abuse and Mental Health Services Administration, 1999). Counselors and therapists follow numerous protocols to assist clients in joining and participating in in 12 step groups (Tonigan et al., 1999).

Twelve-step fellowships originated in American Protestantism, but a variety of other spiritual models have no connection to Christianity or other organized religions. For example, transcendental meditation, which comes from Eastern spiritual beliefs, has been employed within some sectors of the general public as an approach for preventing or discontinuing the use of mood-altering substances (Marlatt & Kristeller, 1999). Another example is Native American spirituality, which established connections with treatment programs that serve Native American populations. These programs employ practices such as sweat lodges as well as other traditional rituals, such as singing and healing services. All such spiritual models seem to share the

understanding of individual limits and the need to attain stability through a relation with that which transcends the self (Substance Abuse and Mental Health Services Administration, 1999).

The psychological model states that substance use disorders represent a maladaptive mechanism for coping with emotional dysfunction, cognitive deficits, or psychopathologies, which could otherwise be treated through behavioral or psychoanalytical therapies. Sigmund Freud's work continues to have a substantial effect on treatments for substance use disorders. Freud was the first to develop the concepts of "defense mechanisms" (e.g., denial, projection, rationalization), to identify the importance of early childhood experiences on behavior, and to advance the idea of the "unconscious mind" (Substance Abuse and Mental Health Services Administration, 1999). An initial thought among early psychoanalysts was that substance use disorders were manifestations of unconscious suicidal ideations and self-sabotaging tendencies, all of which originate in the id (Thombs, 1994). Another theory by some psychoanalysts focused on the belief that oral fixation was a significant contributor to substance misuse. A modern psychoanalytic viewpoint is that substance misuse is the result of inefficient ego functioning (a part of the personality that balances the demands of the id with the realities of the external world). A different perspective regards substance use disorders as "both developmental and adaptive" (Khantzian et al., 1990).

The contemporary concept states that drug use begins as a means to counterbalance deficiencies in ego functioning. In this respect, mood-altering substances constitute a type of self-medication aimed at balancing internal stimuli with external conduct. The psychoanalytic process presumes that the understanding gained through participating in therapy leads to increased capacity to control internal agency, which manifests in behavioral change (Substance Abuse and Mental Health Services Administration, 1999).

Behavioral psychologists view substance misuse as a behavior learned and perpetuated based on the intensity, number, and quality of reinforcements that occur after each use experience. Concepts about the compulsive use of drugs (addiction) stem from the idea that individuals tend to repeat behaviors if such behaviors reinforces their enjoyment of an activity. Positive reinforcements for the use of mood-altering substances depend on the drug consumed, but most have a significant effect on the central nervous system. Social factors, like approval from a network of friends, can also serve as positive reinforcement to use. Types of negative reinforcements include lower levels of anxiety and the nullification of withdrawal symptoms. An individual's presumptions and experiences with regard to the effects of specific mood-altering substances on certain feelings or circumstances ultimately determine drug-using behavior. Change happens if the reinforcements are offset or substituted by harmful repercussions, as well as when a client learns to use coping skills to avoid relapse (Substance Abuse and Mental Health Services Administration, 1999).

Cognitive-behavioral psychologists focus on how thought influences drug use. Bandura's idea of "self-efficacy" (an individual's perception of their ability to change or control their behavior) has had a substantial impact on modern understandings of how to treat addiction (Bandura, 1997). Cognitive therapists have developed treatment techniques that can transform the pathological thoughts, believed to contribute to the use of mood-altering substances (Ellis & Velten, 1992).

The sociocultural model of drug misuse concentrates on the effect of social networks, as well as normative cultural factors, on the development or mitigation of substance use disorders. According to the model, the following elements contribute to alcohol or drug-use: socioeconomic status, cultural and ethnic beliefs, supply and demand for substances, laws and

penalties concerning drug use, the normal behaviors, rules, and beliefs of families, friends and other social groups, models of healthy behaviors, and the inclusion or exclusion of reinforcers. Taken together, all of these elements imply that substance use disorders occur within and as a consequence of complex mixtures of relationships with families, peer groups, and communities; changes in legal statutes, policies, and standards are part of the change process. Establishing alternative peer and family networks, developing the ability to set appropriate social boundaries and coping skills, and cultivating the self-efficacy needed to work within one's cultural connections in an appropriate manner are critical for individuals to achieve transformation in the sociocultural model (Institute of Medicine, 1990). From the sociocultural point of view, some of the other models exclude the possibility of helping clients to reconnect to personal values, which can reinforce positive behavioral change. Another area that other models do not sufficiently explore, is the spiritual realm; the opportunity to grow in this area could help mitigate the guilt, embarrassment, regret, and depression some clients feel as a result of using mood-altering substances as well as the consequences of their substance use for both themselves and those they may have hurt in the process.

The biopsychosocial-spiritual model attempts to include vital elements from other models, and empirical evidence has demonstrated the utility of this approach. Therefore, its an effort for the treatment discipline to develop one modality to meet clients' needs (Wallace, 1990). Many medical disciplines appear to agree that the outcomes of chronic diseases, cancer, diabetes, heart disease and other conditions are benefited by a collaborative and comprehensive approach. The most ideal method would be one that addresses both biopsychosocial and spiritual aspects (Borysenko & Borysenko, 1995). This model for treating drug misuse would also exclude elements from other models that have been shown to be false or unhelpful.

Alcoholics Anonymous (AA)

Alcoholics Anonymous is an international community-based network established to help individuals who have lost control of their alcohol use to obtain sobriety with the assistance of their peers by attending regular meetings and discussing the emotional trauma of addiction. AA provides men and women with a safe space to meet together and disclose personal experiences, struggles to recover from addiction, and efforts to maintain abstinence. The core belief of AA is that alcoholism is a disease that one can contain but not control (Alcoholics Anonymous, 2001).

Bill Wilson and his physician, Bob Smith established AA in 1935, with two more groups emerging by 1939. During that same year, Wilson published the book, *Alcoholics Anonymous*, which detailed the doctrine and techniques of AA. The most well known of these techniques are the 12 steps; a series of actions one must take to achieve and maintain abstinence (Alcoholics Anonymous, 2001). The 12-steps have been adopted by other self-help groups, such as Narcotics Anonymous (NA) and Overeaters Anonymous (OA), to provide coping mechanisms for recovering from addiction. Although, the original 12 steps were replete with Christian language, many groups have revised the language to accommodate secular and/or agnostic principles.

There are no restrictions that would prevent someone from joining AA; that said, potential and current members must aspire to discontinue using alcohol. AA is not affiliated with any institutions, organizations, political groups, or religious sects. Individuals who join AA either do so voluntarily, as an adjunctive to therapy or as mandated by the judicial system.

