

Mindfulness in the treatment of substance use disorders

A phenomenological study of Swedish practitioners' experiences

Matteo Di Placido

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Supervisor: Roberto Scaramuzzino

I said to the wanting-creature inside me:

What is this river you want to cross?

There are no travelers on the river-road, and no road.

Do you see anyone moving about on that bank, or resting?

There is no river at all, and no boat, and no boatman.

There is no tow rope either, and no one to pull it.

There is no ground, no sky, no time, no bank, no ford!

And there is no body, and no mind!

Do you believe there is some place that will make the soul less thirsty?

In that great absence you will find nothing.

Be strong then, and enter into your own body;

there you have a solid place for your feet.

Think about it carefully!

Don't go off somewhere else!

Kabir says this: just throw away all thoughts of

imaginary things, and stand firm in that which you are.

Kabir (Translated by Robert Bly)

Abstract

Mindfulness and mindfulness-based interventions (MBIs) have been applied in numerous fields from behavioral medicine, nursing and psychiatry, to psychology and social work. Research on mindfulness and MBIs is increasingly providing evidence of the efficacy and benefits of MBIs for the treatment of a vast array of conditions. Yet, the application of mindfulness in the field of social work is still at its initial stages and among the most recent areas of its application includes the treatment of substance use disorders. However, the current research on mindfulness is based on epistemological and methodological stances that allow only a partial investigation of the phenomenon, as it is primarily focused on the evaluation of the effectiveness of mindfulness and MBIs or in the search of its underlying neurological mechanism. The aim of this work is to employ the experience of five Swedish practitioners to understand the influence of mindfulness in the social work therapeutic relationship, and exploring the advantages and challenges that MBIs offer in the treatment of substance use disorders in the Swedish context. The aim is pursued relying on a descriptive phenomenological research design. The main findings of this work suggest: (a) the suitability of phenomenology in theorizing mindfulness and MBIs within the therapeutic encounter and in the treatment of substance use disorders; (b) the body is the main tool in the process of understanding one's own emotional and cognitive life in the therapeutic work with mindfulness and MBIs; (c) the compassionate, accepting and non-judging features of mindfulness and MBIs offer a valuable ideological alternative to the zero tolerance model and the treatment methods that characterize the Swedish drug policy; (d) mindfulness is not merely a therapeutic tool but represents an overarching aspect of the life of its practitioners, whether they are social workers or clients.

Keywords: mindfulness, MBIs, phenomenology, substance use disorders treatment, social work.

Table of contents

1. Introduction	1
1.1. Why mindfulness in the Swedish context?	2
2. Aim	5
3. Mindfulness in social work: a research review	8
3.1. Mindfulness and substance use disorders treatment	11
3.2. Concluding remarks: filling the research gap	13
4. Thesis structure	14
Part I	15
1. Methodology	15
1.1. Meta-theoretical perspective: a descriptive phenomenological position	15
2. Method	18
2.1. A descriptive, meaning-oriented phenomenological method	18
2.1.1. The epoché of objective science	19
2.1.2. The phenomenological-psychological reduction	20
2.1.3. The transcendental reduction	21
2.1.4. Understanding the informants	22
2.2. Final considerations on the method and methodology	23
2.3. Data Collection and ethical considerations	24
3. Social work in context	28
3.1. Mindfulness and MBIs in the treatment of substance use disorders: an alternative approach?	29
Part II	33
1. Analysis and discussion	33
1.1. Mindfulness at work: bridging the gap between theory and practice	34
1.2. Another way of knowing: bodies back in business	40
1.3. They say I don't judge them	44
1.4. Mindfulness: therapeutic tool or a way of being?	51
2. Conclusion	53
2.1. Recommendation for future research	57
3. Reference	59
4. Appendix	77
4.1. List of Abbreviations	77

1. Introduction

Imagine you are sipping a cup of tea, or walking to meet with an old friend. Where is your mind, your thoughts, in that exact moment, when you are sipping that tea, or walking to meet your friend? How often do you find your mind wandering in different realms, such as your working life, your relationships or your economic situation? How often is your mind distracted by past experiences, memories and by the future and its uncertainty and promises? And again, how often do you find the tea cup empty, or do you finally arrive at the place where you are supposed to meet your friend, and feel like you never drunk that tea or walked the long alley that brought you to the meeting place?

How many times are you speaking with somebody and thinking about something else (the laundry that needs to be done, your parents aging, your dreams about the future)? How many times are our minds, one, two, or ten steps away from our bodies? The cultivation and the practice of mindfulness is about reducing this distance and finally connecting our minds and bodies. This process can have powerful transformative impacts in the way we live our lives. Mindfulness is about being here and now, moment after moment, fully embracing whatever happens to unfold in the present and thus competently relate to it, because the present is the only time we can inhabit.

Mindfulness, described as moment to moment, non-judgmental awareness of one's experience as it unfolds (Kabat-Zinn, 1990) has received its most elaborated systematization in Buddhism, in which it is described by some traditions as the heart of Buddhist meditation (e.g., Gethin, 2011, p. 266; Kabat-Zinn, 2005, p. 25; Nyanaponika, 1962, p. 14). Today, mindfulness is not merely seen as part of one's spiritual journey, but is increasingly adopted as an integral component of many therapeutic interventions, together with traditional clinical methods in person-oriented services.

1.1. Why mindfulness in the Swedish context?

Although still at its primary stages, the inclusion of mindfulness and MBIs in Swedish clinical settings is currently developing (e.g., Hilde, 2014; Franke, 2014; Sundquist et al., 2015). Thus, the institutionalization of mindfulness in Swedish clinical settings could be considered as a particular aspect of the globalizing processes of transnationalization, popularization, commodification and finally scientification of mindfulness, that both enhances and is enhanced by the convergence between Western and Eastern approaches to knowledge.

In other words, on the one hand, the meeting between first-person perspectives¹ as found in contemplative traditions, and Buddhism in particular, and third-person perspectives as found in the Western take on reality and knowledge production signifies a re-orientation of mindfulness from its original contexts and related ontological and epistemological stances toward rationalist knowledge, constructed as instrumental, techno-scientific and secular (Scholte, 2005, p. 258-9).

On the one other hand, the inclusion of mindfulness within mainstream Western settings is fostered by what could be defined as a paradigm shift transversely investing western scientific communities, and our modern societies overall. In fact we are assisting to ontological (ways of being) and epistemological (ways of knowing) shifts characterizing the confluence of modern Western science with ancient Eastern traditions. These movements of convergence, both at an epistemological level and at a methodological one, have been clearly emphasized by Varela, Thompson and Roach, (1991) and Thompson (2007) in their attempts to merge a third-person scientific perspective with first-person accounts as found in Buddhism and phenomenological philosophy.

¹ Within the framework of this thesis first person-perspectives are understood as experienced-based processes of knowledge acquisition, as found in contemplative traditions, or in Husserl's and Merleau-Ponty's phenomenological inquiries. Third person-perspective are understood as the traditional Western approach to knowledge production based on the scientific landmarks of objectivity, measurement and cause-effect, where the researcher is considered as radically other from her object of study.

The work of Varela and colleagues (1991) and Thompson (2007) are not however isolated voices. In fact the development of highly accountable scientific platforms such as Science and Nonduality (SAND)² and Mind and Life Institute³, where leading researchers, philosophers, teachers and artists among others, contribute to the convergence of science and spirituality, underlines the growing concerns about Western rationalism and its explanatory power.

As underlined by Williams and Kabat-Zinn, “Ancient and modern, Eastern and Westerner modes of inquiry and investigations are now in conversations and cross-fertilizing each other as never before” (2011, p. 15). It is within this framework that, through the contemplative education movement in higher education⁴ (Bush, 2011, p. 185), mindfulness and its underlying contemplative epistemology is gaining access in disciplines as diverse as neuroscience, architecture, psychology and social work.

In other words, narrowing the aim of the discussion to the therapeutic field, we are witnessing the confluence between traditional Western treatment methods and ancient Eastern traditions in our approaches to therapeutic practices. In fact, in the last decades MBIs have been applied in numerous fields from behavioral medicine, nursing and psychiatry, to psychology and social work. Research on MBIs, such as MBSR⁵ (Kabat-Zinn, 1990), MBCT⁶ (Segal, Williams & Teasdale, 2002) and

²For an exhaustive overview of SAND, its missions and current projects see <http://www.scienceandnonduality.com/>.

³ For an exhaustive overview of Mind and Life Institute, its missions and current projects see <http://www.mindandlife.org/>.

⁴ For an overview of the development of the contemplative education movement in higher education in different fields see Bush (2011). Full reference in bibliography.

⁵ Kabat-Zinn and colleagues started their innovative program, namely MBSR at the Stress Reduction Clinic (founded in 1979) and then at the Center for Mindfulness and Medicine, Health Care and Society (founded in 1995) at the University of Massachusetts Medical Center, to help people with chronic physical pain and other medical conditions (Kabat-Zinn, 1990).

⁶ Inspired by the effectiveness and success of the MBSR, Segal, Williams and Teasdale (2002), well-known scientists in their field, developed MBCT for the treatment of depression merging MBSR and traditional Cognitive Therapy, thus further fostering the growing attention gained by mindfulness and MBIs.

MBRP⁷(Bowen, Chawla, & Marlatt, 2010)⁸ is increasingly providing growing evidence of the efficacy and benefits of MBIs (e.g., Chiesa & Seretti, 2014; Grossman, et al., 2004; Kuyken, et al., 2008). The therapeutic employment of mindfulness and MBIs aims to break the chain of the automatic reactions to stressful situations and give its practitioners the means to competently relate with them. This is primarily achieved starting from gaining increased awareness of their minds and bodies in the present, and subsequently, once they have learnt how to recognize their automatic reactive tendencies, substituting them with skillful responses (e.g., Bowen, Chawla, & Marlatt, 2010; Kabat-Zinn, 1990; Segal, William & Teasdale, 2002).

However, despite these promising results there are growing concerns, especially from Buddhist scholars, regarding the plausible inclusion of mindfulness in clinical practice. These concerns arise from the fear that mindfulness as conceptualized in its modern application struggles to account for the complexities and nuances of its conceptualization in the original sources (e.g., Bodhi, 2011; Dreyfus, 2011; Gethin, 2011). Further criticisms, as we will see later on in this work, regards the current epistemological and methodological stances embraced by the mainstream research on mindfulness and its clinical application, which are considered inadequate for the study of mindfulness (Gethin, 2011; Grossman & Van Dam, 2011).

The Swedish landscape is just one among the fields in which these movements of convergence are played out, yet it is a particularly interesting one

⁷ Marlatt and colleagues developed Mindfulness-Based Relapse Prevention (MBRP) (Bowen, Chawla, & Marlatt, 2010), an outpatient program that integrates skills from cognitive behavioral relapse prevention (RP⁷) (Marlatt & Gordon, 1985) and MBIs such as MBSR (Kabat-Zinn, 1990) and MBCT (Segal, William & Teasdale, 2002).

