Meditation: Increasing Peace in Recovery

Meditation is utilized by every culture on earth to relax the body, bring peace to the emotions, and expand spiritual knowledge. Modern health care is now integrating meditation into clinical practice as a method of stress reduction, pain management and improvement in the quality of life (Schaub, 1995a). Pioneering work on the benefits of meditative states has been done by Herbert Benson at Harvard Medical School (1972), Elmer Green at the Menninger Clinic (1977), and Jon Kabat-Zinn (1990) at the University of Massachusetts Medical Center. Two of Dr. Green's principal students, Steve Fahrion and Pat Norris at the Life-Sciences Institute of Mind-Body Health, have integrated meditation into the treatment of addiction in a large-scale project with the state of Kansas. By using meditation and visualization with brainwave biofeedback, Fahrion and Norris are teaching people in recovery how to self-regulate their physical state and how to enter into positive, peaceful mental states (1992).

The Practicality of Meditation

As addiction professionals, we face people everyday who are suffering. We do not have time for abstractions or obscure techniques. When we consider a concept or method, we need to ask the essential question: does it work? Meditation works.

The practicality of meditation has been supported by research since the 1970s. In a study of 1,862 persons, Benson and Wallace (1972) found that those who used prescription and illicit drugs began reducing their intake of drugs as they learned to

experience a deep state of relaxation. The investigators also looked closely at the degree of alcohol use in these same subjects. Most participants in this study, 61.1 percent, reported that meditation was "extremely important" in helping to reduce their alcohol consumption. Marlett and Marques (1977) found that college students who were heavy drinkers were able to reduce their alcohol use by 50 to 60 percent when they exercised and meditated regularly.

In general, the physical benefits of meditation are well documented (Leonard & Murphy, 1995). Positive changes include decreases in heart rate, blood pressure, blood lactate levels associated with anxiety, muscle tension, and insomnia. The gradual acceptance of meditation into health care has been based on the scientific ability to measure these physical changes. Such changes could be put under the broad category of stress reduction (see, for example, Kabat-Zinn, 1990.)

The potential of the meditative process goes much deeper: it offers a way to retrain the mind. Bill Wilson, one of the founders of the 12-Step Movement, referred to this aspect of recovery as the development of "a new consciousness" (Alcoholics Anonymous, 1984).

Since one definition of addiction is "a mental obsession and a physical compulsion" (Alcoholics Anonymous, 1976), the combined mental and physical benefits of meditation are important adjuncts to other treatment.

Meditation and The Root of Addiction

To understand the specific need met by meditation in the process of recovery, the root of addiction needs to be recognized. The root of addiction is described over and

over again by clients at treatment center intake interviews or in 12-Step meeting: feeling bad. This "feeling bad" is not due to substance abuse or withdrawal. It is a "feeling bad" that existed before substances were ever used. Typical statements that reveal this feeling include:

"I'm not enough."

"I'm not good enough."

"I don't feel comfortable in my own skin."

"Everything gets to me."

"Everything is too much."

These vulnerable feelings are often accompanied by symptoms such as light-headedness, palpitations, painful levels of self-consciousness, social discomfort, fight/flight reactivity, and heightened degrees of boredom, agitation or irritability.

In the beginning of the addictive process, the person is experimenting with substances in order to change this bad feeling, this vulnerability. At some point in the experimentation, the person has a vivid experience of relief. Temporarily, the substance moves the person from a state of vulnerability to a state of tranquility, numbness, euphoria, oblivion, power, or indifference. The first experience of alcohol is often described as "I was looking for something ...and I had found what I was looking for." This vivid experience of relief creates an emotional attachment to the substance. For example, one does not become physiologically addicted to heroin after a single use, but one does become attached to the great relief it provided. The substance gains credibility as answer to vulnerability. The repeated use of it is set in motion.