Harm Reduction

The statistics detailing the difficulty of retaining clients in treatment until completion and reducing the risk of relapse after discontinuing treatment may signify a need to shift strategies on a philosophical level. According to Bayless (2014), the human immunodeficiency virus (HIV) pandemic, in the early 1980s, spread quickly from the homosexual community to the heterosexual population through the sharing of needles and syringes during intravenous drug use. The contraction of HIV, which leads to the acquired immunodeficiency syndrome (AIDS), subsequently spread throughout the world. Lee et al. (2011) stated that the outbreak of the disease increased the understanding required to properly address the needs of individuals suffering from the illness, and highlighted the necessity of developing an alternative strategy for the treatment of drug use. The term attached to this approach was “harm reduction.” Harm reduction involves attempts to mitigate the detrimental consequences of addictive behavior (Logan & Marlatt, 2010). To decrease the spread of blood-borne pathogens connected to HIV and other illnesses, such as hepatitis, harm reduction advocates promoted the idea of a needle exchange program that would supply substance users with new needles, educate them on the safe use and sites for injection of needles, warn them of the risks of sharing needles, and allowed them to inject mood-altering substances in the presence of medical personnel (Logan & Marlatt, 2010).

Lee et al. (2011) stated that harm reduction serves as an alternative modality to the moral and disease model of substance abuse treatment. Its primary focus revolves around meeting clients “where they are at,” and developing goals in collaboration with the client as opposed to dictating goals to them. Although they respect the objective of abstinence, advocates for harm reduction understand that this goal may not be suitable for every client, and that the insistence on

abstaining from all mood-altering substances as the only form of success may impede some individuals from seeking assistance or remaining in treatment programs.

By mitigating the destructive effects of substance misuse, the general population experiences a reduction in the need for medical services connected to overdoses, decreased arrests and court costs, and higher employment, which in turn leads to greater taxpayer contributions (Larimer et al., 2009).

Despite their successes, many harm reduction-based programs face difficulties regarding goal statements or verifications of the actual benefits of their chosen interventions. Opponents of harm reduction state that the approach enables clients to continue using mood-altering substances, which may eventually lead to death. The implication here is that harm reduction advocates essentially “give up” on clients (Lee et al., 2011). However, when treating a client who refuses to discontinue using mood-altering substances, an abstinence-only program would ultimately lead to failure. Advocates against mitigating the use of mood-altering substances, without including abstinence, believe that the harm reduction approach misleads the client into believing that their addiction is not a severe problem, which can have fatal consequences (Dimeff et al., 1999).

Mindfulness

Identifying as many different modalities as possible for addressing difficulties in retaining clients as well as for preventing high rates of relapse is a logical step for clinicians in the substance abuse field. One such approach that is gaining more acceptance within the field is mindfulness. Mindfulness refers to a consistent nonjudgmental awareness of one’s ongoing internal contents and processes (physical sensations, perceptions, affective states, thoughts, and imagery) (Kabat-Zinn, 2005). Mindfulness is traditionally cultivated through formal training in

mindfulness meditation, and with the resultant stable, nonreactive awareness appearing to act as a resource for more creative responses by bringing mental processes into higher conscious awareness and under greater voluntary control (Shapiro & Walsh, 2002).

Jon Kabat-Zinn first utilized mindfulness as a means to treat clients suffering from chronic pain. The intervention was called mindfulness-based stress reduction (MBSR). The MBSR program lasts for eight weeks, including weekly 2.5 hour sessions, a one-day retreat, daily homework, and the request to mindfully attend to present moment experiences one or more times daily to apply one's practice to everyday life (Kabat-Zinn, 1990). The program consists of three different methods: body scan, sitting meditation, and Hatha Yoga practice; these methods are thought, to assist practitioners in establishing a state of nonreactive awareness of sensations, feelings and thoughts on a moment to moment basis and to identify the constant flow of distractions that incessantly permeate the mind (Chiesa & Serretti, 2014).

Due to research data that have validated the effectiveness of MBSR in reducing pain, mindfulness-based cognitive therapy (MBCT) was subsequently developed in the psychiatric discipline to mitigate depression and prevent relapse (Ketterer, 2019). MBCT consists of a standard eight-week skills-training group intervention (Segal et al., 2002) based on theoretical methodology processing theories (Teasdale et al., 1995) and combining aspects of cognitive-behavioral therapy for major depression (Beck et al., 1979) with elements of MBSR (Kabat-Zinn, 1990). In a similar fashion to MBSR, MBCT interventions include sitting meditation, body scans, and, to a lesser extent than MBSR, yoga exercises. Mindfulness practice is designed to teach clients decentering, or the ability to create distance from one's cognitive contents (Chiesa & Serretti, 2014).

Mindfulness-based relapse prevention (MBRP) (Witkiewitz et al., 2005) connects Marlatt's cognitive-behavioral relapse prevention program (Marlatt & Gordon, 1985) with mindfulness practice, employing methods similar to those of MBCT (Segal et al., 2002). The mindfulness practice intervention's overall goals are to elevate discriminative awareness and acceptance, with a primary focus on emotions and physical discomfort.

Moment by Moment in Women's Recovery: A Mindfulness-Based Approach to Relapse Prevention (MBRP-W), is the first adaptation of MBSR specifically for culturally diverse, low-income women with complex histories of chemical use and trauma exposure who recently gained admittance to a substance use disorder treatment program (Amaro et al., 2014).

According to Amaro et al. (2014), an initial MBSR intervention received an overwhelmingly negative response from the majority African American and Latina women served by the participating chemical dependency treatment program, even though the facilitators of the groups were experienced and well trained. The feedback received led to an understanding of what aspects of the MBSR program needed further adjustments to foster greater inclusiveness. Alongside these adjustments, as well as assistance from fellow researchers at the University of Massachusetts Center for Mindfulness, the focus of MBRP-W was attuned to relapse prevention and assistance to women in an effort to enhance comprehension about how stress can lead to cravings and relapse. The adjustments also reinforced the ways in which mindfulness could help women cope with stress in a healthier manner. The language of the MBSR manual was simplified to accommodate literacy levels and some of the initial exercises were shortened to promote a sense of success upon completion. More time was allowed for group discussions so that participants could better process the mindfulness practice and understand the connections between the experience and the onset of relapse triggers and cravings. MBRP-W also included a

substance abuse counselor to co-facilitate the group and to address participants' questions that were strictly associated with addiction.

Mindfulness-based Intervention Studies

Research has shown that mindfulness-based interventions (MBI's) may decrease pain symptoms; increase pleasure-seeking thoughts; reduce stress, depression, and anxiety; and mitigate cravings. The brain processes implicated in mindfulness therapy and its effects include activation of the higher orbitofrontal cortex (OFC), deactivation of the thalamus, activation of the anterior cingulate cortex (ACC), and increased size of the prefrontal cortex (PFC). OFC activation is associated with decrease sensations of pain and the ability to contextualize what is perceived in the environment. The thalamus is the portal between the spinal cord and the brain and is also associated with decreased pain sensations. The ACC maintains control over thoughts and emotions. The OFC and AFC contain a significant number of opioid receptors. The PFC region manages the executive functioning of the brain, such as organizing, reasoning, imaging, and higher level cognition, and is associated with the capacity to connect with people, form authentic relationships and show empathy (Zeidan & Vago, 2016, Zeidan et al., 2011).