⁸ Mindfulness-Based Stress Reduction (MBSR) (Kabat-Zinn, 1990), Mindfulness-Based Cognitive Therapy for depression (MBCT) (Segal, Williams & Teasdale, 2002) and Mindfulness-Based Relapse Prevention (MBRP) (Bowen, Chawla, & Marlatt, 2010) manuals are the main protocolled interventions in which mindfulness is included within traditional Western treatment methods. They are commonly known as Mindfulness-Based Interventions (MBIs). Other MBIs which have not explicitly discussed in this thesis because their different focus are: Mindfulness-based Eating Awareness Training (Kristeller, Baer & Quallian-Wolever, 2006), Mindfulness-based Elder Care (McBee, 2008), and finally Mindfulness-based Childbirth and Parenting (Duncan & Bardacke, 2010).

especially in reference to the treatment of substance use disorders with mindfulness and MBIs. MBIs and MBRP in particular, rooted in the tradition of mindfulness and mindfulness meditation as structured in Buddhist philosophy, may provide an alternative to the main treatment methods employed in the Swedish context, which are historically constructed within the framework of zero tolerance ideology (e.g., Edman, 2013; Edman & Stenius, 2014; Ekendhal, 2012). As a consequence Swedish drug policy is prohibitive in character and fosters the implementation of coercive treatments, within a paternalistic approach (e.g., Hallam, 2010; Edman & Stenius, 2014; Moore, Fraser, Törrönen & Eriksson Tinghög, 2015). Within this framework, MBIs and MBRP in particular could be considered as harm-reduction measures offering an ideological alternative to the overall Swedish drug policy and mainstream treatment methods.

2. Aim

The aim of this work is to employ the experience of Swedish practitioners to understand the influence of mindfulness in the social work therapeutic relationship, and to explore the advantages and challenges that MBIs offer in the treatment of substance use disorders. The central concern of this thesis is to explore when and how mindfulness unfolds in the therapeutic relationship in the field of substance use disorders. Yet, this study is not a critical evaluation of mindfulness as a clinical method, but an analysis on the practitioners' experience of its relevance and effectiveness.

This thesis places itself in conversation with the broader debates on Swedish drug policy and consequent treatment methods and on ontological and epistemological stances, namely between third-person and first-person perspectives. This is of extreme relevance since, accounting for the overall approach of this thesis, there is a need to explore the phenomenon chosen not as isolated from the specific socio-political and cultural traits in which it arises.

The research question guiding this work is:

In what way can mindfulness and MBIs influence the therapeutic relationship and the treatment of substance use disorders in the Swedish context?

In the attempt to answer this question three sub-questions have been employed:

1. How is the therapeutic relationship understood and characterized in a mindfulness based intervention?
2. How can mindfulness contribute to the creation, development and cultivation of the therapeutic relationship?
3. What are the main contributions that mindfulness and MBIs offer in the treatment of substance use disorders in the Swedish context?

The first two sub-questions are designed to explore the influence of mindfulness in the therapeutic relationship. As we will see later on in the thesis, most of the literature emphasizes the positive influence of mindfulness in the therapeutic relationship (Birnbaum & Birnbaum, 2008; Gockel, et al., 2013), but does not exhaustively discuss how mindfulness leads to its numerous positive effects (Birnbaum & Birnbaum, 2008). It has been found that mindfulness contributes to the therapeutic relationship in social work, yet we do not know how this influence practically takes place. In fact there is scarce understanding of the actual relation between what mindfulness signifies in theory and how it actually unfolds in practice.

This may be due to both the lack of contextualization that most studies display and to their epistemological and methodological shortcomings. In fact, the mainstream approach to the study of mindfulness and its clinical application is primarily concerned, in line with the dominant scientific paradigm based on rationalism, with theorizing or evaluating mindfulness in its clinical applications within the perspective and with the tools of our traditional Western third-person perspective (Gethin, 2011; Grossman & Van Dam, 2011). Thus, a context-sensitive phenomenological inquiry may offer an alternative approach and contributes to fill

this research gap. In fact, the employment of a phenomenological approach allows to study mindfulness and its clinical application accounting for first-person, experience-based perspectives, thus investigating the phenomenon from its own vantage point (Varela, Thompson & Rosch, 1991; Thompson, 2007).

Furthermore, it allows to account for the practical unfolding of mindfulness within the therapeutic relationship and the advantages of the application of MBIs in the field of substance use disorders treatment, with a focus on experiences as experienced (e.g., Davidson, 2003; Englander, 2010; Giorgi, 2009), or in other words on first-person perspectives, without neglecting the socio-political and cultural dimensions in which the phenomenon studied takes place.

In order to understand the influences of mindfulness and MBIs in the therapeutic relationship, we need a knowledge on the contextual dimensions in which this very therapeutic relationship occurs. For this purpose, the third sub-question has been developed.

Concerning the third sub-question, it is important to underline that the application of MBIs in the field of substance use disorders is the latest area of implementations of MBIs into Western health-care settings, and thus it is still under researched (Bayles, 2014). However, my study of the contributions that MBIs may offer to the treatment of substance use disorders in the Swedish context does not aim to be a comparison or an evaluation between MBIs and treatment as usual. This study aims, among the rest, to underline the importance of including first-person perspectives, as found in both phenomenological inquiries and Buddhism, within the framework of sound scientific inquiries. Furthermore the third sub-question offers the chance to explore on an empirical basis the relation between Buddhist philosophy and person-oriented health-care facilities in the treatment of substance use disorders.

Reframing the aim of this thesis including the three sub-questions presented, this work aims to contribute to the discussion on three great tensions characterizing western science overall, the current state of research on mindfulness, and more specifically mindfulness in social work. The first tension, namely the gap between

theory and practice as found in the literature, is mainly tackled through the first two sub-questions. The second tension, concerned with the mainstream judging and stigmatizing approaches to substance use and substance disorders treatment in relation to accepting and non-judgmental approaches informed by mindfulness, is underlined by the third sub-question. Finally, the third tension, between first-person and third-person accounts is addressed by all the three sub-question.

Concluding, in table 1 the reader can find a schematized version of the aims of this thesis.

Table 1.

Level of analysis	Object of analysis	Tensions	Sub-research questions
Micro	Therapeutic relationship	Theory vs practice	1 and 2
Meso	Drug policies and treatment methods	Judgmental and stigmatizing approaches vs accepting and non-judgmental ones	3
Macro	Ontological and epistemological stances	Third-person vs first-person perspectives	1,2 and 3

3. Mindfulness in social work: a research overview

The current leading research on mindfulness is based on the evaluation of the effectiveness of mindfulness and MBIs or in the search of its underlying neurological mechanism (e.g., Hölzel et al., 2011; Shapiro, et al., 2006; Witkiewitz, Lustyk & Bowen, 2013). This is particularly evident in fields such as medicine (e.g., Davidson at al., 2003; Kimbrough et al., 2010; Lee & Orsillo, 2014) and psychology (e.g., Baer, 2003; 2011; Brewer, Elwafi & Davis, 2014; Gethin, 2011) thus underlining the rationalist logos attached to the study of mindfulness in these disciplines.

This body of work provides evidences of the efficacy of mindfulness and MBIs and on their plausible functioning at a neurological level, yet seems to lack what has been previously named in this thesis as first-person perspective's accounts.

An example of this mainstream approach to the investigation of mindfulness is a recent study conducted in Sweden by a team of researchers from Lund University (Sundquist et al., 2015). This study shows that mindfulness group therapy based on MBSR and MBCT in primary care patients with depression, anxiety, stress and adjustment disorders is as effective as individual Cognitive Behavioral Therapy (CBT). However, CBT is expensive for the tax-financed healthcare system and requires the involvement of more therapists, since in Sweden it is mainly given on an individual basis. Thus mindfulness group therapy displays as effective as traditional CBT but is more cost-efficient (Sundquist et al., 2015).

Although mindfulness has been applied in the realm of social and cognitive psychology (e.g., Baer, 2011; Brewer, Elwafi & Davis, 2014; Ma & Teasdale, 2004) and medicine (e.g., Davidson et al., 2003; Kimbrough et al., 2010; Lee & Orsillo, 2014), its application in the field of social work is still at its initial stages (Birnbaum & Birnbaum, 2008; Gockel, et al., 2013). Furthermore, contrary to the leading research on mindfulness in medicine and psychology, part of the research on mindfulness in social work originates within the contemplative education movement and its concerns for holistic, non-dual and transpersonal understandings⁹ (e.g., Birnbaum & Birnbaum, 2008; Sherman & Siporin, 2008; Wong, 2013). Hence this body of work displays as substantially critical toward the dominant rationalist take on scientific inquiry and is more qualitatively oriented compared with the general trend in health care sciences and psychology.

⁹ In the context of the contemplative education movement in higher education holistic, non-dual and transpersonal indicate an attention toward the overcoming of the Cartesian division between mind and body, subject and object, self and other, thus being substantially attuned with certain strands of Buddhist philosophy and certain interpretations of phenomenological philosophy.

Moreover, leading strands of research emphasize the role of practitioners' own mindful practice, or as Germer (2005) puts it of mindful-presence in psychotherapy, to be of crucial importance in the therapeutic relationship. As a result, the social work therapeutic relationship, defined as both the physical encounter between clients and social workers and as the overall therapeutic process, seems to offer a privileged vantage point for the practice and the study of mindfulness.

In fact, studies have been acknowledging the positive correlation of mindfulness with foundational aspect of successful therapeutic relationships, such as practitioner's attention, acceptance, empathy, and self awareness (e.g., Brenner, 2009; Germer, 2005; Turner, 2009). These therapeutic qualities have been recently related as the "common factors" transcending therapists' orientation and treatment methods (Bennett & Nelson, 2008) for effective clinical practice and have become of increasing interest in clinical social work.

Considering the benefits of mindfulness in the development of practitioner's skills and consequently for the social work therapeutic relationship and the effectiveness of MBIs, there is growing interest for the potential role of mindfulness within social work practice and education (Birnbaum & Birnbaum, 2008). More specifically, the benefits that mindfulness trainings and MBIs may have for social work students (e.g., Birnbaum, 2005; 2008; Gockel, et al., 2012; Gockel, et al., 2013; Wong, 2004; 2013), practitioners (e.g. Brenner, 2009; Germer, 2005; McGarrigle & Walsh, 2011) and clients (e.g., Broderick & Metz, 2009; Coholic, 2005; Kane, 2006) have recently started to be investigated.

With specific reference to the Swedish context, it is worth mentioning a recent book of Mats Hilde, senior lecturer at the School of Social Work of Lund University. The book *Mindfulness i socialt arbete: en introduction* (2014), is the first Swedish introduction on mindfulness thought for both students and practitioners. The book provides an overview on the role of mindfulness in relation to social work and related helping professions, stressing the intrinsic values that its inclusion may add to these professional practices (Hilde, 2014).

Hilte (2014, p. 9), summarizing the current state of research, further underlines how, among the different purposes and work areas in which mindfulness fruitfully relates with social work figure:

- The fostering of the therapeutic relationship between social workers and clients.
- The development of practitioners' self-care.
- The development of practitioners' ability to reflect towards one's own actions.
- The use of mindfulness as an intervention for social work clients, in particular in the field of addiction.

3.1. Mindfulness and substance use disorders treatment

Among the most recent areas of application of MBIs is the treatment of substance use disorders¹⁰ (e.g., Bowen et al., 2009; Bowen & Enkema, 2014; Witkiewitz et al., 2013a). However, the research on MBIs in the treatment of substance use disorders is still relatively unexplored (Bayles, 2014). Accounting for the finding of this body of work it is possible to conclude that MBIs are successful in treating a vast variety of substance use disorders, ranging from alcohol dependence (Zgierska et al., 2008; Garland, et al., 2010), alcohol and cocaine use disorders (Brewer et al, 2009) and nicotine dependence (Bowen & Marlatt, 2009; Davis, et al., 2007). Furthermore, the results of these studies are consistent with the current neurobiological research emphasizing the relation between mindful practices and changes in brain regions involved in modulation of arousal and emotional regulation (e.g., Hölzel et al., 2008; Hölzel et al., 2011; Lazar et al., 2000; Witkiewitz, Lustyk, & Bowen, 2013). For a review of the growing number of studies on the assessment of the efficacy of MBIs

¹⁰ Substance use disorders at the purpose of this project are understood as only referring to illegal substances thus excluding the consumption of legal substances such as alcohol or prescribed drugs, eating disorders and other addictive behaviors such as sex, gambling etc., etc.

in the treatment of substance use disorders the reader is referred to Chiesa & Serretti's (2014) recent work.

