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## *Meditation - The Less Traveled Road to Recovery*

*Social Work Today*

**By Dan Orzech**

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Arthur Margolin, PhD, has seen the devastation that HIV/AIDS has wreaked in New Haven, CT's inner-city neighborhoods—and he hopes that meditation can help ease the suffering. Margolin and his colleague Kelly Avants, PhD, researchers at Yale University School of Medicine, are developing a treatment program for hard-core substance abusers that uses meditation to help reduce the high-risk behaviors contributing to the spread of HIV.



Across the continent at the University of Washington, another researcher, Alan Marlatt, PhD, clinical psychologist, professor at the University of Washington, and head of its Addictive Behaviors Research Center, is also working with meditation and substance abuse. The two are part of a small but growing number of researchers who are looking at how meditation and spirituality might be useful in treating addictions.

Margolin's research, which is funded by a three-year National Institutes of Health (NIH) grant, focuses on severely addicted clients of a New Haven methadone clinic—a group at high risk of HIV transmission from unsafe sexual practices and the use of cocaine and other stimulants that increase impulsivity. "Those are behaviors that have been largely unaffected by interventions such as methadone maintenance," he says.

Margolin's approach involves teaching clients meditation as part of a program of individual therapy and is based in both Buddhist psychology and contemporary cognitive behavioral techniques. Called Spiritual Self-Schema, or 3-S Therapy ([www.3-s.us](http://www.3-s.us)), it aims to help clients protect themselves—and others—from harm by helping them learn to identify their addict self, or self-schema, and then replace that way of being in the world with a self-schema for abstinence and harm prevention—the spiritual self-schema.



### **A Habit Pattern of The Mind**

The addict self, patients are told, is "a habit pattern of the mind" that causes suffering but is not your real self. The real self, says Margolin, is "your spiritual nature, which is always there. It can't be taken away, but the addict self makes it difficult to experience it."

Margolin's patients are taught meditation, which is based on awareness of the breath, and are introduced to Vipassana, or Buddhist insight meditation. They begin with 10 minutes twice per day and gradually progress to 60-minute meditation sessions. The idea, says Margolin, is to increase mindfulness of thoughts and feelings, which can help to make previously automatic thought processes conscious, thus reducing their habitual nature.

Although the intervention is rooted in Buddhist psychology, there is no attempt to convert clients to Buddhism, says Margolin. In fact, he says, the Buddhist approach was chosen because it is spiritual but nontheistic. Clients are told that the approach will help them strengthen their own faith and find their own spiritual path. It will help them

develop the spiritual “muscles” that have atrophied due to chronic overuse of the addictive habit patterns.

The treatment approach at the University of Washington is also based on Vipassana meditation. Rather than meditating for a few minutes or one hour per day, however, clients sit in silent meditation for 12 to 14 hours per day for 10 days in a row. The intensive format is the same as that followed in meditation courses taught at a half-dozen retreat centers in North America under the guidance of Indian meditation teacher S.N. Goenka. As in those courses, the University of Washington program uses videotapes of Goenka teaching meditation and is staffed by volunteers from the local meditation community.

There is one difference, however: The courses, which Marlatt described last year in the journal *American Jails*, took place in a prison in Washington State. The meditators were severely addicted drug and alcohol users serving sentences for drug use.

Marlatt has finished analyzing the initial results from the two-year-long study that began in 2000. Compared with prisoners who received a standard course of treatment for addiction, the prisoners in the study were using significantly less tobacco and heroin three months after their release and had fewer peak drinking episodes and alcohol-related problems.

They also had fewer adverse drinking-related consequences and a greater sense of control over their drinking behavior, suggesting, says Marlatt, a more thoughtful attitude toward when, where, and how they were consuming alcoholic beverages. The meditators were also less depressed and scored significantly higher on measures of optimism, indicating that they were more hopeful about their future.

While promising, the data are still preliminary, says Marlatt, who is in the process of analyzing data on the patients' rates of relapse and rearrest. If the treatment continues to appear useful, Marlatt hopes to eventually extend it to community trials conducted with addicts not in prison. He recently submitted a grant proposal for a five-year study comparing the effectiveness of various combinations of intensive 10-day retreats, mindfulness-based relapse prevention—similar to that being used at Yale—and relapse prevention skills training without a mindfulness component. The study would include following the research subject's progress for at least two years.

Marlatt's preliminary results are encouraging, particularly since not all researchers looking at using meditation in substance abuse treatment are getting the same results.

At the Center for the Studies of Addiction at the University of Pennsylvania Medical School, for example, researchers recently ran a pilot study using Mindfulness-Based Stress Reduction (MBSR) to treat severely addicted adults. MBSR, developed nearly 25 years ago by Jon Kabat-Zinn at the University of Massachusetts Medical School, is an eight-week program of meditation and mindful yoga that is taught at more than 240 hospitals, clinics, and private therapy practices in the United States and other countries.

In the Penn study, which will be published in an upcoming issue of the *Journal of Substance Use*, severely addicted adults living in a recovery house were provided training in MBSR in addition to their standard addiction treatment.

Six months later, there were essentially no differences between them and a control group, according to Arthur Alterman, PhD, the study's principle investigator. Larry Ladden, PhD, the psychologist who taught the course, suspects that modifying the standard MBSR approach to focus more on mindful movement in the form of stretching or yoga might have improved the course's impact. “It was difficult for the residents to be physically still initially,” Ladden says.