There are of course many explanations for why a person continues to seek relief through substances and in time develops an addiction. The explanations for addiction

include genetic, medical, bio-chemical, familial, post-traumatic, cultural, psychological and spiritual factors (Schaub & Schaub, 1997). In each explanation, a central theme is repeated - the person feels too much vulnerability and has the compelling desire to get rid of it.

The path of recovery must therefore include the learning of new, healthier responses to vulnerability. Since vulnerability consists of mental perceptions ("I'm not good enough") and physical symptoms (e.g., light-headedness), we need a self-care tool that addresses the mental state and the body state at the same moment. Meditation does so perfectly. Meditation triggers a coordinated response of the whole body-mind system, shifting the mind from fearful thinking to peaceful awareness and shifting the body from hyperarousal to relaxation and stability. The effects of meditation are attained in a minute or two under proper guidance from the counselor, and in time clients can learn how to do this on their own.

In order to teach meditation to clients, it is important for the counselor to know the different types of meditation and to match those types to the individual needs of the client. One type of meditation may appeal to one client and be ineffective with another client. This requires clinical judgment in the same way that other techniques need to be assessed for their timing and appropriateness for a particular client.

This role of teaching meditation implies of course that the counselor is personally experienced with the various types of meditation. Without personal knowledge, the counselor will not be effective in teaching the skills to clients. Increasingly, there are secular health professionals with thorough knowledge of meditation who can train counselors. The Internet may help you locate a competent teacher in your area. (The author's training institute includes a ten month course in clinical imagery and clinical

meditation.)

Types of Meditation

In general, sitting meditation techniques can be classified as concentrative, receptive, and creative. All meditative traditions have all three types of meditation, but tend to emphasize one technique over another, especially to beginning students.

Concentrative meditation. Concentrative techniques emphasize a single-minded focus on one object - the breath, a phrase, a thought, an image, a repeated movement. In such techniques, the goal is to ignore all other experiences and to keep returning attention to the single meditative object. This concentrated focus on one object has great potential: it can lead to states of blissful ease. Such experiences can give the person in recovery an ability to change their state from fear to peace and thus give a new sense of self-control. Examples of concentrative techniques include:

- the focus on breath in the early phases of Zen and mindfulness training
- the focus on mantra in transcendental meditation
- the focus on a single word linked with the breath cycle (the relaxation response technique) developed by cardiologist Herbert Benson.

Focus on breath is particularly effective for the person in recovery. This is true because moments of vulnerability produce holding of breath or shortening of breath, resulting in at least mild hyperventilating. Hyperventilating in turn produces more excitation, more anxiety. Focus on the breath restores a more normal breathing cycle, and the change in respiration rate calms the entire physical sense of self. Having developed a concentrative meditative practice, several clients can now travel, give public

talks and be in demand situations that were previously sources of phobic fear.

Limitations of concentrative meditation. There is a limitation to concentration techniques. By turning attention over and over again to one object, all other experiences are ignored. In the extreme, other experiences may even be repressed, kept out of awareness. Concentrative meditation can bring temporary peace to the bodymind, but its avoidance of thoughts and feelings prevents the development of self-understanding so crucial to later recovery.

Receptive meditation. Receptive techniques begin with a concentration technique, such as focus on breathing. They then gradually let awareness open to the stream of experiences:

- body sensations
- thoughts
- feelings
- moods
- sounds
- energy shifts.

This receptive behavior is sometimes called witness consciousness, or being the observer, or engaging the observing ego (Assagioli, 1965). One brief case example gives a sense of the possibilities of receptive meditation.

Case Study: Glen

Glen, a 35 year old with a diagnosis of HIV positive and in recovery from heroin addiction, was referred for meditation training by a physician because of episodes of

extreme fear and anger. Glen had refused medication for his episodes, rightly asserting he was having extreme feelings because of the extreme situation he was in. He said he did not want to learn any mental tricks or simple relaxation techniques or be hypnotized out of his fear and anger. Quite clearly, he knew he needed some new way to work with his states of mind.