The application of MBIs to the field of substance use disorders is closely associated with the work of Alan Marlatt and colleagues from the University of Washington's Addictive Behaviors Research Center (e.g., Bowen et al., 2009; Bowen, Chawla, & Marlatt, 2010; Witkiewitz et al., 2013a). Marlatt and colleagues developed Mindfulness-Based Relapse Prevention (MBRP) (Bowen, Chawla, & Marlatt, 2010), an outpatient program that integrates skills from cognitive behavioral relapse prevention (RP¹¹) (Marlatt & Gordon, 1985) and MBIs such as MBSR (Kabat-Zinn, 1990) and MBCT (Segal, William & Teasdale, 2002).

MBRP is a protocolled 8-weeks aftercare treatment merging cognitive-behavioral treatment with mindfulness and, in line with other MBIs is designed to foster competent responses to stressful situations and decrease automatic and reactive behaviors (Bowen, Chawla, & Marlatt, 2010). This is achieved through the training of the participants in recognizing both internal (e.g., emotional or cognitive) and external (e.g., situational) cues previously associated with substance use (Bowen et al., 2009, p. 296). Participants are encouraged to develop self-awareness, acceptance and tolerance of cognitive, emotional and physical states, thus decreasing the need to alleviate discomfort through substance taking behaviors (Bowen, Chawla, & Marlatt, 2010).

MBRP offers an alternative stance to the theoretical foundations of mainstream approaches to the treatment of substance use disorders, such as the 12-steps approach (Bayles, 2014; Bowen et al., 2009). The latter, rooted in the disease model of addiction, assumes addiction is derived in the biochemical imbalances

¹¹ RP is a cognitive-behavioral treatment combining skills-training with cognitive interventions to prevent or limit relapse with a focus to high-risks situations. RP has been previously applied for treatment of several types of substance abuse such as amphetamine (Baker, Boggs & Lewin, 2001), cocaine (Schmitz, Stotts, Rhoades & Grabowski, 2001) and marijuana (Stephens, Roffman, & Simpson, 1994).

occurring in the body of the consumers and thus outside of their control (e.g., Goldberg, 1999; 2001; Uusitalo, Salmela & Nikkinen, 2013).

On the contrary, MBRP theoretical foundations, rooted in mindfulness and Buddhist philosophy (Marlatt, 2002), contribute to shape a highly accepting, non judgmental and compassionate approach to the treatment of substance use disorders. Hence, MBRP displays as an harm-reduction measure, which considers relapses as part of the recovery process, contributing to dismiss moralism, shame, idealism, and judgment toward substance consumers, in opposition to the war on drugs, its zero tolerance ideology (e.g., Bayles, 2014; Global Commission on Drug Policy, 2011; 2014; Marlatt, 2002) and consequent treatment methods (Bowen et al., 2009).

3.3. Concluding remarks: filling the research gap

Although mindfulness and MBIs are increasingly evaluated and thus providing growing evidence of their effectiveness, the integration of mindfulness into the field of social work is still at its initial stages (Birnbaum & Birnbaum, 2008; Gockel, Cain, Malove & James, 2013). Furthermore, most of the literature emphasizes the positive influence of mindfulness in the therapeutic relationship but does not exhaustively discuss how mindfulness leads to its positive effects (Birnbaum & Birnbaum, 2008).

The literature explored presents a void between the knowledge we have on theoretical conceptualizations of mindfulness, its benefits and contributions to the therapeutic relationship and how these practically take place. Most of the studies revised are based on epistemological and methodological assumptions which are at odd with the experience-based nature of mindfulness (Gethin, 2011; Grossman & Van Dam, 2011) and do not take into account the socio-political and cultural contexts in which the therapeutic application of mindfulness occurs. Therefore it seems particularly important to open up the discussion including these dimensions in order to approach the phenomenon studied, not as if unfolding in a social vacuum.

Thus, research on MBIs in the treatment of substance use disorders is still relatively unexplored (Bayles, 2014).

Most of the current research on the application of MBIs for the treatment of substance use disorders, such as MBRP, is focusing on evaluating the feasibility and efficacy of these interventions, thus neglecting qualitative inquiries. However, it is worth to mention the work of Cecilia Franke (2014) as an exception at these regards. Within the framework of her master thesis at Linköping University, she conducted a qualitative study exploring the experiences' of participants with substance use disorders after completing MBRP, and the impact it had on their substance use and relapses in a long term perspective. The results of this study display further evidence of the effectiveness of MBRP for the participants' substance use and relapse prevention and for their overall well-being.

4. Thesis structure

The thesis is divided in to two main parts. Part I introduces the methodology, meta-theoretical concerns, methods of inquiry and theoretical references. Methodologically and theoretically, the study is based on Husserlian descriptive phenomenology (e.g., 1970; 1981; 1983), while the method of inquiry, based on Davidson's (2003) descriptive, meaning-oriented phenomenological approach, is open-ended interviews. Furthermore Part I, in line with the context-sensitive phenomenological approach employed, contextualizes the research in its socio-political contexts. It discusses the mainstream understanding of substance use and substance use disorders treatment with particular reference to Sweden, and the plausible alternative stance provided by MBIs' non-judgmental, accepting and compassionate features.

Part II introduces the analysis of the empirical material, composed by five open-ended interviews with practitioners working with mindfulness and MBIs in the field of substance use disorders treatment in Sweden. Part II ends with a short conclusion, where the main findings of the thesis are summarized. Finally it also sketches s few ideas for further research.

Part I

1. Methodology

In this section I aim to provide a comprehensive overview of the underlying assumptions and research procedures informing the thesis' research design. More specifically this section discusses the overall research design, the method used and the theoretical framework of this thesis. According to the employment of a descriptive phenomenological research method, epistemological, methodological and theoretical discussions are intrinsically bound and thus need to be approached simultaneously (Davidson, 2003; Eriksson, 2015).

1.1. Meta-theoretical perspective: a descriptive phenomenological position

In this work meta-theory is understood as the theory of science embraced by the researcher, or in other words as the epistemological standpoint of reference. Despite the apparent focus on a philosophical level, meta-theoretical positions are highly practical considering their fundamental role in guiding each subsequent step of the research design. Considering the meta-theoretical position of this work as emerging within Husserlian descriptive phenomenological philosophy (e.g., Husserl, 1970; 1981; 1983) both data collection and data analysis, will follow descriptive phenomenology in order to achieve scientific rigor (Davidson, 2003; Englander, 2012, p. 15).

Furthermore, descriptive phenomenology is here employed as both the epistemological ground of the thesis and as its methodological and theoretical reference. As underlined by Eriksson (2015, p. 21) even if phenomenology is highly theoretical it is not a theory within an already established theory of science, but it is primarily an epistemology in itself. Hence, when phenomenology is applied as a research method it does not require theoretical engagements besides its unavoidable theoretical grounding in phenomenological philosophy (Davidson, 2003).

The approach used is descriptive as it privileges description over other philosophical alternatives such as interpretation, construction or explanation. Yet

Langdrige (2007; 2008) argues that interpretation is not in opposition with a descriptive phenomenological approach. Following Ricoeur (1981) it could be said that despite Husserlian phenomenology remains the unsurpassable presupposition of hermeneutics, interpretation is intrinsic in any process of understanding, and thus even in Husserlian phenomenology itself. Hence, the phenomenological approach followed in this project aims to remain primarily descriptive, however without neglecting theoretical grounding and interpretation (Davidson, 2003).

The analysis of the empirics gathered has been descriptive, meaning that the empirics stand for their self-evidence (Davidson, 2003; Gallagher & Zahavi, 2012; Giorgi, 2009). As a result in this work interpretation does not occur as a philosophical and methodological choice on how to approach the empirical material, but rather as an unavoidable aspect of any process of understanding (Ricoeur, 1981).

The approach used is phenomenological in that it accounts for the experience of a given phenomenon, as it manifests itself to the consciousness of the experiencer. As Sokolowski (2000, p. 2) states “Phenomenology is the study of human experience and of the ways things present themselves to us in and through such experience”. To quote the words of Amedeo Giorgi, the founder of phenomenological psychology, “It is the experience as experienced that interests phenomenology” (2009, p. 69).

Consequently, within the phenomenological perspective proposed, subjective experiences are considered to be the departing point of any investigation. However, contrary to some reductionist reading, phenomenology is not a solipsistic empiricist project (e.g., Davidson, 2003; Gallagher, 2012; Zahavi, 2001), but one that has highly scientific accountability as its primary concern (Gallagher, 2012). It is not surprising then, given its focus on the structures and components of human experience, that despite the fact that phenomenology starts as a philosophical project with Husserl’s work (e.g., 1970; 1981; 1983) it has developed to both a plausible theoretical framework and as an empirically oriented qualitative methodology for social scientific research (Davidson, 2003).

Yet, even in disciplines such as cognitive science, the contributions of scholars such as Varela, Thompson and Roach (1991) and Thompson (2007) rely on phenomenological philosophy, stressing the need to include first-person inquiries within the framework of Western scientific paradigms if our exploration aims to be sound. For instance, as underlined by Gallagher and Zahavi (2012, p. 28) the dominant approach to our current scientific inquiries it has been so far to understand consciousness mainly as an object in the natural world, and thus subjected to its law of causality. Hence the natural consequence of this vantage point is to study it employing a third-person perspective.

The link between the phenomenological position embraced in this thesis and contemplative traditions such as Buddhism, is that contrary to the dominant Western rationalist approach to knowledge, both phenomenology and Buddhism consider experiences as bodily and thus subjectively inhabited by the experiencer to be the primarily step in the process of knowledge acquisition. This point is of extreme relevance for the discussion at hand, since it addresses the dual root of modern rational thought as deriving from Cartesian metaphysics (e.g., Husserl, 1970; 1981; 1983; Kelly, 2006; Varela, Thompson & Rosch, 1991; Thompson, 2007). Thus within the framework of Cartesian inspired understanding the only knowledge that was assumed to be objective in nature was the knowledge produced by the cognizing subject through the thinking process, relegating the body to the role of useless spectator (Kenny, 2006, 36-40). Yet, as Thompson (2007, p. 14) underlines, once science opens up to first-person, experiential inquiries it cannot avoid employing phenomenological analysis therefore reclaiming the importance of this vantage point in the study of subjectivity and consciousness.

Then, how does a Husserlian descriptive phenomenological perspective translate into practice when doing social scientific research?

2. Method

In this section the method used to collect the empirics, its underlying theoretical references and the process of data collection are discussed.

2.1. A descriptive, meaning-oriented phenomenological method

As emphasized by the phenomenological psychologists Amedeo Giorgi (2009) and Magnus Englander (2012), there is a great deal of literature on how to conduct qualitative interviews; however, there is very limited material on how to conduct interviews from a Husserlian phenomenological, human scientific perspective.