Other addiction specialists are hoping that meditation might contribute more indirectly to recovery by helping addicts stay in treatment. At the Cenikor Foundation, a Houston-based drug abuse therapeutic community, residents are being taught MBSR in an attempt to cut the dropout rate, which is typically high in therapeutic communities.

Therapeutic communities—residential self-help programs for recovering addicts, typically run by recovered addicts—are tightly structured, highly restrictive environments. “It’s a very difficult program to go through,” says Marianne Marcus, EdD, RN, FAAN, professor of addiction nursing at the University of Texas and a member of the board at Cenikor. “We realized that the rigor of the environment could be one of the reasons we have such a high dropout rate and that stress management tools might help.”

After experiencing an MBSR course herself, Marcus decided to introduce the program at Cenikor. Two separate pilot studies failed to demonstrate any significant stress reduction—at least as measured by paper-and-pencil tests. However, when researchers looked at a physiological marker of stress—cortisol levels in residents’ saliva—they saw a significant drop. And the residents’ self-reports were encouraging. “I’ve learned [from MBSR] that I don’t have to respond to everything that happens here,” said one resident, according to Marcus.

Marcus suspects that stress reduction might be useful not only in reducing the dropout rate at Cenikor but also in helping addicts in recovery avoid returning to old addictive patterns. “There is data that stress is related to relapse,” she says. “When researchers have questioned people about why they thought they relapsed, what they say is that some stressor, perhaps having to do with work or relationships, has come up in their life. We all assume that relapse is triggered by craving, but it actually appears to be stress.”

While researchers explore various approaches, some clinicians are already beginning to use meditation techniques as an addition to conventional therapies such as cognitive-behavioral therapy. The Center for Motivation and Change, a private substance abuse treatment center in New York City, recently began offering a mindfulness meditation and yoga group to its patients. “Previous work has indicated that mindfulness techniques can assist in reducing impulsive behaviors in certain patient populations,” says Robin Nemeroff, PhD, the psychologist who leads the group. “We’ve attempted to adapt some of these techniques for substance abuse populations with the hope that they might increase patients’ ability to be aware of their cravings without feeling a need to act on them.”

### **Practicing What You Preach**

Like Marcus, many of the clinicians researching meditation began exploring the therapeutic benefits of mindfulness practices after discovering the benefits of meditation in their own lives. Marlatt began meditation in 1970 after a doctor suggested he try it for borderline hypertension. After discovering that he felt more relaxed and his blood pressure had dropped enough so he did not require medication to lower it, Marlatt and some of his graduate students began investigating the effectiveness of meditation as a preventive intervention for high-risk drinkers.

At Yale, Margolin and Avants also meditate regularly and recommend that therapists using the Yale 3-S therapy learn meditation themselves. Without knowing the skill, using meditation in therapy would be “like trying to teach piano without being able to play yourself,” says Margolin.

A daily meditation practice and at least two extended—five- to ten-day—silent meditation retreats are required for certification as an MBSR provider by the Center for Mindfulness in Medicine, Health Care and Society at the University of Massachusetts Medical School.

### **A New Attitude**

Changing attitudes toward meditation—and spirituality in general—are making it easier to do research on meditation and addiction, according to Marlatt. “When I first started in the addiction field 25 years ago, if you mentioned spirituality, people would have laughed at you,” he says.

Among government funding agencies, the new attitudes are being driven, at least in

part, from the top down. “The White House’s interest in faith-based programs is creating a more open environment,” Marlatt says. That has led to a willingness to fund new approaches to treatment.

The University of Washington project, for example, marks the first time the NIH’s National Institute on Alcohol Abuse and Alcoholism has funded research using Vipassana, despite the fact that it has become quite popular in the West in the past few decades, both through Goenka’s retreat centers and at places such as Insight Meditation Center, in Barre, MA, and Marin County, CA’s Spirit Rock Center.

Other researchers welcome the increased interest from funding agencies. The MBSR study at the University of Pennsylvania was funded by the Center for the Studies of Addiction itself, according to Alterman. Outside funding would have permitted a larger study population size, which might have led to different results, says Alterman, by enabling the researchers to see statistical trends not visible in a small sample.

Another factor contributing to changing attitudes is the rapidly growing and increasingly compelling body of published research on the physiological effects of meditation. This growing body of research demonstrates the effects of meditation in terms that western researchers and treatment providers are used to. Pioneering research published last year in the journal *Psychosomatic Medicine*, for example, demonstrated that an eight-week MBSR course can bring about changes not only in brain function, but also in immune system response. The research subjects, employees at a biotechnology company, were given a flu vaccination after taking the course and showed significant increases in antibody production compared with a control group. Most interestingly, the magnitude of the increases corresponded to changes in the level of activity in the anterior cortical area on the left side of the brain—an area that is associated with positive emotional expression.

#### **Addicts as Informed Consumers**

Spirituality, of course, is one of the foundations of Alcoholics Anonymous, Narcotics Anonymous, and other 12-step approaches to addictions. But those approaches don’t appeal to everyone, says Marlatt—and there are plenty of people who need treatment for addiction. More than 80% of the 26 million people in the United States who needed help for drug or alcohol problems in 2002 received no treatment at all, according to the National Institute of Drug Abuse.

Marlatt believes that making more approaches available will lead more people with drug and alcohol problems to try one. “People are looking for a range of options,” he says. “For some, the reason they’re not in treatment is not because they’re in denial. If you think of them as informed consumers, they haven’t really seen anything that appeals to them.”

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