Brewer et al. (2009) conducted a small-scale study for individuals who met the DSM-IV criteria for alcohol or cocaine abuse or dependence in the past year. Participants were randomly selected to either attend mindfulness training (MT) or cognitive behavioral therapy (CBT) at an outpatient treatment facility. The participants were monitored for alcohol and drug use weekly. After treatment, participants' responses to personalized stress provocation were assessed. The MT group met weekly, for nine weeks, with one therapist who had extensive experience in mindfulness. Although the MT group derived inspiration from the MBRP manual, several adaptations were necessary to make it more relevant to the treatment process (e.g., the modules

were condensed to fit the time frame of group meetings and sessions were shortened to one hour). The CBT group met for 12 weeks using the National Institute Drug Abuse CBT manual.

According to Brewer et al. (2009), there were no differences in alcohol or cocaine use during the treatment period. However, there was a reduction in psychological and physiological symptoms of stress in the MT group compared to the CBT participants. This study demonstrates that mindfulness can serve as a sufficient treatment modality for individuals struggling with substance use disorders and can be advantageous for decreasing stress, which in many cases can trigger a relapse.

Bowen et al. (2009) directed a small-scale study of an aftercare program following a period of stabilization in which, patients were assessed after completing either inpatient or intensive outpatient treatment. The study analyzed the use of mood-altering substances up to four months after the postintervention assessment. The subjects arbitrarily attended either an eight-week closed MBRP group or treatment as usual (TAU) aftercare group, which consisted of the 12 step model and psychoeducational content. The outcomes for those who both stabilized and received MBRP demonstrated substantially lower rates of substance use and cravings and higher scores on the acting with awareness subscale of the Five-Factor Mindfulness Questionnaire (Baer et al., 2006) across the four-month follow-up period compared to those who received the stabilization in addition TAU aftercare.

In a similar report, Bowen et al. (2014) conducted a study of 286 participants who completed either intensive outpatient or inpatient treatment at a nonprofit chemical dependency treatment center. The participants were randomly assigned to either MBRP, cognitive-behavioral relapse prevention, or TAU based aftercare programs. The subjects were assessed at baseline and at three, six, and 12-month follow-up points. At the final follow up point (12-month), the MBRP

participants reported substantially lower rates of excessive alcohol use and fewer days of drug use than those assigned to the other groups.

Garland et al. (2014) performed a study with 115 opioid treated chronic pain patients of primary care, pain, or neurology clinics. The patients randomly assigned to either the mindfulness-oriented recovery enhancement (MORE) group or a support group (SG). The MORE group met once a week for eight weeks, which were two hours per session. The participants were also instructed to complete 15 minutes of daily journaling, daily guided meditations at home and mindful breathing before taking medication. The SG met for the same amount of time and frequency as the MORE group. The SG participants also needed to journal for 15 minutes a day. Measurements were taken before and after treatment, as well as at a three month follow up. The brief pain inventory evaluated changes in pain acuteness and interference. Changes in opioid use disorder were evaluated by the current opioid misuse measure. Cravings for opioids, stress, nonreactivity, reinterpretation of pain sensations, and reappraisal were also measured.

According to Garland et al. (2014), MORE participants reported substantially higher decreases in pain severity and interference than did the SG subjects; these results remained the same at the three month follow up and were moderated by increased nonreactivity and reinterpretation of pain sensations. When comparing the results of SG and MORE participants, it was shown that the MORE participants experienced considerably less stress arousal and cravings for opioids. They were also substantially more likely not to meet the clinical criteria for an opioid use disorder immediately after completing treatment. However, these characteristics were not maintained at the three month follow up.

An additional small study done by Bowen et al. (2017) introduced MBRP to participants at a methadone maintenance treatment (MMT) program. Although MMT is supported by over 50 years of statistical data demonstrating it to be the most effective modality for combating opioid dependency, few adjunctive methods are used to support behavioral change among MMT clients. Especially, behavioral interventions that assist clients when tapering off of methadone and attempting to maintain sobriety without the medication. The six-week MBRP course included participants who were willing to complete multiple questionnaires and who were judged to be stable by clinic staff. The participants received the surveys at baseline and post-course immediately after the final MBRP session. A substantial number of the participants reported improvements concerning depression, anxiety, craving, trauma symptoms, and experiential avoidance from baseline to the completion of the course. Reductions in depression, cravings, and trauma symptoms were statistically significant, and medium to large effect sizes were for depression and cravings; both of which are critical contributors to relapse.

Via an intriguing small-scale sample of adults diagnosed with stimulant use disorders and who were receiving contingency management, Glasner et al. (2017), contrasted MBRP participants with a health education control group. For those with depressive and anxiety disorders, MBRP correlated with a lower probability of stimulant use. Also, MBRP reduced negative affect and mental health impairment and was especially effective in mitigating stimulant use among adult users with mood and anxiety disorders.

Such overwhelming data support mindfulness as a means to help clients achieve better outcomes with respect to relapse prevention from mood-altering substances. However, much of the current empirical evidence has limitations. For instance, a number of the studies had relatively small sample sizes, which in turn limited the generalizability of the results to the

overall population. Additionally, participant diversity was generally limited, usually, comprising mostly Caucasian participants; as such it is clear that researchers should make a more concerted effort to include non-Caucasian subjects in studies. Another issue is the lack of uniformity when applying MBI's to treat clients with substance use disorders. Also, using MBI's on clients who had disorders for different mood-altering substances (alcohol, opioid, and stimulant). These limitations make it difficult to develop a specific profile for which MBI's would represent the best practice for a particular substance user. However, the fact that MBI's, regardless of which modifications are made to their delivery have been successful in mitigating substance use and cravings for a variety of substances, is a positive development.

The research data on the use of MBI to treat those with mood-altering substance use disorders are still preliminary. It seems that over the last decade, more studies on mindfulness as a means to treat substance misuse have been conducted. The need for more longitudinal and randomized trial studies is necessary to make more definitive conclusions regarding feasibility of MBIs to treat clients with substance use disorders. The goal of the present study is to contribute adding qualitative data that could reinforce the capacity of MBIs to assist clients who are struggling with substance use disorders to cope with stress effectively, since current data show that stress is a significant contributor to relapsing. With this additional information, researchers may come closer to validating MBIs as a viable option for those who are struggling with substance use disorders. The industry needs more alternatives to combat addictions' negative impact on society.

Primary Experience with Models of Treatment Use

As a licensed alcohol and drug counselor for 10 years, I have valuable knowledge about how models of treatment commence in real-world situations. This section describes my

experiences in the field as well as the results of models on clients from my perspective. Also, I provide a sample case that was typical for each discipline based on one of the clients I have met with throughout my career. None of the clients mentioned in this section participated in the study. The clients were given pseudonyms to protect their identity and privacy.

My training in substance abuse programs conforms to a counseling style called “motivational interviewing.” Motivational interviewing is a method where by a clinician assists the client in the change process and communicates mutual respect for their choices. The method is used to collaborate with clients who struggle with illicit substance use, not an additional style to combine with other therapeutic styles, a type of counseling that can help to mitigate ambivalence that distracts clients from attaining personal goals. Motivational interviewing follows Carl Rogers’ optimistic and humanistic philosophy about individuals’ ability to use free choice and to evolve through a process of self-realization (Substance Abuse and Mental Health Services Administration, 1999). The counseling relationship for both Rogerian and motivational interviewers is intended to represent an equal partnership. The position of the counselor is aimed at evoking self-efficacy and behavioral change in clients, as well as highlighting discrepancies in behavior in an effort to increase the likelihood of productive development (Substance Abuse and Mental Health Services Administration, 1999).