In the literature there are a variety of different phenomenological research methods, such as descriptive phenomenological research methods (e.g., Davidson, 2003; Giorgi, 2009), interpretative phenomenological analysis (IPA) (e.g., Davidsen, 2013), and phenomenological ethnographic methods (e.g., Neergaard et al., 2009). However, after having conducted a pilot interview in early October using Giorgi's (2009) descriptive phenomenological method I decided to employ Davidson's (2003) method. Despite Giorgi's (2009) method, together with the works of sociologists such as Schütz (1967) and Gurwitsch (1979), has the merits to be among the first structured attempts to include phenomenological inquiries in the social sciences, Davidson's (2003) method has been chosen for the following reasons: it is in line with the overall philosophical positioning of this thesis, namely Husserlian phenomenology; it allows the collection of thick first-person descriptions without requiring the time needed for conducting a phenomenological study accounting for Giorgi's phenomenological research method; and it is concerned with the socio-cultural context in which the phenomenon studied takes place, thus being in line with the Global Studies orientation of this thesis.

Other approaches that could have served well the purpose of this work are narrative oriented ones. However Davidson's (2003) method has been chose over others since it offers a context-sensitive, phenomenological inquiry based on the collection of participants' narratives, thus representing a very suitable tool.

With these premises in mind we can now proceed to the discussion of Davidson's (2003) method.

2.1.2. The epoché of objective science

The first step of this method is the "epoché of objective science" meaning the momentary setting aside or the bracketing of our theoretical-scientific assumptions about the objective nature (in natural scientific terms) of the phenomenon investigated (Husserl, 1970, p. 135). This first step allows us to switch the focus from the physical realm to the psychical one, understanding the latter as the locus of experience.

Accounting for an analysis grounded in Husserlian phenomenology (Husserl, 1983), in the natural world, objects are regulated by the law of causality, and are subject to ordered, predictable laws that allow measurement and objectification. Drawing a parallelism with the law of causality we can then claim that in the psychic realm its objects are subject to the law of motivation (Davidson, 2003; Husserl, 1983). In the realm of the psychic, in the life-world or world of everyday life we find subjectivities to be embedded in a network of motivational relationships which allow us to make sense of even seemingly obscure and inaccessible experiences.

The realm of the psychic, or phenomenal realm, contrary to the physic realm, allows to look at the individuals not as relating with their surrounding environment merely on the basis of material nexus of causality but as intrinsically embedded in historical, social and cultural motivational dimensions.

Through the first step of the method, once the realm of concern for the research has been defined and the law of causality momentarily suspended to leave space to the law of motivation, the second step can be introduced, the "phenomenological-psychological reduction" (Husserl, 1970, p. 235).

2.1.3. The phenomenological-psychological reduction

The phenomenological-psychological reduction implies the bracketing or reduction of everything else beside the participant's experience that we aim to access. What are the implications of this, momentarily setting aside everything except our participant's narrative account?

The main implication is that when performing the phenomenological-psychological reduction, rather than attempting to explain our participant's experience, according to the law of causality and its inherent causal explanation model, we establish a new ground of what has to be considered as real. Thus the phenomenological-psychological reduction allows the researcher to set aside her commonsense understanding of reality embracing an understanding of the real based on the acts of experiencing themselves (Davidson, 2003, p.100-101). In other words the researcher is not interested in her own understanding of a specific phenomenon, for instance mindfulness, but on the process of meaning constitution of that specific phenomenon in the experience of the research informants.

Hence, we assist to a further significant shift, from what is traditionally considered as a scientific domain, namely the objects experienced, to the constituting acts of experiencing these objects in consciousness. This shift is what Husserl (1970) named the movement from our everyday "natural attitude" about our relation to a physical world constituted of measurable objects, to the "personal attitude" of human sciences, where contrary to the object themselves, the act of constituting whatever object in consciousness becomes the primarily focus of attention.

In phenomenological terms, thanks to the phenomenological-psychological reduction we set aside the natural attitude and enter the personal attitude, thus attempting to understand our participant's constituting meanings and their structures accounting for their experience of the phenomenon, as lived by the participant (Davidson, 2003, p. 100).

It could be said that the main task of the researcher employing this method is to make explicit those meanings that even if implicit in the participant's narrative,

highly characterize it. How do we practically identify these implicit but highly characterizing aspects and make them emerge from the narratives gathered?

The answer to this question is intrinsically related with the third and final step of Davidson's (2003) method, the transcendental reduction (Husserl, 1970).

2.1.4. The transcendental reduction

Why to bother and involve into the discussion such a controversial concept as the "transcendental"? Is not phenomenology primarily concerned with the worldly unfolding of experiences? And furthermore and most importantly, did not authorities such Giorgi (1970), Merleau-Ponty (2002) and Ricoeur (1966) claim that the transcendental is an exclusive domain of philosophy?

However, Davidson (2003, p. 109) argues that the transcendental reduction is of central concern in conducting research in the social sciences because it allows to account for subjective experiences as arising from a shared world and thus to gain access to someone else's experiences and their meanings.

The phenomenological position proposed throughout this thesis, and on which the method discussed is rooted, claims that each individual is both an embodied being that exists on the ground of a shared world and at the same time the meaning maker of her personal world exactly on the ground of her inhabiting that very same world. Thus, the subjective experiences collected and analyzed by the researcher, in contrast to most other qualitative approaches that on this aspect remain vague and thus subject to criticisms, are not understood as arising from within the highly subjective, close and inaccessible individual's experience. On the contrary, the subjective experiences collected and analyzed are understood as arising from the very same shared world the person inhabits with her fellows human beings.

Now we are ready to tackle the issue pertaining to how we are to gain access to somebody else's experience. Although discussing the transcendental is of higher relevance within philosophical debates, it here serves the purpose of underlining that the transcendental is intersubjective in nature. In fact, the transcendental is the bridge

between a person's experience of something and the experiences of the other. For example, we do not experience this world as our own world, different from the one others experience, but rather as a world that is cohabited by them (Merleau-Ponty, 2002). As underlined by Davidson, "We are always already connected to others by virtue of sharing in an experiential reality larger than ourselves" (2003, p. 116).

Thus, the transcendental reduction allows us to propose an alternative understanding of subjectivity, not as something partial, closed, incidental. It establishes intersubjectivity as the realm where to locate the constitution of the real, that as we have seen, is never merely an individual concern. Thus transcendental intersubjectivity, universally structured as goal-directed emphasizes motivation as the teleological structure of the psychical world (Husserl, 1970; 1989).

Finally after we have recognized the intersubjective nature of even the seemingly most subjective experiences, how are we to uncover the functioning of the law of motivation as it is at play in the experiences of the research participants?

2.1.5. Understanding the informants

The key issue here, in order to uncover the functioning of the law of motivation as it is at play in the experiences of the research participants, is the one of understanding our informants. This is primarily possible thanks to empathy (Davidson, 2003), defined in phenomenological terms as a direct perception of the meanings expressed by the other, as an intentionality directed towards the other's intentionality. As the philosopher Dan Zahavi (2010, p. 291) expresses it:

"Empathy is a basic, irreducible, form of intentionality that is directed towards the experiences of others. It is a question of understanding other experiencing subjects. But this doesn't entail that the other's experience is literally transmitted to us. Rather, it amounts to experiencing, say, the other person's emotion without being in the corresponding emotional state yourself".

Hence the researcher accesses the informant's experience directly, simply being present to the other's expressive unity, defined as the unity between mind and body, or as an embodied mind (Scheler, 1954, pp. 218, 261; Zahavi, 2010, p. 292).

In fact, it is thanks to our ability to readily embrace the other as she is given to us through her expressive unity that we can access, not only what appears (e.g., behaviorist reading), but its underlying lived meanings (e.g., phenomenological reading). Thus the phenomenological notions of empathy and expressive unity are useful conceptual tools in underlying both the empathic understanding occurring between the interviewer and the informants, and the one occurring in the therapeutic encounter, between social workers and clients. However, although there are similarities between the attitude and ability of the interviewer to be fully focused on the unfolding of the interview, and the therapist attention toward her clients, and even considering that interviews may reveal cathartic moments, there is a qualitative difference among the two (Davidson, 2003).

2.2. Final considerations on the method and methodology

Summarizing and simplifying the discussion presented in the previous paragraphs, it could be said that the three main steps of Davidson's (2003) method are in turn: first, defining the field of interest of the researcher, namely social workers' experiences of mindfulness and MBIs in the treatment of substance use disorders; second, accounting exclusively for the social workers' experiences, bracketing one's own preconceptions, judgments and assumptions about the phenomenon investigated and the experience of the informants; third, accessing and understanding social worker's experiences, thanks to our empathic understanding, namely our ability to be present to the other and her expressive unity, thus considering the other's experiences not as an inaccessible individual's experience but as arising from a very specific contextual dimension, which is in turn rooted in the same world we all share.

Furthermore, it is important to stress how the phenomenological approach adopted here is not only able to fruitfully account for the interaction between

researcher and informants, but it is a useful tool in understanding the interactions between social workers and clients. In fact, as we will explore in part II, phenomenology offers itself as an ideal theoretical tool box to investigate the relationship between social workers and clients within the framework of mindfulness and MBIs and the practical unfolding of mindfulness in the treatment of substance use disorders.

Finally the employment of this phenomenological approach allows to explore on empirical basis the relation between Buddhist philosophy and persons-oriented health-care facilities in the treatment of substance use disorders, thus fostering the inclusion of first-person, experience-based perspectives within the Western approach to knowledge production. In fact, considering how the mainstream approach to the study of mindfulness and its clinical application have been criticized for not being theoretically and methodologically sound as it is based on substantially divergent epistemological assumptions (Gethin, 2011; Grossman & Van Dam, 2011), the employment of the phenomenological design proposed, based on first-person, experience-based perspectives allows to investigate the phenomenon from its own vantage point (Varela, Thompson & Rosch, 1991; Thompson, 2007).

However, the main strengths of the approach embraced in this thesis, namely the employment of first-person, experienced-based perspectives and its philosophical and theoretical roots in phenomenology represents also its main limitations. The terminology that phenomenological philosophy provides is on the one hand a useful tool in further mapping the still relatively unexplored field of inquiry of mindfulness, but on the other challenges the reader that is not familiar with this tradition. I believe that the benefits deriving from the choice of this particular research design overcome the limitations that it brings with itself.

2.3. Data Collection and ethical considerations

In order to answer a research question with any qualitative method it is necessary to select participants that have the knowledge the researcher is aiming to access and that

are willing to share it with her. In these regards Davidson's (2003) phenomenological research method is not different.

In accordance with my research question Swedish practitioners employed in the field of substance use disorders' treatment working with MBIs have been contacted. The first informant has been contacted via email, after having found the contact online. Snow-ball sampling has then been employed relying on the informants' professional networks. The choice of interviewing Swedish practitioners was influenced by several factors. Firstly, there is a growing interest in the Swedish health-care landscape concerning the role MBIs (Sundquist et al., 2015), and specifically mindfulness in social work (Hilte, 2014) and substance disorders treatment (Franke, 2014). Secondly, at the moment of my writing I am not aware of any study that specifically focuses on the treatment of substance use disorders with MBIs in the Swedish context accounting for practitioners' experiences. Thirdly, I have a pre-existing knowledge of the Swedish system of treatment of substance consumers, since I have been working on this issue before (Di Placido, forthcoming; Guidi & Di Placido, 2015). Thus I have noticed the contrast between the overall Swedish approach to substance use and substance treatment and the philosophical roots of mindfulness and MBIs.

This pre-existing knowledge is primarily oriented towards a macro and meso levels of analysis, namely on the Swedish welfare system, the organizational structure of public services for treatment of substance consumption, Swedish drug policy and its ideological framework of reference. Consequently, thanks to this understanding of the macro and meso dimensions of the Swedish system of substance disorders treatment, I could easily contextualize the micro level of analysis of this work, namely the social worker-client relationship, within its organizational and institutional frameworks.

