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From New Age to Neuroscience; Creating New Narratives with Meditation Programs and Guided Imagery in Addiction Treatment

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Introduction

I have facilitated residential treatment groups for two and a half years. As a result, I observed three obstacles to successful addiction treatment: (a) client resistance (b) pejorative labels and (c) orthodox treatment models with little empirical support. Former

offenders in residential treatment can be resistant to the counseling process. Referring to them as: powerless, recidivists, perpetual alcoholics and through the prism of a DSM diagnosis can leave such individuals feeling hopeless and beyond help (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995). Traditional treatments usually involve residential or inpatient hospitalization, education, directive or punitive approaches and admonitions to attend self-help groups as after-care. These interventions often work, so long as the client resides in the treatment facility. However, relapse after treatment is common. Researchers have gathered little efficacy data on this model. Despite evidence that their model does not work, it remains the dominant method of addiction treatment (Miller, & Carroll, 2006; Riessman & Carroll, 1996; White, 1993).

My model proposes to differ by incorporating some of the promising, new ideas for residential treatment with sensitivity to conventional treatment approaches and clients' past experiences with them. (Copeland, 1998; Miller & Carroll, 2006; Mitchell, 2006; Rohsenow, Monti, Martin, Colby, et al., 2004; Shults, 2004). It also introduces clients to a narrative based way of constructing their problems.

I developed a group program based on Epston and White's narrative therapy (1990). Narrative therapy substitutes a narrative approach for the conventional medical-psychological approach. Narrative refers to how people construct stories out of their lived experiences. Stories both describe and shape people's lives. Meaning is shaped in narrative form. Narrative stories are not myths or simple metaphors. What we emphasize and what we omit has real effects on people's lives. Epston and White (1990) believe that therapists must allow the client to be an active expert on his or her own life. Narrative therapy is not a cognitive approach. Narratives are not equivalent to cognitive templates, maps and so on. A narrative approach constructs the problem as outside the person. Personal narratives are embedded in social, cultural, political and economic contexts. The model also includes consideration how various "cultural narratives" have contributed to the client's problems. In practice, the counselor takes a collaborative position and learns with the client, and helps them to "co-create" new meanings.

Michel Foucault's social critique forms the basis for the widespread applicability of the narrative to diverse clientele. Michael White and David Epston collaborated, during the 1980's, to form their model of counseling based on Foucault's theory of power and knowledge. Foucault argued (1975) that power and knowledge are so closely related that truth is not absolute, but is determined by the dominant culture. To illustrate, he offered this example: quantum physics and classical mechanics are contradictory, yet both are used concurrently by different sciences. Both are deemed "true" because each is useful in its own milieu. Foucault believed that the meaning (truth) assigned to language is determined by the dominant culture because it supports the power of the accepted paradigm. He believed that suppressed people can resist subjugation by refusing to cooperate with those definitions.

A narrative approach emphasizes how new client narratives can lead to new action

possibilities (Combs & Freedman, 1990; Denborough, 1996; Evans, 2004; White & Epston, 1990). Clients become stuck when they continue constructing negative stories about themselves. In narrative therapy, the counselor encourages the client to locate the problem outside of themselves, to experience it as a separate entity. With the problem outside the client, he is free to act to reduce its influence or at a minimum, to see himself as separate from it. His support group can also ally themselves with him against the problem. Shame, guilt and blame are reduced.

Psychodynamic based approaches encourage therapists to assume a one-up, omnipotent position. Person-centered therapists aim to create a non-directive, non-judgmental relationship with the client. In narrative therapy, the counselor maintains a collaborative position and encourages the client to restory his or her experience in a self-empowering way.

Objectives

My tripartite meditation-style program for the 2008 ACA annual conference, featured breath work, progressive relaxation and modified guided imagery. It addressed these six objectives:

- a. Counselor identity: This adaptation of traditional guided imagery is congruent with counselor identity when it allows the client to choose his own goals, identify his strengths and externalize pathology. The counselor takes a one-down position by allowing the client to be the expert the process.
- b. Criminal offender issues: There is empirical evidence that these meditation-style activities are effective in reducing symptoms of anxiety and other co-morbid disorders that often accompany addiction.
- c. Group process: This exercise allows the offender to use the symbols, values and language from his culture. This lends authenticity to his story and enhances bonding and normalization within the group.
- d. Addiction: Through a didactic on the neuroscience of addiction, addicted offenders learn how meditation and similar interventions facilitate the repair and regeneration of neurons that have been damaged by chemical abuse and environmental stressors.
- e. Theory: Once the client has begun the guided imagery portion of the session, the counselor may subtly introduce appropriate therapeutic techniques. Narrative Approaches are introduced in a way that gives the client control of the content and goals.
- f. Research: References and case studies offer empirical support for each intervention.

Neuroscience, case studies, field and clinical research support the rationale for each of

the group objectives. These references appeared throughout the session.

It is the experience of this author that addicted offenders in group settings are open to learning about their bodies. Moreover, they are more likely to cooperate with new practices if there is scientific evidence to support it.

Meditation and relaxation techniques have been used for centuries in a variety of settings. Therefore, the meditation-style exercises should be culturally appropriate in most situations. This author adapted traditional models to accommodate reluctant populations.