The first treatment program for which I worked was a methadone maintenance clinic. The purpose of MMT is to help those individuals who suffer from an opioid use disorder. MMT began in New York City during the 1960s under the leadership of Dr. Vincent Dole and Dr. Marie Nyswander. MMT is supported by over 50 years of data legitimizing its modality as the most effective treatment of opioid dependence. My experience working at an MMT clinic supports this finding. Clients did not abruptly leave the program as often as compared to my later

work experiences outside of the MMT clinic. However, there were other issues of concern with clients in this type of program, such as diverting take home medication (illegally selling their doses), overdoses typically caused by drug interactions with another chemical substance of the same depressant class (alcohol or benzodiazepine), and minimal changes in life besides discontinuing opiate use.

Once I had worked at the facility for a few years, I offered a meditation group for clients every week. This group was one of many offered at the clinic on a volunteer basis. I facilitated this group for three years, but attendance was consistently low. There were a couple of aspects of MMT that made meditation difficult for the clients. For instance, new clients must receive a stable dose of methadone, i.e., a level at which neither withdrawal nor euphoria occur. Therefore, new clients often had difficulty staying awake during the group sessions (this was common for other groups as well) or coping with excessive sweating (another side effect of methadone), which made them uncomfortable and therefore hindered their ability to learn a new technique.

Overall, my experience with MMT left me ambivalent about whether it served as an effective treatment modality. It did, however, present the opportunity to build long-term relationships with clients due to its status as a maintenance program. I worked with some clients for as long as four years, which allowed us to develop rapport, and I witnessed signs of progress. However, the culture that revolves around some of the MMT clients led to questions about whether the program helped them or enabled them. Ultimately, MMT seems to be grounded in the philosophical standpoint of harm reduction. The most essential aspect of treatment is derived from the idea of reducing harm. From that viewpoint, MMT did indeed effectively reduce dysfunction in the lives of many of the clients.

Sample case. Darryl was a single father in his early 40s. He had been on MMT for six years before I began working with him. Darryl was on a stable dose and had a month's worth (27 doses) of carry-out privileges. MMT clients are eligible for carry-outs based on their time in the program, negative urinalyses for every mood-altering substance besides methadone, and compliance with annual physicals. Due to Darryl having a severe medical diagnosis in the past, he relied on disability social security for his income.

Early in his life, Darryl had made the choice to engage in a high-risk lifestyle related to crime, drugs and gang activity. He never graduated from high school, nor did he get his GED. However, he reported coming from a stable nuclear family. Darryl admittedly made poor decisions to fit into a particular social network.

Darryl made a choice to move from the city of his birth to a new location. He initially moved to this city to enhance his lifestyle within the black-market economy. However, Darryl soon became addicted to heroin. He met the mother of his three daughters during this time, and she used heroin as well. Due to the birth of his first daughter, Darryl reported that he had attempted to transition from illegal activities to legitimate work at different jobs. Unfortunately, due to his consistent drug use, Darryl eventually lost each employment opportunity.

In his early 30's, Darryl was diagnosed with a life-threatening illness. After receiving treatment for the illness, he was admitted to the MMT program. Although, once he had transitioned to no longer using heroin, his significant other had not and eventually she left the family. Darryl was now responsible for raising three girls by himself.

For the vast majority of the time I worked with Darryl, he consistently complied with program expectations. Once a year, it seemed he would get depressed or spend time with a high-risk individual and then relapse. After each relapse, he would readily admit that it was a bad idea

and willingly accepted the consequences of his decision. This meant that he received a reduction in carry-out privileges for a month and would be required to submit at least two consecutive urinalyses, both of which would have to be negative for all mood substances besides methadone before his original take-home medication privileges were restored. Darryl was against attending groups like NA due to negative experiences in the past. He stated that many of the individuals in NA had a negative view of methadone, and that sitting in those meetings made him feel uncomfortable. Darryl did not like including any outsiders in his circle and he primarily reported only connecting with his immediate family.

Darryl was most proud of being a father and of the academic success of his two oldest girls. On more than one occasion, he would bring his daughters' high school report cards and show them to me as proof of their achievements. However, Darryl never made any improvements in his own life besides being a stable parent. He consistently found reasons why he could not get his GED. Due to his criminal record, he regularly stated that any job he applied for would deny him once the employer conducted a background check. At that point in time, it seemed Darryl was content with his progress.

My second place of employment was at an outpatient treatment clinic. This clinic offers a cultural and gender-specific treatment program. The clinic serves clients who have alcohol, cannabis, opioid, or stimulant use disorders. A substantial number of clients previously had some involvement in the criminal justice system. The rate of program completion among clients was moderately lower than that of participants in MMT. It was not unusual for a client to arrive at the group once or twice and never return. For those individuals who did stay in the program for an extended period of time, many struggled to abstain from mood-altering substances, even though most were being drug tested by both the Department of Corrections and the treatment facility. In

cases where clients, upon staff request, did complete outpatient treatment (usually four to six months; less than 20 percent of the clients make it to graduation), it was not uncommon to see them readmitted the next year.

I avoided introducing meditation to clients with substance use disorder at this facility. Due to inconsistent attendance on the part of many clients, I felt it was unwise to start a program for a technique that requires some measure of regularity. That said, I did consistently use mindfulness-based topics (attachments, letting go, impermanence) in the group. The clients seemed to have some interest in discussing these issues, suggesting that the related themes have some level of universal appeal.

Sample case. Ray was a single father in his 30s. He was initially admitted to the program the previous year after getting released on parole. He had gotten out of prison after seven years due to a severe criminal offense. Ray's first attempt at treatment did not go as planned, and he was discharged at staff request for being absent without leave (AWOL). Before going AWOL, Ray consistently struggled to abstain from cannabis use. Ray was diagnosed with a mild cannabis use disorder but was unable to adhere to program expectations, since he believed that his marijuana use was not a problem and was only involved in treatment in order to comply with the conditions of his parole. He regularly failed to comply with weekly urinalysis, probably because he was still using marijuana. He was also not interested in attending any outside support groups (AA, NA) for additional assistance. Ray was eventually violated and sent back to prison. He had been to two outpatient treatment facilities before his latest attempt and never graduated from the program.

In his recent treatment episode, Ray made significant progress. He took his urinalyses as requested and consistently tested negative for all mood-altering substances. Ray also reported

gaining part-time employment and sharing custody of his daughter. He stated that a family member also had custody since Child Protection Services had become involved when he was sentenced to jail for violating his parole. His significant other had a criminal background as well and did not seem to have substantial involvement in the care of their daughter. However, Ray reported having issues with his landlord due to alleged non-compliance with the expectations at his apartment complex. Ray eventually stated that he needed to find a different location to live since he had received an eviction notice from his landlord for unpaid rent.

During his time in treatment, Ray was able to advance and reduce the number of days he needed to attend the program. However, he was eventually discharged at staff request for financial reasons. Ray had moved out of his county, where he had received funding for treatment, due to his eviction notice. This caused him to lose his financial agreement, which forced the treatment center to deny care. Ray must now set up funding with his new county and get discharged again before completing the program.