From a review of the Swedish landscape of services for substance use disorders treatment performed at the purpose of this thesis it appeared that mainly three types of interventions for substance use disorders are provided in the Swedish

context: 12-steps program, CBT and Acceptance Commitment Therapy (ACT). Only a few facilities in Sweden offer MBIs for the treatment of substance use disorders, although them being an alternative to traditional treatment methods (Bowen et al., 2009) and their underlying ideologies (e.g., Bayles, 2014; Global Commission on Drug Policy, 2011; 2014; Marlatt, 2002).

Considering that very few people work with mindfulness and MBIs in the treatment of substance use disorders in the Swedish context, very limited biographical information is displayed in order to guarantee participants' anonymity. It is enough to state that all the participants at the moment of the interviews were employed in the field of substance use disorders treatment and worked with mindfulness and MBIs among other treatment methods. All the informants have had several years of mindfulness practices such as Yoga and meditation and have received training in MBIs such as MBSR, MBCT and MBRP. Furthermore, all the facilities where they were employed at the moment of the interviews offered MBIs and in particular MBRP for less than a decade.

All the interviews have been performed in English between early February 2015 to April 2015. This research involved 5 informants for a total of 5 interviews, of which one a double interview and one a follow-up interview with an informant already interviewed. The final interview protocol was composed by only three open-ended questions: *How would you describe a good therapeutic relationship? How can mindfulness contribute to a good therapeutic relationship according to your professional experience? Can you give an example from your professional practice of the main advantages of working with MBIs in the treatment of substance use disorders?*

The duration of the interviews varied between a minimum of 49 minutes to a maximum of 68.

Although the interviews were carried out in English neither the participants nor the researcher were English native speakers, and some minor language editing has been done to the interviews in order to facilitate their reading.

To conclude this section a final clarification in line with the method chosen has to be done. I am myself a practitioners of mindfulness, in particular mindfulness meditation and Yoga. My first encounter with these practices is dated a few years back thanks to my mother's encouragement to explore Yoga. Yet it was only subsequently, around one year ago that I developed a daily practice in the attempt to cope with stress, anxiety and depression. In the beginning I primarily relied on a vast array of material available on line and on some of the material employed in this thesis (e.g., Kabat-Zinn, 1990; 2005; Williams, Teasdale, Segal, & Kabat-Zinn, 2007), beside the support of a friend with over a decade of experience of meditation practice. My personal, first-hand experience of the effectiveness of mindfulness and MBIs is very positive.

However, in line with the purpose of this thesis, and according to the second step of the method employed, namely the "phenomenological-psychological reduction" (Husserl, 1970, p. 235), I attempted to suspend my pre-understanding of mindfulness and MBIs, thus merely accounting for practitioners' accounts.

Yet, if as emphasized by Merleau-Ponty (1962) and the later Husserl (1970) a total reduction is never achievable, how to relate with the aspects of our own experience of the phenomenon investigated that we fail to skillfully bracket?

In fact at times I found myself identifying with the informants' narratives although the results of this thesis are not based on my personal experience but on the ones of the practitioners. A solution to this apparent conflict was found in bringing into awareness my assumptions and pre-understanding rather than ignoring them, allowing me to clearly distinguish between my own experience and the informants' ones.

Recognizing how a total reduction is an impossible task, subjective experiences play a major role in defining how a person relates with a particular

phenomenon. In other words, rather than ignoring these personal biographical instances I deliberately brought them into discussion, in a manner that allowed me to see my positioning toward both substance consumption and more specifically mindfulness practices. For instance, accounting for the latter, I posed myself questions such as: what does it mean for me to practice Yoga and meditations? What are the expectations I have toward the informants' narratives? What are the results I expect to find considering my experience with mindful practices?

An honest and mindful recognition of my positioning in relation to the answers to these questions has been in constant dialogue with the empirics gathered in the attempt to clearly distinguish the former from the latter. Hence it is clear how both my own experience and the informants' share an understanding of mindfulness as transcending the boundaries of a mere clinical intervention and regard mindfulness in very positive terms. However, the informants still approached their experiences primarily from the perspective of practitioners working with mindfulness and MBIs, and I approached the encounter with them as a researcher interested in hearing about it. Yet, I am perfectly aware that the engagement with mindfulness that the informants and I share helped to create a bond that facilitated the access to rich narratives that otherwise may not have been reached.

3. Social work in context

As previously underlined, any experience is always arising within a specific cultural, social and political context, and thus is historically grounded. The same is true for the experiences of the informants of this thesis. In these regards it is important to consider the informants and their narratives not as arising in a social vacuum, but as embedded in a very particular socio-political context.

In fact social work theories, practices and methodologies always inhabit and promote certain discourses even when they claim to be ideologically free (Carey & Foster, 2013). For instance, as underlined by Carey and Foster (2013), the role of science, neo-liberalism and professionalism, three different facades of our

Western rationalist stance (Scholte, 2005), highly influence both professional and academic social work.

The next section provides a short overview on two complementary aspects that characterize the overall Swedish discourse on substance use and substance disorders treatment. They are the discussion between disease models and choice models of addiction and on a zero tolerance approach to substance use and treatment. In particular regarding the latter it is argued that MBIs' non-judgmental, accepting and compassionate features display as a plausible alternative stance to substance use disorders treatment, if compared to traditional treatment methods and their underlying ideological reference.

3. 1. Mindfulness and MBIs in the treatment of substance use disorders: an alternative approach?

This section introduces the main accounts of substance use and how they relate to both the Swedish drug policy and social work practice. In order to better understand the therapeutic encounter between clients and social workers in the field of substance use disorders treatment, and thus its implications, it is fundamental to consider the socio-political context in which it takes place.

Substance use can be addressed through the lens of biochemical and neurological perspectives or in psycho-sociological terms. Susanne Uusitalo, Mikko Salmela and Janne Nikkinen (2013) frame such a distinction in terms of disease and choice models of addiction.

In the first case, the disease model of addiction, what is at stake are the biochemical processes that the substances activate in the bodies of the consumers. The consumers are seen as passive, dictated by the substance they need in order to keep a sustainable biochemical balance. This implies the possibility to measure the nature and the quality of the biochemical or neurological processes involved, drawing on a cause-effect understanding (e.g., if one assumes the substance Y the hormone H is produced and in the long run the production of another hormone X is

inhibited, leading to dependency, mood switches, etc.), confining the problem to the individuals and to the substances themselves. A causally reductionist idea is then enforced, where addiction is depicted as a chronic medical illness (Uusitalo, Salmela & Nikkinen, 2013, p. 35).

The disease model of addiction still dominates many national policies and treatment methods (Global Commission on Drug Policy, 2011;2014) and in line with this model, the mainstream attitude towards substance use and substance users is to understand the first as a cause of biochemical changes in the body structure of the second. If we account for this “medical” perspective, the individuals are seen just as somebody to fix, since not functioning correctly anymore because of biochemical imbalances induced by the substances. Here the individuals lose their status as conscious subjects, able to choose if to use or abuse substances and thus they are seen as mere objects, passively influenced by the biochemical changes in their body.

This model and its practical implications are based on a certain political, ideological and methodological¹² assumptions: that the production, sale, possession and consumption of illegal substances should be criminalized (Global Commission on Drug Policy, 2014). Consequently substance use disorders have to be faced by (a) the attempt to reestablish the normal biomedical and neurological balance through medications and (b) preventing access to narcotics (Goldberg, 2001, p. 1299).

Accounting for the second perspective, namely the choice models of addiction, substance consumption appears to be a more complex phenomenon, arising from the interplay between individual and socio-environmental factors. However, accounting for a psycho-sociological understanding does not mean to deny the valuable contribution of biomedical and neurological accounts, as Susanne Uusitalo and colleagues (2013) clearly argue.

However, the major implication of the choice models of addiction for the social work relationship is to switch the attention from the substance and its

¹² In the sense of which treatment methods are implemented and how.

consumption to the person and her lived meanings. It rests on the assumption that in order to understand the meanings of substance taking within a certain historical and biographical context, and to facilitate its cessations through the most suitable treatment methods, social workers have to primarily listen to their clients' narratives and life experiences.

This shift of perspective is particularly important considering how social work practices inhabit and promote certain discourses (Carey & Foster, 2013). In fact social work theories, methodologies and practices even when claimed to be ideologically neutral are situated and arise from a very particular discourse, understood as self-referential body of knowledge which aims to legitimize its propositions on the assumption of their truthfulness (Foucault, 2000).

The Global Commission on Drug Policy¹³, a forum of internationally recognized experts in the field, which aims at increasing awareness about alternative approaches to mainstream drug policy and consequent treatment methods, offers a valuable contribution to the discussion at hand.

As underlined by the Commission "...many countries [among which figures Sweden] still react to people dependent on drugs with punishment and stigmatization. In reality, drug dependence is a complex health condition that has a mixture of causes – social, psychological and physical (including, for example, harsh living conditions, or a history of personal trauma or emotional problems)" (2011, p. 6).

As further underlined by the Commission (2014, p. 11), substance use is not necessary problematic. In fact, as the data provided by United Nations Office on Drugs and Crime (UNODC¹⁴) (2013), show only 10 per cent of people who use illegal substances globally are considered to be problematic users. Thus, the greatest

¹³ For a detailed overview see <http://www.globalcommissionondrugs.org/about/>.

¹⁴ The UNODC defines 'problem drug users' as 'those with drug use disorders or dependence'. UNODC (2013, p.) retrieved in www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf Accessed 16.04.15

part of substance users do not use substances in a problematic way, despite the fact that drug policy and treatment methods are based on a narrative on illegal substances as a major threat for society.

This seems to be very much the case in the Swedish context (e.g., Edman, 2013; Edman, 2013a; Ekendahl, 2012). In fact the Swedish model has been used as an example by supporters of zero tolerance policy for it unequivocally stands for a drug-free society (e.g., Hallam, 2010; Ministry of Health and Social Affairs 2011; UNODC, 2006).

As previously mentioned stigmatization and punishment towards consumers are among the most damaging consequences of zero tolerance approaches (Global Commission on Drug Policy, 2011, p. 6). Such a focus on consumers has practical repercussions on the treatment methods employed (Global Commission on Drug Policy, 2014). With specific reference to Sweden it brings about the enforcement of abstinence upon the recalcitrant consumers rather than promoting harm-reduction measures specifically aimed at the management of the consequences of the use.

Swedish drug policy is historically constructed within the framework of a zero tolerance ideology (e.g., Edman, 2013; Edman & Stenius, 2014; Ekendahl, 2012) thus being prohibiting in character and further fostering the implementation of coercive treatments, within a paternalistic approach (e.g., Hallam, 2010; Edman & Stenius, 2014; Moore, Fraser, Törrönen & Eriksson Tinghög, 2015). Yet such a stance it is not considered in punitive terms by its advocates, but as underlined by Hallam "...rather as providing protection, assistance and support..." (2010, p. 3).

Furthermore, as underlined by previous research (Ekendahl, 2012), even when the general zero tolerance stance is enlarged to embrace harm-reduction measures, it is done according to a very restrictive vision of harm reduction measures, substantially based on methadone or buprenorphine treatments as in the case of heroin treatment. Hence the harm-reduction measures employed in the Swedish context, mainly based on medication, contribute to reproduce an understanding of substance consumption in line with the disease model of addiction, which as we have

discussed, stands for a limited understanding of substance users and their life situations.

MBIs, and in particular MBPR, figure as harm-reduction measures that in line with the overall recommendations of the Global Commission on Drug Policy (2014) are not so much oriented toward avoiding consumption and treatment with medication, but on ameliorate the lives of the consumers (Bayles, 2014). Hence, contrary to mainstream interventions, within the framework of MBRP relapses are considered not as failures but as parts of the recovery process, contributing to dismiss moralism, shame, idealism, and judgment towards substance consumers standing thus in opposition with the war on drugs and its zero tolerance ideology (e.g., Bayles, 2014; Global Commission on Drug Policy, 2011; 2014; Marlatt, 2002).