I began my conference session with a brief history of addiction treatment and the narrative philosophy behind my intervention and the paradoxical link between traditional meditation processes and neuroscience. This synopsis of the program I use with clients in treatment

New Age to Neuroscience: A Program for Clients in Residential Treatment

Neuroscience Didactic

I start the program with an educational program on the neuroscience of addiction, for three reasons: (a) the clients will be expecting a conventional program and may be startled by the narrative philosophy, so this approach will be congruent with their expectation; (b) when people feel silenced, we may need to initially take an active role, modeling imagination and creativity that can open spaces for new stories and (c) I aim to increase self-efficacy and participation by asking *the clients* to teach neuroscience. I have noticed that those who have experience with mind-altering substances are also likely to have a sophisticated knowledge of their delivery systems (White, 1996). When the clients do the teaching, they become the knowledge-providers and the program is also delivered in their own language.

In the next segment I offer evidence that some damage can be permanent and can lead to a decreased ability to feel pleasure, even from natural endorphins (Powledge, 1999). Some of these pleasures include: exhilaration, sex, ambition and nurturing. There is also evidence that same kinds of damage done by chemical abuse can have other causes: poverty, malnutrition, PTSD, abandonment/attachment issues and stress (Black, 1997; Cohen, Hitsman, Paul, McCafferty, Stroud, Sweet, Gunstad & Raymond, 2006; Masser, Rothbaum & Aly, 2006; Pfefferbaum, Rosenbloom, Serventi & Sullivan, 2004; Powlege, 1999). Sharing this information helps reduce self-blame and guilt and opens the door to discussions about ways to counter the effects. Thus, the correlation between cause, effect and repair becomes evident. The group will construct remedies that correspond with the aforementioned etiology such as: improved nutrition, counseling, exercise, good sleep hygiene and so on. The discussion of these remedies provides a segway to a discourse on the efficacy of meditation techniques and guided imagery for addiction treatment (Cropley, Ussher & Charitou, 2007; Kissman & Maurer, 2002; Kominars, 1997;

Mazumdar, 2000; Winkelman, 2003).

Restorying

Because the previous information will have primed the clients to understand how mental processes can aid neurological repair, I can introduce the concept of restorying. I choose an event such as a robbery and tell a story using words like: victim, numbness, violation, fear or flashbacks. And then retell the story using different language: survivor, alive, support, gratitude, renewed priorities, courage and tenacity. The new language uses the same event, but creates a new, preferred story (White & Epston, 1990). This piece will come into use during the guided imagery segment of the experiential portion of the program which follows:

Breathing

With the group members in comfortable positions, and gentle music playing, I explain entrainment (the synchronism of heart rate and breathing) as an optimum condition for cell repair enhances participation. Since many people with substance abuse problems or a history of incarceration experience anxiety, panic attacks or insomnia, they are interested in learning how these techniques can help. In fact, while it is not easy to control one's heart rate, it *is* simple to control one's breathing. If the breathing slows, the heart rate will follow. Panic attacks cannot continue without a rapid heartbeat. I ask the clients to notice their heart rate at the outset and instruct them to begin to slow their breathing.

Progressive relaxation

I begin a short progressive relaxation narrative, instructing the group members to relax their bodies, starting with the feet. When we reach the chest area, I instruct them to visualize "unwanted stories" leaving with each exhale and new "preferred stories" entering with each inhale. As we visualize the heart area, I ask them to notice their heart rate. It has already slowed since I first asked them to notice it. The exercise continues in the traditional way.

Guided imagery

My guided imagery process differs from some others. Instead of describing a predetermined scene, I ask the clients to create their own. I find it poignant that they still have so little control of their environment, even though they are no longer incarcerated. After they form a scene, I ask them to imagine a setting in the distance where they can see themselves doing whatever they wish, and to people it with those they care about. I then ask them to create a pathway of sorts, some obstacles and a few objects along the path (Combs & Freedman, 1990; Guiraud, 1975; Harre' & Gillett, 1994; Lakoff & Johnson, 1980). As they move along the path, they are to choose an object (it may be a weapon, jewel, tool, wand, flower etc.) and to notice that it is a symbol of a strength they have already used. I note that the life of addiction is encumbered with obstacles and the clients have already used strengths such as these to survive. They continue on, noticing more and more strength symbols. The swelling and ebbing of the music aids in the story-

making process.

Mindfulness and acceptance

After a time, the narrator looks for a distraction or interruption. Learning to accept incongruent experiences is a part of mindfulness (Hayes, Follette & Linehan, 2004). During meditation I point out a distraction such as the sound of a phone ringing in the next room. I encourage them to notice the ringing and to also notice that they are still in the scene they created. They can hold both; one need not cancel the other out. Or they may include the sound into their story (for example: a call relaying good news). Some people in treatment have trouble with black-or-white thinking, practicing acceptance can be one way to soften that stance. I let the clients know they can come back to the present when they are ready and that they are able to create more personal narratives whenever they wish.

Summary

My program addressed the problem of resistant clients in residential treatment. I cited some barriers to active participation. The problems and new model were framed in terms of narrative approaches. I provided a rationale for the objectives of my model. I explained the didactic segment and how each successive segment provided a transition to the next, culminating in private stories created by the clients. I presented the tripartite mediation portion to the audience at the 2008 ACA annual conference, with a demonstration and experiential event.

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