The final experience which I will discuss revolves around my time counseling military personnel. The majority of time spent within this role requires me to conduct chemical health assessments on staff who either test positive for mood-altering substances on a urinalysis, get arrested for a DUI/DWI, or have an alcohol-related incident on duty. Over 80 percent of the service members who receive assessments do not meet the clinical criteria for a substance use disorder. Those who do meet these standards receive a referral to a treatment facility based on their medical insurance or if they are eligible for care through Veteran Affairs (VA).

Military personnel who do not meet the clinical criteria for a substance use disorder are required to attend an education class related to the prevention of alcohol and drug use. The

course includes information about the effects of chronic substance use on the body, coping skills to manage stress, and a brief introduction to mindfulness-related stress reduction techniques.

The program that produces this class for service members seeks to retain military members who comply with all recommendations of the assessment. Granted, depending on how many alcohol and drug incidents service members have had during their careers, retention within the military might not be an option. While I have worked in this program, a substantial number of military members were repeat offenders. However, the number of participants in the program versus the whole military population equals less than one percent, so the overall numbers are small.

Sample case. Tommy was a military member in his early 20s who had been referred for an assessment due to testing positive for cannabis on his urinalysis. He had been in the military for two years and did not report any problems with regard to his leadership. Tommy admitted to smoking marijuana regularly before joining the military but claimed that he's only used twice since completing boot camp. Tommy stated that he happened to get tested after recently using marijuana.

Tommy reported that he was raised by a single mother but, overall, he had a normal childhood. He stated that he worked full-time outside of his military career and was in the process of attempting to share legal custody of his daughter with his ex-girlfriend. He reports that this issue, along with his mother having a severe medical illness, triggered him to use marijuana to reduce his stress levels. Tommy alleged that his mother's health was deteriorating and that he had to perform many caretaking duties. He mentioned how challenging it was to see his mother in that condition.

Due to his reported infrequent use of alcohol and cannabis, Tommy did not meet the criteria for a substance use disorder. His requirement was to attend the drug education class and speak to the military's designated psychological coordinator. Tommy followed through and talked with the mental health professional. He reported that everything was fine and that he did not need any additional services. However, Tommy never followed through with attending the class as he had been directed. He also tested positive for cannabis again and, consequently, will be discharged from the military due to non-compliance with his commander's directives.

Methods

The primary goal of this qualitative study was to gather first-hand accounts from mindfulness practitioners in recovery on how the practice of meditation has enhanced their well-being. It was imperative to record their interpretations of the power of mindfulness from their own perspectives. Even though the sample size was small, there was some diversity concerning the experiences of the participants, warranting further research in this area.

Participants

Recruitment of participants for this study was voluntary and was offered to individuals attending a mindfulness recovery group through a meditation center in a midwestern city. The researcher spoke briefly to the group about the study before requesting volunteers. There were approximately 30 individuals in that meeting; 11 signed up to participate. Out of those 11 individuals, seven completely followed through to the interview process. These seven participants consisted of five males and two females, ranging in age from the mid 30s to early 70s. Six of the subjects were Caucasian, and one was of mixed-ethnicity. The length of abstinence from mood-altering substances varied in time from 70 days to 28 years. The median length of sobriety among the participants was eight years.

Five of the participants attended treatment at some point in their recovery process; two of them did not. One of the participants stated that she had attended outpatient treatment for a week but had left because she felt that the program was not an appropriate fit. She felt that most of her peers in the program were only there as a requirement from a court proceeding, and she did not feel safe enough to confide with those individuals. The participant was able to obtain recovery through mindfulness/12-step groups and AA. Another participant stated that he had completed outpatient treatment and never used illicit substances again. One participant said he had completed outpatient treatment but had consumed alcohol throughout the whole process. He admitted to attending treatment again after receiving his third DUI. This participant was sober for a year and a half before once again drinking alcohol on a regular basis. He subsequently attended treatment for a third time and has not consumed alcohol since completing that program. One of the participants attended inpatient treatment for 60 days but did not graduate. However, he was able to attain sobriety through AA. Another participant completed inpatient treatment. Once he completed treatment, he attended AA meetings. This participant also went on to join a variety of self-help groups throughout his recovery (12-step programs, Workaholics Anonymous (WA), Al-Anon, Co-dependence Anonymous (CA) and Sexaholics Anonymous (SA)).

The remaining two participants obtained sobriety without attending treatment. One participant had liver issues and knew he needed to discontinue his alcohol consumption. This participant had been sober for a year before beginning to drink again for a considerable amount of time. He stated that during that time, he had pancreatitis and was told by his doctor that he needed to abstain from alcohol. The participant stopped drinking again but eventually relapsed and returned to alcohol use. He stated that a friend of his was dying from substance use, and that this had triggered him to stop with the assistance of AA. The last participant stated that she

attended recovery meetings via a 12-step meditation group. She had also started attending an AA group as well to help achieve abstinence.

Interview Procedure

Once the individuals agreed to participate in the interviews, their email addresses and phone numbers were written down by the researcher. The researcher emailed each individual a consent form and asked for them to return it signed. After the forms were returned, the researcher scheduled phone interviews with each participant. At the beginning of each phone call, the researcher gave the participants more specific information regarding the purpose of the study. The participants were also notified at this time that they did not have to answer any question about which they felt uncomfortable, or that they could end their participation at any moment during the interview. Once the participants had verbally stated that they understood their options regarding their participation, the interview began.

Nine questions (see Appendix A) were asked of each participant to determine how mindfulness had assisted in their recovery. Specifically, they were asked about what aspects of mindfulness helped them to obtain sobriety, and in what ways these aspects were different from other recovery-based aspects (AA, NA, outpatient treatment, inpatient, etc). They were also asked whether mindfulness had any impact on their mental health diagnosis or overall stress. Considering that struggling to cope with stress for those with a substance use diagnosis plays a significant part in relapsing, the possible value of getting first-hand accounts how (or whether) mindfulness mitigates emotional distress could have significant implications for future treatment programs.

Data Analysis

The seven phone interviews were recorded and transcribed via a cell phone app. The researcher was the only one in the room when conducting the interviews. Participants were told that they could refuse to answer any question and could discontinue the interview at any time. The median length of the interview was 26 minutes, with the longest lasting for 45 minutes. Thereafter, content analysis was performed by reading the responses and labeling consistent themes. The themes came from the data, and the researcher conducted the analysis. The researcher was the only one to view the material; thus care was taken to reduce the possibility of personal bias impacting the results.

Results

Seven main themes emerged from the qualitative data analysis. These themes corresponded to common experiences that participants shared when applying mindfulness in their recovery process. The labels for the themes are as follows: helped to investigate emotional and mental habits, accepting the moment, calming effect, AA as a foundational component of recovery, concept of god problem, treatment as usual techniques and mindfulness vs medications. Direct quotes from the participants appear below in the appropriate subsection to demonstrate how mindfulness impacted their recovery journey. Participants' names were changed to pseudonyms to protect their identity and privacy.