Part II of this thesis will thus attempt, among the rest, to underline the plausible role of mindfulness and MBIs in providing a practical alternative stance to the treatment of substance consumers and their underlying ideological reference.

Part II

1. Analysis and discussion

This part of the thesis presents the empirics gathered, my analysis and discussion. The empirics are systematized accounting for the recurrent themes emerged in the participant's narratives as suggested by Davidson's (2003) method. Furthermore, the empirics are discussed in relation to the conceptual tools and the issues presented in Part I of the thesis. In other words the three tensions identified and summarized in table 1 (p. 8) will be explored in the light of the empirical material. Part II ends with presenting the conclusions drawn from this work and suggesting a few plausible directions for future research.

1.1. Mindfulness at work: bridging the gap between theory and practice

According to the current state of research on mindfulness and in particular on its application in the social work field, mindfulness is shown to contribute in a variety of ways to the improvement of the therapeutic work (e.g., Brenner, 2009; Hilde, 2014; Wong, 2013). However, there is a lack of research regarding how this advantages practically takes place (Birnbaum & Birnbaum, 2008; Gockel, et al., 2013).

Thus this section attempts to fill this research gap relying on the analysis of the narratives gathered, answering to the following questions: how is the therapeutic relationship understood and characterized in a mindfulness based intervention? How can mindfulness contribute to the creation, development and cultivation of the therapeutic relationships?

Let me start with a short presentation on how the informants perceive and describe a good therapeutic relationship.

it is based on trust, that both parts feel that they can trust each other and that they can tell staff that is difficult of course...Here I can feel always that they come back, that they call me, even if they have taken a relapse, they call me, they want to come back, they are not afraid, or maybe they are afraid and ashamed but they still come and want to try. For me this is the relationship that is good (interview 2).

it is about caring a lot, that we are all humans...So that's about being human, so we share a lot with the emphasis on the client of course (interview 1).

A good therapeutic relationship. My ground thinking about this is that when I meet a client we are two sciences who meet together. Because I know the theories and the methods...but the client I meet he is the professional of his life. And this is my ground thinking, that I can't tell you what to do because I don't know how you are or what you are. And you have to have a relationship. It's the most important thing in

the therapy of all. [The relationship] takes out all theories...you have to validate your clients, you have to see them, you have to respect them (interview 5).

From the narratives gathered there emerges a certain continuity of contents, namely the centrality of the relationship with the clients. This may be framed in terms of trust, as in the case of the first fragment; in terms of the common human ground shared by the therapist and the client, as in the second narrative; and finally in terms of autonomy and expertise of the clients over their own lives, as in the third case. In more recent years the therapeutic relationship has been addressed as the most transformative aspect of the therapeutic process, thus transcending clinicians' orientations and treatment methods (e.g., Giorgi, 2005; Howe 2008, Turner, 2009).

How is the employment of mindfulness of use in the process of building a trustful relationship, that transcends the therapist-client roles and foster the client's will?

The informants in the following fragments describe how, thanks to the inhabiting of central mindfulness features such as acceptance, non-judgment and compassion the therapist is able to competently work with her own emotional-cognitive world in a manner that prevents burn out and work related stress, to foster the establishment of a solid ground with the client. These findings are in line with a broad range of studies that specifically underline how mindfulness may help social work students and practitioners to consciously embrace their own emotional and cognitive experiences, favoring the ability to be present in the experiences of their clients in turn and prevent work related stress (e.g., Gockel, et al., 2013; Hilte, 2014; Wong, 2013).

But in my daily work it makes me more calm when I am in a session and more aware of what is going on and more focused. But of course I have days when I can do a lots of Yoga and nothing of this will happen (informant laughs) to me, because it is a shitty day or something. So for me it's just a way of being with myself. I mean we

work with people that have very difficult situations in life and I have family and kids and I have to be there for them too and I need it [mindfulness] to like rest myself from what I experience here and when I come home and the other side around too, with conflicts and stuff going on with kids and just, ok this there, and this is now. So for me it is more a way of treating myself, of taking care of myself in this work I am doing with people (interview 2).

Such an awareness of one's cognitive and emotional world may also be what allows the therapists to avoid interpretations and judgments toward their own cognitive and emotional world and the client's experiences. Thus the concept of phenomenological-psychological reduction (Husserl, 1970, p. 235) discussed in Part I is a useful tool in theorizing what the participants describe as gaining awareness, which in fact entails an open attitude, freed from interpretation and judgment. Let us turn to the therapist narrative in what follows.

It's really important for me to observe my reactions. For all therapists in some way. Because it affects the relationships with the clients...so then I have to know my thoughts here and be aware of them and not judging and doing interpretations.

Interviewer: *So we have to put, do you mean to fully understand the clients you have to put aside your judgments and interpretations and see what is for the client like?*

Informant: *I can't get rid of them. But just to know that they are there, because there is, always, always. So. Just to be aware (interview 4).*

As explored in Part I discussing the phenomenological-psychological reduction, a total reduction is never possible (Merleau-Ponty, 1962; Husserl, 1970). What is possible is to bring into awareness our pre-assumptions, judgments and expectations. This process is substantially the same for the researcher in relation to her informants and the phenomenon studied as noticed discussing the method, and for

the therapists in relation to the clients and their own emotional and cognitive life, as the empirics confirm.

However, can we identify other ways besides the fostering of practitioners' awareness, in which mindfulness unfolds within the therapeutic relationship?

Analyzing the following fragment in phenomenological terms, it could be said that the grounding in the present was obtained due to joint mindful exercises, which helps to highlight the shift from the natural attitude to the personal attitude (Husserl, 1970), emphasizing how clients and practitioners gain access to each other's phenomenal realms, or in other words how they can be present to each others' experiences.

Interviewer: *I would like to ask you if you could recall an example from your professional practice on how mindfulness contributed to this therapeutic relationship let say?*

Informant: *I don't know if I can pin point something, but it's more then when I do interventions that are mindful, if you do an exercise, like a body scan or whatever, when I do it with clients we do this exercise and afterword we are much closer together, and we are much more genuine, both of us...So this I can notice, even if in the beginning I can feel like, oh maybe not this client, this won't work, I mean almost always [mindfulness] adds this, not relax maybe but more here sense of, this here sensation and more genuine. And also that I am here, I am doing the same. It is not that I am doing this stuff to you and you are sitting there and something happens to you. So, and this I notice almost every time I do a [mindfulness] exercise with someone. That we become closer and it is easier to talk (interview 2).*

Thus the therapeutic involvement of mindfulness fosters the encounter between client and practitioner thanks to the shared commitment arising out of practicing mindfulness together.

The same informant further underlines that even though not all the clients always engage in all the mindfulness exercises that the MBRP manual suggests, they still gain a new perspective over their life and over themselves. Again, this is in line with the current literature on mindfulness where with time and practice, an attitudinal shift in the life of its practitioners is recognized to occur (e.g., Bowen, Chawla, & Marlatt, 2010; Kabat-Zinn, 1990; Witkiewitz et al., 2013b). This may signify, as in the case of the social work clients, being able to relate to the source of their distress, being it addiction, anxiety or anything else, with a renewed, more open attitude.

...we are always so surprised that even though they are hardly doing their homework, hardly practicing these exercise, almost just practicing when they are meeting us once a week, it still makes a huge difference for them! And that it makes a difference in the long run somehow. It is not just that here and now they stop to take drugs or whatever, it's also this way of thinking of themselves that I feel they really need to be able to do the change and keep the change somehow. So, when I do exercise with people and I feel they understand in a deeper level, somehow, that's what I think is one of the main things about it.

Framing the analysis relying on Husserl's (1970) distinction between the natural attitude and the personal attitude emphasizes how mindfulness' practitioners, whether they are clients or therapists, thanks to the observational stance and the suspension of judgment required by mindfulness exercises as included in MBIs (e.g., Bowen, Chawla, & Marlatt, 2010; Kabat-Zinn, 1990; Segal, Williams & Teasdale, 2002) gain access to their phenomenal realm, understood as the realm of experience as experienced, in a renewed manner. When one is able to access one's own experience in a more open, non-judgmental and direct manner, the chance to recognize reactive and automatic tendencies and substitute them with skillful responses is then made available to the person.

Moreover, there is a further contribution that mindfulness and MBIs seem to add to the work with substance users, especially if compared with treatment as usual. The inclusion of mindfulness seems to help to foster the ability of the clients to stay with the source of their distress, just observing it, as also previously pointed out by some (e.g., Bowen, Chawla, & Marlatt, 2010; Kabat-Zinn, 1990; Segal, Williams & Teasdale, 2002).

We teach other practitioners RP and what I see is the problem with this stance is somehow that you always talk about what you should do...Super good thing, but the problems that they are not focusing on is the stopping! To stop and stay there! That's the biggest quest somehow. And I think mindfulness is just working on that spot a lot! To just stop and stay and then anything can happen afterword, or around them or whatever but it's just this... so I think this mindfulness for RP is really about this point of stopping, or even if you are working with aggression or something, some feelings or sensation or emotion that is really strong that you need to catch in the movement, ok how you do it? It does not help me if I know I am a good problem solver over here, I need it now! And how do I do this? So I feel mindfulness works really good and with this compassion, that it's ok feeling angry or upset or bad about yourself, that you didn't stop earlier, whatever. This is the main thing for me at least (interview 2).

In summary, the main contribution of mindfulness and MBI in the therapeutic relationship and in the treatment of substance use disorders that emerged in this section regards both the establishment and development of a stronger therapeutic alliance and a substantially different approach to one's own experience in general and source of distress in particular. Furthermore, the phenomenological reading proposed attempts to catch these points as they unfold in the clinical practice and contrary to the mainstream study of mindfulness it provides conceptual tools attuned on first-person, experience-based inquiries. Thus the phenomenological approach proposed

not only contributes to fill the research gap previously underlined but provides an alternative methodology for the study of mindfulness in its clinical applications.

1.2. Another way of knowing: bodies back in business

Bringing into the discussion the body is as an unavoidable part of this thesis. In this section it will be shown and discussed how one of the main contributions of mindfulness and MBIs in the treatment of substance use disorders in the Swedish context is related to the role of the body as the main tool to understand oneself. Thus, the tension previously identified between first-person, experience-based perspectives found in Buddhism and phenomenology, and third-person perspectives, characterizing our traditional Western take on knowledge, is in fact a fruitful platform in which to contextualize the discussion at hand.

However, let me start by introducing a fragment in which the participant states that when she integrates mindfulness in her therapeutic practice the clients seem to gain a deeper understanding of their life situations, an understanding that is not merely cognitive. Thus the clients are making sense of their situations in an experienced based manner, where the body, as much as the mind, is the place where life unfolds. From this vantage point the bodies of the clients are primarily psychological bodies, where their emotional and cognitive world manifest and can be accessed. In other words, the body, besides entering within the domain of the therapeutic encounter as an unavoidable tool, becomes the primary medium through which knowledge can be accessed.

It is more a sensation that they understand with everything in their body. Not just their head. And this almost always comes the time afterword, when I see them next time. So I always ask, did you see any, did anything follow you during the week from the things we talked about? They say, yeah, this thing, is just settling in the body. So sometimes I feel like in therapy you can talk the stuff, and it's not really working, so instead of talking just doing it, makes it, they internalize it in another

way that makes it more, more potent, quicker, more real for them somehow, and then that it connects with something that they understand from themselves...And I am always surprised. Shouldn't he, like explain what happened or something? But it is not necessary. It's there (informant laughs)(interview 2).