He was first trained to follow his breathing and to say out loud any experiences he was having moment to moment. After several training periods of this, he was instructed to verbalize internally whatever he was noticing. The technique was then shortened to (1) following his breathing, (2) noting internally with a single word whatever he was experiencing, and (3) returning to his breathing. He was taught to (1) consider his breath as his center, (2) to be interested in whatever thought or image or feeling or sensation pulled him away from his breath, away from his center, (3) to keep his attention long enough on the off-center experience to know what it was, e.g., worrying, (4) to mentally note, "Worry," (5) to then return his attention to his breath, to his center. This inner movement from center to off-center and back to center was taught as the normal flow of the meditation period. No attempt was made, as it is in concentrative meditation, to stay fixedly focused on the center. Rather, the receptive technique builds the skill of noticing whatever is being experienced and then being able to center oneself again. In this way, Glen was establishing a base of relaxation in his breathing and at the same time not denying whatever experiences were present.

Within two weeks of daily practice, Glen began to realize he was having a wide variety of internal experiences, of which fear and anger were only two. When the fear or anger did come, they were like big waves, taking him over. But then they would pass. He began to realize fear and anger were present along with questioning,

sensitivity, religious searching, self-hatred, self-compassion, practical thinking, remembering, and so on. His fear and anger were not blunted or denied. They were instead simply experienced, in a receptive way, within a larger array of experience. This technique of mindfulness has been successfully taught to many patients in extreme situations (Kabat-Zinn, 1990).

Observations. Receptive meditation, or mindfulness, is particularly suited for anyone with struggling with internal conflicts and impulses. This would therefore include anyone in early recovery. The very technique asks the person to be receptive to himself. It asks him to notice the full range of his inner and outer experiences. Inherent in receptive meditation is the insight that the inner conflicts and impulses are, at one level, just momentary, passing thoughts: do not act on them and they pass away.

Glen noticed, in meditation, an array of experiences - some pleasant, some unpleasant, some new, some depressingly familiar, all coming and going, coming and going. He could either attach to them or let them go. Letting thoughts go does not magically change inner conflict, but it does take some of the energy out of it. In time, the person learns meditatively he can attach to the thought or just notice it and let it go. Choice becomes involved in thoughts, feelings, and urges that previously seemed to be real and compelling.

Creative meditation. Creative meditation can be added to concentrative and receptive techniques. Creative meditation brings the vast resource of the imagination into meditative practice. The absence of the imagination in meditative practice is an unnecessary deprivation. The imagination is a dominant force in human nature and deserves to be utilized in our clients' service. Two religious traditions that greatly utilize the imagination in the path of meditation are Roman Catholicism and Tibetan Buddhism.

They both utilize art and images extensively to awaken spiritual experiences.

The imagination is a key concept in the psychological meditation practices of European psychiatrists Carl Jung and Roberto Assagioli. Creative meditation is the most active form of meditation because of the interaction between the conscious mind, imagination, feeling states, memories, and periods of emptiness and silence.

Case Study: Frances

Frances, 50 years old, was in recovery from alcoholism. She felt that her drinking had been a slow form of suicide, and she wondered why she hated herself so much. She asked for help in understanding how or why she had done this.

She was taught to follow her breathing (concentrative), then to open to her stream of experiences (receptive), and then to imagine a wise being with which she could dialogue in her mind (creative). She was instructed to ask the wise being about her "self-hatred."

In her imagination, she met a spiritual teacher who brought her to a scene from early childhood: she is locked out of her house and desperately has to urinate. She urinates in her pants and then hides in the backyard in humiliation.

At the conscious level, this disturbing memory seemed to her to have nothing to do with her question about her self-hatred. She returned to her creative meditative technique and asked the imagined spiritual teacher for more information: she was led to another disturbing childhood memory. Frances began to realize these images were all telling her how many times she wanted to die from humiliation. She then felt compassion for the little girl in the memories and cried with relief at feeling such

kindness toward herself. Her self-hatred softened as she continued her meditation practice.