Helped to Investigate Emotional and Mental Habits

A consistent point made by many of the participants was that the practice of meditation helped them to recognize habitual mental patterns. Through engaging in mindfulness practice,

these participants permitted themselves to explore all parts of their mind without significant aversion or harsh self-judgment. One participant, named Stan stated:

Mindfulness is about observing without preconceptions and doing that observation with compassion and then an intention to compassionately awaken and heal. In the mindfulness process, you are encouraged to be kind of like a scientist without a lot of dogma so that you can really trust. Also, learn to trust yourself and what is arising to become more empowered to really see what it is.

For many participants this new awareness led to the realization that their thoughts were transient. Instead of experiencing an impulse to react, many stated gaining a new understanding and appreciation for not making immediate decisions. Terry said, "I guess with mindfulness, it is the habit of stopping. It is the habit of being aware of thoughts and feelings, therefore understanding stuff that's going on in the back of my head, so I don't get into situations." Jill stated, "All these thoughts were really just in my head. So, I have used mindfulness to help me realize that it's just a thought. The beauty of tomorrow is it's a new day, and I'm not alone." Shawna stated, "I'm not reacting to those cravings or obsessive mindsets but kind of coming back to myself and reminding myself what it is that I'm wanting. I'm just aware that those feelings will pass and are not permanent."

Accepting the Moment

Mindfulness was also instrumental in introducing acceptance into many of the participants' lives. Ruminating about topics sometimes begins a cycle that leads to unhealthy choices. Acceptance seemed to allow participants a chance to relieve the pressure of pushing against what's occurring at the moment, to make a decision on which action was best in the next moment. Stan stated:

In the Dharma talks that I've received it is said that our goal is to have an open acceptance and allow mind and heart with what is arising. So, while we're trying, we're practicing cultivating equanimity itself, we're also cultivating equanimity for when we don't have equanimity. That permission and acceptance without judgment of the way things are, stops a feedback loop.

In a similar vein, Terry stated, "With mindfulness, there's an element of acceptance to learning to accept my thoughts, feelings, and emotions. Learning to accept things the way that they are so that I know if I have to change them."

An additional aspect of practicing acceptance led to the personal motivation of attempting to not emotionally attach oneself to a desired outcome, thereby, mitigating the experience of stress, which could in turn lead to dysfunctional behavior. Jill stated, "I got to let it be. I can't try to have control over it, which is really hard but the only person in the end that's going to get hurt is myself because I'm not practicing mindfulness." David stated, "Acceptance is a big thing. Actually, I prefer the phrase, let things be rather than let things go, because in order to let something go, you got to grab it first. I prefer to just say, let things be."

Calming Effect

When the participants were able to improve their ability to investigate their mind and gain acceptance of the moment, a noticeable change in their demeanor became apparent. This led to the ability to relax almost immediately after experiencing a stressful event, which in the past would have taken a substantial amount of time to accomplish. Peter stated:

For the most part, when I need to focus on a task and I'm stressed out over it because my timeframe is really, really tight. I am under a lot of stress until after that event, after my

timeline is past the stress just like melts away and I owe that, I think I owe it to mindfulness because that's the big component in my life that has changed.

Phil stated, "I tend to be an emotional person. If I'm starting to get upset, I take time to breath and clear my mind. I'm taking time, even if it's just a minute to clear my mind and then come back."

This new skill of calming also caused participants to stabilize relationships and make better life decisions. Consequently, they seemed to become more relatable in their social networks. Shawna stated:

I would say that my mind's been clearer. I've been able to tap in with my intuition and what I need, oppose to before I would be more reactive. The only way I would cope would be with drinking. Now instead, I might take a moment to breathe or go for a walk. My relationships have become richer and more meaningful. I've been able to connect with the people in my life and have additional purpose.

David stated, "Mindfulness helps me to achieve a calmness and serenity or equanimity, whatever you want to call it, that other spiritual practices didn't encompass."

AA as a Foundational Component of Recovery

Establishing recovery support with AA and other self-help groups was essential to each participant. Mindfulness seems to have contributed to the participants' recovery, but AA was the starting point that each participant had in common. It seems that belonging to a community of individuals who had similar experiences gave participants the safety and security to know they were not alone in their struggle. Also, there was hope for a better alternative to living. David stated:

Actually, my wife started ignoring it, which is what you're taught to do in Al-Alon, and I realized this is not good. There was no pressure against me to stop drinking, so, there was no pressure holding me up to keep drinking. And I just kind of fell flat on my face, I made a commitment not to drink over Christmas holiday, and I was unable to keep up with it, so I called a friend who is in AA and started going to meetings, did outpatient treatment, and have been sober and in recovery ever since.

AA also seemed to help participants stabilize their lives and give them structure. Once they had established stability, the space to explore other possibilities related to recovery became possible. Terry stated, "I went to an AA meeting. That was almost 10 years ago. That was my recovery path. I didn't do an official treatment program. AA was what really got me through the first couple years." Peter stated, "When I first sobered up this time around I didn't know anything other than traditional Alcoholics Anonymous. At first it was okay, then my belief structure and Alcoholics Anonymous came to blows." It stands to reason that without AA, the discoveries made at that time might not have been possible.

Concept of God Problem

While AA was an essential part of the recovery process for all the participants, it was not something that everyone continued to attend overtime. Particular aspects of the AA program became incompatible with how some individuals viewed the world. Specifically, the consistent focus on a higher power, or "God," was too difficult for a couple of participants to withstand.

Peter stated:

I am a very staunch atheist, and Alcoholics Anonymous higher power is how that works. I was really dissatisfied in traditional Alcoholics Anonymous. My former partner observed me come home from AA and she would see the change from week to week,

getting more and more sad about how I got to live my life this way. I got to deal with this crap every week, I'm going crazy. Then, I discovered mindfulness and, recovery, and my heart rejoiced.

David stated, "I've always struggled with the G word, with God. When I was studying Sufism or Hinduism or Christianity through Methodism, that was always holding me back but Buddhism and mindfulness meditation does not."

In a related source of contention, a couple of participants reported having some difficulty with AA's sometimes harsh self-judgments and strict guidelines. Despite this, these participants chose not to leave the program but rather to incorporate the mindfulness principle of compassion.

Stan stated:

The original Alcoholics Anonymous program personality type that the program was written for was a bunch of hardened people who needed to have their asses kicked in order to let go of their resistance. A lot of the people in other programs like myself, our problems are quite different. We're already hard enough on ourselves, so there isn't enough compassion. When you bring love and kindness to the 12-step program, which is a core part of the mindfulness meditation process, it's the other half that's missing.

Shawna stated, "Instead of doing what people think you're supposed to do, like go to treatment or meetings and saying all the things you're supposed to say by reading the big book. I feel mindfulness connects you to spirituality." Including mindfulness into the 12-step program seemed to give these participants an additional peace of mind, which was vital for them to continue to evolve on their recovery journey.

Treatment as Usual (TAU) Techniques

Treatment made an impact on the recovery of a few of the participants. However, the level of importance was on a continuum from insignificant to influential. There was no overwhelming insistence by these participants on insights obtained from treatment. AA and mindfulness were more effective in motivating long term behavioral change. Phil stated, “Treatment is more about drugs are terrible for you, it will ruin your life, so change your lifestyle, like get a new hobby. They teach techniques like making sure you get enough sleep and eating the right food.” Stan stated:

Sometimes I wish we had the ability to keep people in a residential treatment program for as long as a year or so. It takes a long time for the body and whole system to change.