Thus, according to the practitioner, an experienced-based, first-person perspective provides the clients with a direct and effective way to face the challenges they undergo, which is reported in the literature as well (e.g., Bowen, Chawla, & Marlatt, 2010; Kabat-Zinn, 1990; Witkiewitz et al., 2013b). An example of how mindfulness is practically employed in the process of bringing clients' bodies within their field of awareness, is provided by an informant in the next fragment:

... when they are going to the wood and first they do a breathing exercise, can you feel your body, can you feel what's happening? And now we are going to train in the wood, when you walk in the wood, what do you feel under the ground? How is the ground? What do you hear? What do you smell? What do you see? And try to stay in that place and they walk and then H and Z ask them a few questions again, and the clients feel that it helped, it's nice. And H and Z can see the difference before they went out in the wood and when they come back. (interview 5).

Here the informant unveils the importance of deliberately directing attention towards their perceptive sensory experiences in an open and non-judgmental manner, in order to break the ruminative cycles that are causing the clients' distress. Such a role of mindfulness' experienced-based, first-person perspective in breaking ruminative cycles is supported by the findings of current research on the neurological mechanisms of mindfulness (e.g., Hölzel et al., 2011; Shapiro, et al., 2006; Witkiewitz, Lustyk & Bowen, 2013), by leading evidence-based clinical research (e.g., Baer, 2011; Bowen & Enkema, 2014; Witkiewitz et al., 2013a), and finally by

the main MBIs manuals (e.g., Bowen, Chawla, & Marlatt, 2010; Kabat-Zinn, 1990; Segal, William & Teasdale, 2002).

However, such a focus on an experienced-based, first-person perspective is not merely of concern for the clients. It is also helpful for the therapists themselves. As the informant underlines, when training other social workers in RP she manages to transcend the mere cognitive components of this method including some mindfulness in her teachings. As a result of the integration of mindfulness she teaches other practitioners to assume the observational stance that characterizes this approach.

Yes. So RP, that's a good example...So when I do that I use the body more. So I can do like a small meditation but I don't call it meditation, just to feel like what's good about being sober, just to get them from the head down to their body and heart, because it's very important. But usually when you work with RP many group leaders, they are afraid to talk about the body. And of course because they don't have the experience themselves with mindfulness perhaps, but I think it is an important link. And during training me and X are doing more mindfulness, but it's really a RP training, but we use mindfulness like staying when they [the therapists] feel uncomfortable and the client is not ready to change anything but they [the therapists] want to hurry and find the solution to this. So we use mindfulness just to stop and observe their own thoughts (Interview 4).

Thus the inclusion of mindfulness in regular RP training supports the therapists in gaining the ability to face the unease intrinsic in certain therapeutic encounters, when the clients do not seem to gain much out of the intervention. As underlined by Bayles (2014) there are growing evidences of the positive impact that mindfulness has in therapeutic protocols such as CBT and RP. Moreover, the informant provides a short example on how she attempts to guide the social workers attending the training to gain a growing awareness of their bodies.

...one of the participants was really talking, really wanted to know in theoretical way about RP. Why, tell me what to do. So I just said we will get back to that but for now can I ask you what it feels like? Well, I am really confused. Where do you feel this confusion? And she was really, what a strange question. But she could feel it here [the informant pinpoints her chest]. So just as an example what we can do in a group...to use the body instead of trying to explain and know everything (interview 4).

Hence, working with mindfulness provides a new way of accessing experiences, thanks to the observational stance towards one's own experiential field, being it cognitive, emotional or perceptual. In fact, as emerges in the following fragment the mindful practitioner seems to struggle less in order to understand her clients and thus manages to be fully present to the other.

...still I know in a group when someone is really restless, really struggling. They don't have to say, but still I know...So sitting with clients, sometimes I feel what they feel. So I think that's [something] everybody can do it, but you need to notice it and practice it...So it is asking in a very intuitive way. So it's really fascinating...when I need the information or knowledge, it comes to me (interview 4).

What at a first reading may be regarded as a mystical perspective toward understanding the other, in reality addresses a central capacity of humans, which is our ability for empathy. Such an ability allows the practitioners to fully understand her clients just being present to their expressive unity (Scheler, 1954, pp. 218, 261; Zahavi, 2010, p. 292) and it is thanks to this ability to readily embrace the other as she is given to us through her expressive unity that the therapist can access, not only what appears, but its underlying lived meanings (Englander, 2014).

In this section the link between the phenomenological position embraced in this thesis and contemplative traditions such as Buddhism emerges, especially in

relation to their take on the body. In fact, contrary to the dominant western rationalist approach to knowledge, they both consider experiences as bodily and thus subjectively inhabited by the experiencer to be the primarily step in the process of knowledge acquisition.

Such an experience-based, first-person perspective has been also proven by previous studies to provide effective treatment when working with substance users (Bowen, Chawla, & Marlatt, 2010) and further allows to reflectively detect mindfulness at work as one's awareness is increasingly the stable object of one's attention.

1.3. They say I don't judge them

It has been argued that one of the main contributions of mindfulness and MBIs in the treatment of substance use disorders in the Swedish context is the compassionate, accepting and non-judgmental character of these interventions. Thus, the second tension identified in this thesis, between mainstream judging and stigmatizing approaches to substance use and substance disorders treatment and accepting and non-judgmental approaches informed by mindfulness is tackled in this section.

Features such as compassion, acceptance and non-judgment seem to be particularly important considering the overall approach to substance use and substance use disorders treatment characteristic of the Swedish context, and thus of extreme relevance when working with substance users. In fact this specific group typically suffer from social and institutional stigma, prejudice and judgment as underlined by the Global Commission on Drug Policy (2011; 2014). As an informant states, “... *non judging is essential for working with these kind of people*” (interview 1).

For instance relying on the following exchange between the participant and the interviewer the compassionate, accepting and non-judgmental nature of mindfulness is detected at work within the context of the clinical encounter. According to the informant such features differentiate between her work as therapist

and the work of other practitioners, and this seems to be confirmed by the clients feedback.

...for me mindfulness is also this compassion thing flowing under everything, that makes a difference when I meet clients, from maybe other therapist...This is also the feedback I get from clients. I feel you are working for me, you are there for me. I mean, I guess everyone gets it but I sometimes I connect it with this compassionate, ok you felt bad, and that's the way you felt so, this non-judgmental style...

The reader may wonder how this compassionate, accepting and non-judgmental approach is practically unfolding in the encounter with the clients. In the following the interviewer attempts to access exactly this dimension:

Interviewer: So how would be a typical exchange with a client? Let say I am a client and I am telling you something related to my drug use, how would you respond to me? When you are working, how does this [compassionate, accepting and non-judging style]in practice happen let say? How it goes in your words, in your way...

Participant: ... I would just hear you out of course, and then, this is what we do all the time in therapeutic work, validate you but at the same time bringing up the stuff that is coming to you. When you are telling me something difficult, for instance I can't deal with my anxiety. So ok, you feel anxiety is a problem for you, ok you have a feeling that you have difficulties in dealing with anxiety. I make it more like, ok, here are you and there is your anxiety, but you are not the same. So trying to have this, this non-judgmental style, can sometimes sounds quite harsh, because it is like, oh you have a drug problem so! But it is not this way because you have this compassion going on that I can't explain. So that's what I am aware of, trying to make the separation somehow, ok that you are here, you are telling me that this is your problem (interview 2).

The informant primarily stresses the importance to be present to the client and her experience. Such a reading is in line with the phenomenological discussion presented in Part I, where the concepts of empathy and expressive unity (Scheler, 1954, pp. 218, 261; Zahavi, 2010, p. 292) underlines how a deliberate, open and non-judgmental attention toward the other allows us to fully understand and empathize with them.

Furthermore, in the previous fragment it emerges how once the perceived problem is detected, the therapist needs to underline how the problem is not the person herself. In fact as underlined by MBIs manuals the consequence intrinsic in realizing that one is not the problem that troubles her or him has a transformative impact (e.g., Bowen, Chawla, & Marlatt, 2010; Kabat-Zinn, 1990; Segal, William & Teasdale, 2002). Regularly inhabiting a space of non doing, of deliberate and non-judgmental awareness of the present moment has in fact profound transformative and healing implications (Kabat-Zinn, 2005), meaning not that all our problems will disappear but that our relationship to these problems will drastically change.

How are the clients understanding the therapists' suggestion to not identify themselves with their problem?

Interviewer: *And the clients get that? For me it is easier to understand because I am into this as well, but does the client get you?*

Participant: *I think in the beginning they don't notice it. They are not aware of that they are noticing it. But as it stays around, as I keep on meeting someone then I start to address when they talked bad about themselves, so you have a self value there, that you are biting up yourself, how does that feel and make you feel? That they start learning this way of talking...So I think they learn while being in the sessions. If I feel that they in the beginning find it odd the way I talk, then I talk about it. That I am trying to make this, if you told yourself that you are this problem, it is a difference between being the problem or having the problem. So, but usually I don't talk about*

it, it feels like it is something they learn about, how this goes on. But it is very different from person to person of course (interview 2).

It is hence suggested that because of the mindfulness exercises and the guidance of the therapist the clients naturally gain an observational stance toward their problems. This is in line with the MBRP manual (Bowen, Chawla, & Marlatt, 2010) that underlines that the main task of MBIs is to gain a space of observation for the client over their own emotional and cognitive world, thus learning to competently relate to them with acceptance and non-judgment. The next fragment further explores the issue at hand:

You just need to be in an observing state, that's ok, and that's what I am trying to, actually that's the only goal I have with my clients. Just to observe, they don't have to do anything else but observe what happens, the thoughts and emotions. So that's also compassion. Because you don't have to do step 1, step 2, step 3 and be blissful and loving...Because something happens when you observe...And also compassion with just letting things come to you without an effort, also in meditation, not to be lazy and fall asleep of course, but to, just sit, that's all you have to do, just to sit. But I think that also is compassion: that you are ok just the way you are, also in meditation practice and also when I ask questions afterward they don't have to say anything. If they think it's hard to remember what happened so I just ask, how do you feel right now? What do you notice in your body or thoughts right now in this second? So just trying to help them, they don't have to achieve anything, they don't have to be good. It's just the way it is (interview 2).

As underlined by Bayles in his review of the current literature on mindfulness application in the treatment of substance use disorders (2014) the accepting and non-judging features of mindfulness and MBIs allow us to promote a stronger alliance with clients and thus further support behavioral goals and commitment.

Paradoxically, the therapist's requirement of just observing seems to promote the client's engagement in their own healing process. In fact, as several studies have pointed out (e.g., Bowen et al., 2009; Kelly, Stout & Slaymaker, 2012; Witkiewitz et al., 2013a), MBRP displays a dropout rate sensitively inferior to treatment as usual, such as the 12-steps approach, where the clients are required to commit to the accomplishing of certain established goals, such as total abstinence by the end of the treatment (Bayles, 2014).

Then considering the contextualization of traditional treatment methods within the framework of a disease model of addiction and zero tolerance ideology, as we discussed in the final section of Part I, it is not surprising that clients are reported to experience a sense of relief when meeting with therapists that work with mindfulness and MBIs.

A new client a month ago told me, the first time he met me, you don't judge me! He was really surprised. And for me it's more like, well why should I? But for him, he really meant it. I just told you, I took a very big relapse and people are suffering and you don't judge me. You are really in the right place, he told me, working as a therapist (interview 1).