Other forms of creative meditation include

- reflecting on a philosophical principle
- contemplating a spiritual image
- identifying with the life force (Schaub, 1995).

Meditation and Spiritual Development

Participants in Alcoholics Anonymous and other 12-Step programs are encouraged to seek spiritual growth and connection with their "higher power." There has always been controversy about this "religious" aspect of AA and is often cited as the reason that AA is rejected both by mental health professionals and by new people going to their first AA meeting.

To resolve this, we can ask that same essential question: does it work? Spiritual development works. It is a process that leads the person beyond their constricted identity as an "addict" filled with self-centered fears and opens them to deeper aspects of their nature and innate potentials. The founders of AA discovered this for themselves and passed it on to others.

The question becomes how to develop spiritually. The 11th Step overtly asks the person in recovery to seek "conscious contact" with God through prayer and meditation. AA itself has prayer in meetings, but meditation is not taught. In the author's experience, people in AA seek out meditation retreats in both their own religious

tradition and in foreign meditation traditions.

Meditation is of course not the only path of spiritual development. Other paths include service, social action, aesthetics, ceremony, knowledge, physical training, devotion (Schaub & Schaub, 1997). The cultivating of the meditative state, however, in which the body and the personality quiets, and the mind is able to become subtler and more harmonious, is central to all the spiritual paths.

Cautions With Meditation

Meditation needs to be thoroughly practiced and understood by the counselor before it is introduced to a client. This is especially true of creative meditation and imagery. It is the most evocative form of meditation and can rather quickly bring up thoughts and feelings and images from all levels of consciousness. The development of proficiency and insight in meditative states on the counselor's part requires a knowledgeable and ethical teacher.

In addition, teaching meditation without an integrating framework of psychological and spiritual development is shortsighted (Shapiro, 1994). Meditation without a framework may produce calmness but will not produce the kinds of healing and spiritual developments that are possible. In western psychology, Roberto Assagioli's psychosynthesis (1965) and Ken Wilber's spectrum of consciousness (Wilber, Engler & Brown, 1986) offer psychospiritual frameworks for development through meditation.

References

Alcoholics Anonymous. (1976). Alcoholics anonymous ("The Big Book"). New York:

AA World Services.

Alcoholics Anonymous. (1984). Pass it on. New York: AA World Services.

Assagioli, R. (1965). Psychosynthesis. New York: Penguin Books.

Benson, H. and Wallace, K. (1972). Decreasing drug abuse with transcendental meditation. Drug Abuse--Proceedings of the International Drug Abuse Conference, Boston. 369-375.

Fahrion, S., Walters, E., Coyne, L. and Allen, T. (1992). Alterations in EEG amplitude, personality factors, and brain electrical mapping after alpha-theta brainwave training: A controlled case study of an alcoholic in recovery. Alcohol Clinical and Experimental Research, 16(3), 547-552.

Kabat-Zinn, J. (1990). Full catastrophe living. New York: Delta.

Leonard, G. and Murphy, M. (1995). The life we are given. New York: Tarcher/Putnam.

Marlett, G.A. and Marques, J. (1977). Meditation, self-control and alcohol use. In Eds. R. Stuart and B. Stuart, Behavioral self-management: Strategies, techniques, and outcomes. New York: Brunner/Mazel. 117-153.

Schaub, B. (1995). Imagery in health care: Connecting with life energy. Alternative Health Practitioner, 1(2), 45-47.

Schaub, R. (1995a). Meditation, adult development and health. Alternative Health Practitioner, 1(3), 205-209.

Schaub, B. and Schaub, R. (1997). Healing addictions: The vulnerability model of recovery. Albany: Delmar.

Shapiro, D. (1994). Examining the content and context of meditation. Journal of Humanistic Psychology, 34(4), 101-135.

Wilber, K., Engler, J., & Brown, D. (1986). Transformations of consciousness. Boston: New Science Library.

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