You have to change your diet and have replacement activities. It takes such a long time to change and it costs so much to facilitate the process.

In regard to current treatment trends, one participant shared his belief that mindfulness is starting to appear in programs on a consistent basis. David stated, “I had a lot of exposure to how treatment has evolved over the last 20 or 25 years. Where, before there was zero mindfulness meditation involved in treatment. Now, it’s starting to become more common.”

Mindfulness vs. Medications

Mindfulness effects on the participants were overwhelmingly positive. The benefits for those participants who had a co-occurring disorder (mental health and substance use diagnoses) caused them to question whether they needed to continue taking their mental health medications. The outcome within this study was mixed, with two participants attempting to get off medications but then concluding that it was not the right decision. The other two participants seemed to have some success with discontinuing medications and maintaining stable mental health. However, it is vital to state that the two participants who had this success were only

taking medications briefly after their mental health diagnosis. Meanwhile, the two participants who returned to taking their medications had been taking them for a longer period of time before attempting to discontinue.

For the participants who did not maintain stability once they discontinued taking their medications, one was able to reduce his dose. Terry stated:

I have been diagnosed with generalized anxiety. I do take medication for it. I'm actually on an incredibly low dose of medication that I've taken for a number of years. So, I would say having a mindfulness practice has obviously lowered the need for the medication. I did try to go off of it a couple of years ago, going off of it completely was not the right answer, but I did drastically reduce the dose.

David reported having a similar experience, "I thought, mindfulness practice is going so well. I'm just going to slow down on these meds and wean myself off of them. Both times that didn't work out well. I had to go back on the meds." It seems that even though mindfulness was significantly beneficial for the participants, there was some importance in not viewing it as a panacea.

For the participants who stopped taking medications, it felt as if their condition got worse after beginning a regimen. Shawna stated:

It's pretty crazy because I was in state of anxiety and constant worry after my divorce and moving out on my own for the first time, and doctors prescribed Xanax and all these medications that I felt like was making it worse. So, I went off all of that and did meditation and therapy.

Similarly, the other participant stated that she felt like AA and support groups helped her cope with depression more effectively. Jill said, "I went to a doctor, and they diagnosed me with

depression. I had medication but I'm not doing that anymore. I have a counselor, but I feel my support group and AA are there for me in that way."

Discussion

The current study was relevant in that it confirmed data related to what makes a mindfulness practice valid for those who struggle with mental health and substance abuse. One participant specifically mentioned experiencing a stressful event, but mindfulness had helped him to develop the skill of distancing himself from the episode once it concluded. This seems very similar to the goal of MBCT for depression (Segal et al., 2002). The primary purpose of the treatment revolves around gaining awareness of depressive thinking, moods, and emotions that serve as a warning for a possible relapse into depression. Clients develop the ability to accept these events as moments in time, not as representing something permanent or portraying who they are as individuals. Mindfulness cultivates the ability to stop thought processes that might eventually lead to depressive symptoms. For instance, one participant indicated that, he had intense experiences at work but knew now that these episodes would not last indefinitely. Once the event ends, the stress dissipates.

In a similar manner, a number of participants articulated the ability to investigate internal stimuli without the need to make changes, but rather to simply observe. This observation led to them noticing the impermanence of their thoughts and recognizing the value of not responding reactively in these moments. One of the participants mentioned that acceptance stopped a feedback loop. This is a crucial point, because both the experience of negative mood states and the desire to circumvent them constitute a central motivation for substance use (Wikler, 1948). For individuals who have used illicit substances for a significant period of time, they may habitually respond to adverse emotional states with relapse-related thinking due to past

connections between experiencing cravings and then relapsing on mood-altering substances. As evidenced by the data in this study, once recognition of the impermanence of feelings and thoughts occurs, MBIs can be employed to subvert the connection between negative affect, cravings, and comfort through illicit substance use.

One intriguing issue that arose from the participants' responses was ambivalence toward the effectiveness of the treatment program for their recovery. A few of the participants mentioned how important treatment was in helping them to stabilize their lives. In contrast, others did not seem to place any significance on their participation in treatment. This illustrates a complex conundrum concerning substance abuse treatment and how it is valued by society. For example, criminal justice reform in the US has caused many states to rethink how they approach those addicted to mood-altering substances. There has been a shift away from incarcerating non-violent drug offenders to sending them to treatment programs instead. However, given how low substance abuse treatment retention is among clients, as confirmed by a couple of the participants in this study who did not complete the programming, this new direction may not yield the anticipated results. When coupled with the fact that at least 60 percent of participants relapse once they leave treatment, the consequences of this policy change in many states might eventually lead to a backlash.

The suggestions offered within this study revolve around adding mindfulness as an intervention in combination with other recovery-based themes (AA, treatment) to increase clients' recovery success. Schaef (2016) believed that the whole system needed to be reset due to her contention that society reinforces addictive behavior. In her ground-breaking book, *When society becomes an addict*, Schaef (2016) stated addictive behavior sometimes emerges out of society's need to enforce conformity among its citizens. If an individual chooses to live out their

truth completely, society may deny them inclusion. The nation needs addictions to persist so it can survive. Family relationships are addictive in so far as they distract from the reality of society's harmful requirements to earn acceptability.

Schaef (2016) gave an example of society's sickness by mentioning that addicts are known for being deceitful to protect their addiction. For instance, addicts will lie about their lives and everything else to attain their goal of continued use. Schaef (2016) mentioned that politicians regularly lie to obtain votes from their constituents. Car mechanics lie to unknowledgeable automobile owners to make more money. Religious leaders lie and behave in a manner that completely contradicts the doctrine which they profess to represent as a means to establish power. Thus, Schaef (2016) claimed that lying is an accepted part of the process.

The main culprit that Schaef (2016) implicated in driving society's behavior revolves around the illusion of control in addictive systems. Human beings desperately attempt to have control over their environment, which leads them to exaggerate their grasp of the unknown otherwise, they could not handle the uncertainty and discomfort of never having all the facts. The idea of having control supposedly represents a good thing: Fortune 500 company CEOs are recruited based on their ruthlessness and ability to make decisions without much compassion or consideration for their staff or competitors. Also, the CEO's capacity to make their staff work at the highest level possible earns them substantial financial rewards.

In AA, the term for always trying to exhibit control is "stinking thinking." Schaef (2016) suggested that stinking thinking is a normal function of society in general. She asserted that greed and self-centeredness, which permeate society, comes from a loss of spirituality within the culture and on an individual level. This in turn results from individuals succumbing to the process of the promise. The idea revolves around a society or company giving an individual what

they need, again with the point of exerting control. Schaefer (2016) provided an example of how some people will stay with their jobs only for the benefits. Even though they may know that staying with the company no longer meets their needs, they persist in their jobs due to the benefits they receive. Schaefer (2016) also mentioned that companies operating as a supposedly efficient version of a family retain specific individuals, primarily if they come from dysfunctional homes. Such companies operate under the concept of dualistic thinking, stay or go, good vs. evil, strong vs weak, as a means to feed the illusion of only having two options. Schaefer (2016) stated that existing with only those two options keeps most members in society feeling stuck, as they often do not want either option. Individuals struggle to explore the unspoken third option: what is right for me.

Support groups are essential to Schaefer (2016) as a means to allow individuals the space to explore how abnormal their lives have become and learn steps to implement effective changes. She believed that the non-supportive attitude of society is normal. Schaefer (2016) also made a vital point about how traditional therapists, counselors, and stress reduction programs only function as a means to help people cope with society. She contended that these disciplines coordinate services with the underlying theme of protecting the supplier (culture). Instead of demanding a change to the system, such disciplines assist people in getting through their lives.

Developing an alternative mind system serves as the logical next move. Schaefer (2016) stated that the addictive mind tries to make everything static, which cannot happen. Things are impermanent and constantly evolving. She suggested that our planet regularly changes or is in the process of changing. The communities in which we reside are frequently changing as well. Human beings affect this evolving set of circumstances, and in turn, the circumstances affect them. Schaefer (2016) stated that it does not matter what happens to an individual in life, the real

issue is what one learns from the process. She believed that how an individual processes their life affects everything. According to Schaefer (2016), all the spheres (individual, family, community, and planet) are all separate and yet, the same (the paradox). Behaving from an awareness of how society has affected everyone and encouraged compliance, all members will have to actively move toward an alternative mind system to effect change.

It is possible that attempting to completely shift the system is not achievable in a single lifetime. The more sensible choice would be for change on the individual level. A different viewpoint of why treatment, as usual, was so underwhelming with some of the participants might relate to the inefficiency in counseling relationships. Karpman's (1968) drama triangle addresses co-dependent relationships. It is also described as the rescue triangle, with one individual as the perpetrator, one as the victim, and the other as the rescuer. In a dysfunctional family or culture, individuals are regularly participants in those roles. The roles are not static, so in different situations, a person may go from the victim role to that of perpetrator or rescuer. Schaefer (2016) suggested this point, as well as why she believed counselors and therapists maintain co-dependent relationships with their clients.

When the victim role loses energy, the perpetrator and rescuer are both energized by the interaction, each acting on their own selfish needs. The rescuer gets to feel important for saving someone, and the victim has an individual taking care of them. In turn, this creates a cycle from which the rescuer traps the victim into a constant status of victimhood from which they need saving. The clients are consistently de-energized due to not having a healthy relationship with their therapist; whereas, the therapist is empowered, but such power is unsustainable and so they continue in the profession. Schaefer (2016) discontinued her meetings with clients for this very reason. This could explain why participants in this study did not stay engaged in treatment: They

did not want to live as victims. Also, with respect to high relapse rates, a contributing factor might be the subconscious need to maintain a relationship with the treatment program.

A final result of this study was that participants who also had mental health diagnoses attempted to discontinue taking their medications due to the benefits of mindfulness. Out of the four participants who mentioned ceasing their mental health prescriptions, two (David and Terry) admitted needing to restart their regimen. According to Van Dam et al. (2018), the news media's coverage of mindfulness tends to skew toward hyping it as an ultra-effective therapeutic technique that heals whatever negatively impacts human beings. This ignores some legitimate concerns related to a current lack of empirical evidence about mindfulness and its utility treating mental health disorders. However, these two participants in this study were not novice meditators and based their decision to suspend taking their medications on their own experiences. It is still valid to mention the current limitations of mindfulness and its impact on mental health.

According to Goyal et al. (2014):

Specifically, the efficacy of mindfulness was only moderate in reducing symptoms of anxiety, depression, and pain. Also, efficacy was low in reducing stress and improving quality of life. There was no effect or insufficient evidence for attention, positive mood, substance abuse, eating habits, sleep, and weight control. (p. 361)

This could explain Terry's response to decreasing his medication dose due to his meditation practice. Once he experienced the moderate effect of mindfulness on his generalized anxiety disorder, he assumed this would allow him to completely discontinue his use of medications. Fortunately, he was able to reassess and begin his regimen without any severe life consequences.

David's case seems to reinforce another misnomer related to mindfulness. David had mental health diagnoses of depression and generalized anxiety disorder. Goyal et al. (2014)

stated that mindfulness effects are erroneously promoted as proportionate to taking anti-depressant medication (ADMs). Preliminary data from studies comparing MBIs versus ADMs support MBIs for depression-related relapse in those with intermittent depression (Segal et al., 2010). However, there are significant differences in effectiveness between individuals. For some people, it could have substantial effects, while others may receive minimal to no benefit from MBI participation (Dobkin et al., 2011). It is important to exercise caution when interpreting data from clinical studies using MBIs as, many of these studies did not employ active control conditions. With the majority of the empirical evidence from clinical studies on mindfulness being insufficient due to lax scientific protocols, statistics from these studies should be viewed as merely conditional (Goyal et al., 2014). David's return to taking medication twice after ceasing should serve as a warning. MBIs are beneficial, but more clinical evidence needs to be gathered to verify for whom or if an individual coping with either depression or anxiety can replace medications with meditation.

Conclusion

Addiction will continue to plague society. The use of illicit substances in society spans all socioeconomic groups and affects everyone. Whether it is the cocaine epidemic of the 1980s or the opioid crisis of the early 2000s until the present, individuals continue to seek refuge from life via the use of mood-altering substances. Developing effective strategies to help members of society cope with life's difficulties without resorting to drug use would significantly reduce suffering for all constituents, either directly or indirectly.

Participants in this study seemed to confirm that MBIs serve as a crucial component of mitigating stress. Empirical evidence shows that emotional distress significantly increases the risk of relapse for those who struggle with substance use. Therefore, establishing a mindfulness

practice decreases the probability of relapse and further disturbance for those who are in recovery. With low retention rates for clients in treatment and the high likelihood of relapse for those who do complete treatment programs, finding additional interventions to assist in care seems logical.

Critics of MBI's rightly point out that mindfulness research remains in its infancy. There are too many studies related to mindfulness that did not incorporate active controls, which raises the question of how effective is mindfulness when only comparing to waiting lists? There is no way to know what is responsible for a change if greater scrutiny is not applied to clinical studies of mindfulness. However, the data in this study point to obvious benefits for those in recovery who employ meditation as a regular practice, detailing specifically how accepting the present moment and becoming an observer creates distance from emotions that, in the past, caused feedback loops that culminated in relapse.

Further research regarding mindfulness that specifically addresses the most effective dosage for those who struggle with substance abuse and mental health disorders remains crucial. Defining which mental health or substance use disorders benefit most from mindfulness will lend the practice more credibility and supports its implementation in clinical settings.

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Appendix A

SEMI-STRUCTURED INTERVIEW GUIDE

1. Please describe your treatment history as it relates to substance use?
2. What has been your longest period of abstinence?
3. How has your experience been with using mindfulness with addiction treatment?
4. Did you meditate before entering into 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. How has your ability to cope with stress been changed (or remained the same) by having a mindfulness practice?
8. If you have a dual diagnosis, have noticed any changes in your symptoms since beginning a mindfulness practice?
9. Have you utilized more than one addiction treatment process (a 12 step and mindfulness, cbt and mindfulness)?