As mentioned earlier, in contrast to mainstream treatment methods, MBRP does not consider relapses as a failure, but as consistent part of the treatment process (e.g., Bayles, 2014; Bowen, Chawla & Marlatt, 2010; Marlatt, 2002).

Moreover, the same informant further stresses how cultivating a compassionate attitude supports the coping with the distress intrinsic in working with vulnerable people, and thus accepting their suffering without being automatically overwhelmed by it.

I remember before I started with more daily meditation I was more perhaps worried about the clients. And if they took a relapse I had more of a though like, Oh

no! Did he have to? But now it is not that I don't care, but, it is like (T laughs) it is hard to explain. When you explain it sounds like coldness...(interviewer 1).

In fact, despite the challenges in trying to define what compassion is the trust that emerges from the cultivation of an open, non-judging and compassionate attitude seems central in the informant's narratives.

It is really hard to explain compassion, but it is when I use my heart instead of my mind. So I can still see their suffering, if they really need a hug I give them an hug, when they go, but I trust that they can manage, fully. So it is quite good also for us to work with it. Because you don't have to bring it [the work] home. I can think about a client sometimes but I know they manage. They are on a journey. Somehow I trust that they will get there, where they want go, anytime, in a year or next week (interview 1).

In the fragment presented the informant clearly states how compassion helps to equip the therapist with a sense of trust toward her clients and their ability to manage their problems. Such a stance implies an understanding of the clients as already fully able to account for their life contrary to the main underpinnings of the disease model of addiction. In this sense the therapists seem to embrace a perspective that is closer to the choice model of addiction than to the disease model and thus in line with a harm-reduction approach to substance treatment (Bayles, 2014).

Among the main implications of such a vantage point is that treatment is not considered as compulsory and thus is not implemented in a coercive manner (Bayles, 2014). This opposes the paternalistic approach to drug treatment that characterizes the Swedish context (e.g., Hallam, 2010; Edman & Stenius, 2014; Moore, Fraser, Törrönen & Eriksson Tinghög, 2015) and its underlying zero tolerance ideology (e.g., Edman, 2013; Edman & Stenius, 2014; Ekendhal, 2012). Secondly, in line with the

choice model of addiction users are considered active agents able to decide if use or not use substances and are the sole responsible for their lives and healing.

Furthermore, the compassionate, non-judging and accepting features of mindfulness are both central components of mindfulness as systematized in its original sources and in its application in the therapeutic encounter. Thus the implementation of mindfulness and MBIs in the treatment of substance use disorders in the Swedish context may offer a substantially different take on substance use and substance disorder treatments if compared to treatments as usual and their underlying reference to zero tolerance ideology (e.g., Bayles, 2014; Bowen et al., 2009; Marlatt, 2002).

The therapist's ability to embody and promote acceptance, non-judgment and compassion into the therapeutic encounter with the clients could be considered as a translation of the Dharma¹⁵ in the therapeutic context as underlined by some authors (Bodhi, 2011; Feldman & Kuyken, 2011; Kabatt-Zinn, 2011). Thus, inclusion of mindfulness and MBI in Western clinical settings, and in particular in the treatment of substance use disorders in the Swedish context is substantially in line with the philosophical roots of mindfulness, whose overall aim is the reduction of suffering (e.g., Kabat-Zinn, 2011; Marlatt, 2002; Teasdale & Chaskalson, 2011a; 2011b).

As an informant underlines:

Mindfulness is a lot about being present but also a big portion of it is kindness. We don't talk about it that much, it's just about moment to moment and being present, but kindness is very important, because you can be present without kindness of course (interview 1).

¹⁵ The terms signifies in this context the teaching of the Buddha.

1.4. Mindfulness: therapeutic tool or a way of being?

As we have noticed in Part I and in the previous analysis, mindfulness and MBIs are both an effective and an alternative approach to substance use disorders treatment. However, considering their roots in Buddhist philosophy, it is important to explore if and how mindfulness and MBIs, as employed in the Swedish landscape of substance use disorders treatment, are merely another therapeutic tool or maintain the foundational features that mindfulness has within its original sources.

In the following the analysis and discussion of the informants' narratives attempts to clarify this point. From a careful reading of the empirics gathered, it emerges that mindfulness is perceived by the informants as both an effective therapeutic tool and as fostering a substantially different way of being. This way of being displays an alternative to the doing mode and its automatisms (Kabat-Zinn, 1990; Williams et al., 2007). Thus a picture of mindfulness as transcending its role as a mere therapeutic tool emerges as a central theme in several narratives.

The following extract is a good example of the informants' take on mindfulness, which is considered as both a therapeutic tool and a way of living.

It gives you a chance to widen it up...But quite a few [clients] come here, and if I ask them, what do you want from this group? Well, I want to be sober, I want to have a better relation with my wife and so on. Yeah, and then what do you really want? What are you really longing for? Then comes like this, well I'm not really, I don't really like the way I am living and there is something missing and I am longing for something else...but [mindfulness] it gives you, it's a double chance that is quite extraordinary compared to a lot of other things we can give them (interview 3).

According to the informant MBIs display as a double chance for the participants. On the one hand MBIs are considered as a therapeutic tool, able to help the participants to deal with their problematic conditions, and on the other hand they offer the chance to further explore on a deeper level the possibility of transformative

life's changes. As the same informant further stresses, even though the focus of MBRP is to maintain sobriety and prevent relapses the transformative impact of this approach, given its roots in mindfulness and its underlying philosophy, are profound and pervade every aspect of its practitioners' life, such as eating, speaking with others and being a parent among the rest.

This is more like, I do this to maintain sober, you don't want a relapse in your all life, but mindfulness is very much how you eat, how you talk with the other person, how you handle your children, so I think, the side effects could be very positive and profound (interview 3).

However there are growing concerns, especially from Buddhist scholars regarding the plausible inclusion of mindfulness in clinical practice. These concerns arise from the fear that mindfulness as conceptualized in its modern application struggles to account for the complexities and nuances of its conceptualization in the original sources (e.g., Bodhi, 2011; Dreyfus, 2011; Gethin, 2011). There are many voices that support the integration of mindfulness in clinical practice, underlying how the overall aims of both mindfulness as originally conceptualized and therapeutic practices is the reduction of suffering (e.g., Kabat-Zinn, 2011; Marlatt, 2002; Teasdale & Chaskalson, 2011a; 2011b).

Is there a conflict between mindfulness as a therapeutic tool on the one hand and its being a philosophy of life on the other? The following fragment exemplifies the informants take on this issue, emphasizing that the therapists need to be aware of the double role of mindfulness, as both a philosophy of life, as conceptualized in the Buddhist sources, and as a therapeutic tool.

I had and I have still some problems because for me of course it's [mindfulness] more religious, and as my client said it's something more, what did he say? Magical and holy and stuff...So here I have to keep track that I am like, keeping

it in the limits, saying we are not doing traditional meditation, saying we are doing sitting exercises where we are observing our thoughts or whatever (informant laughs) but for me it's highly spiritual of course. And secret somehow, and I think the clients who dig into it deeply come into contact with this. But I don't think, I don't see, I mean, it's not really a conflict. It's more that I have to be aware of that.

Thus, the double nature of mindfulness is at times a challenge for the therapists, but there does not seem to be a substantial conflict between mindfulness as originally conceptualized and its application in the Swedish landscape of substance use disorders treatment. Hence the empirics suggest that mindfulness is both a therapeutic tool and a way of being for both therapists and clients. In fact, even if many of the issues related to the inclusion of mindfulness in clinical practice deserve further attention, the previous narratives contribute to delineate how mindfulness as it is applied in clinical work transcends this very contextual delimitation, expanding into other aspects of the lives of its practitioners, for both therapists and clients. In this light it is possible to claim that the Buddhist roots of mindfulness are somehow an integral part of mindfulness and MBIs in Western clinical contexts, and that the major concern should be directed not on its inclusion per se, but on the scientific investigations used in order to validate such an inclusion. However, the fact that mindfulness is for the social workers more than a mere therapeutic tool represents a challenge for their professional practice since it requires them to carefully balance their own take on it and its implementation as a clinical tool.

2. Conclusion

What have we learned from this context-sensitive phenomenological analysis of social workers experiences of working with mindfulness and MBIs in the field of substance use disorders in Sweden? What main implications can we now indentify, for both future research and clinical practice? Recalling the main question this thesis

attempts to answer, in what way can mindfulness and MBIs influence the therapeutic relationship and the treatment of substance use disorders in the Swedish context?

This final section is dedicated to answer this question. But before providing the conclusions of this work, the aim and overall content of the thesis are briefly re-proposed in order to facilitate the contextualization of the findings presented.

The aim of this work has been to contribute to the current body of work on mindfulness in social work, attempting to overcome the mainstream approach to the study of mindfulness and its clinical applications. It has employed the experience of five Swedish practitioners to understand the influence of mindfulness in the social work therapeutic relationship and the advantages and challenges that MBIs offer in the treatment of substance use disorders. Thanks to the context-sensitive descriptive phenomenological research design implemented, the research has been contextualized within the debates on substance use and substance disorders treatment in the Swedish context.

This work has been built around the recognition, analysis and discussion of three great tensions.

Regarding the first tension, namely the gap between theory and practice as found in the literature, the phenomenological approach employed displays as a valuable tool in understanding social workers' interactions with the clients within the framework of MBIs and in further detecting the practical unfolding of mindfulness and MBIs in the treatment of substance use disorders. As emerged from the analysis and discussion of the empirics, within the framework of the therapeutic employment of mindfulness and MBIs, the social workers' relationship with their clients seems to be characterized by trust, recognition and autonomy. Furthermore mindfulness helps to foster practitioners' awareness of their own cognitive and emotional life, preventing burn-out, work-related stress and allowing them to establish a solid relational ground with the clients.

Framing in phenomenological terms what emerged from the analysis and discussion of the empirics, mindfulness seems to allow the therapists to fully account

for the psychic realm of their clients, thus accessing their lived meanings. Thus the therapists move away from the natural attitude, defined as our common lenses characterized by judgments, pre-assumptions and based on our rationalists cause-effect reasoning. As a result the therapists are primarily directed toward the clients' experiences and their underlying motives. It is exactly this shift to the phenomenal realm that, as previously underlined, allows the social workers to gain an increased awareness of their own cognitive and emotional life. Moreover, the shift to the phenomenal realm facilitates an understanding of the practitioners' empathic presence toward their clients and their expressive unity. Finally, the employment of mindfulness and MBIs in the treatment of substance use disorders helps to develop an observational stance towards one's experience, thus fostering the substitution of reactive tendencies with skillful responses.

In these regards, the notion of phenomenological-psychological reduction, defined as the process of deliberately bracketing everything else (e.g., one's own pre-assumption, judgments and considerations) apart from the clients experience, has also proven to be a valuable tool to theorize the practical unfolding of mindfulness in clinical work, with particular reference to the relationship between social workers and clients.

Secondly, regarding the debate between first-person and third-person perspective, the centrality of the body in the therapeutic work based on mindfulness recalls to our attention both phenomenological inquiries and contemplative practices such as Yoga and meditation. This focus on the body is substantially in antithesis with treatment as usual such as RP and CBT, where, in line with a rationalist stance to knowledge, the cognitive dimension is the focus of the intervention. In fact the analysis proposed here suggests that the understanding of one's situation in the context of MBIs is primarily a bodily understanding. Here the client's perceptual engagement with their senses, or in other words their first-person, experience-based perspective, helps to break the ruminative cycles. It is important to stress once again how the observational stance promoted by the cultivation of one's awareness fosters

in this context the ability to be present to one's own experience and to emphasize with the experiences of the other.

Thirdly, mindfulness and MBIs display as a valuable alternative to both the overall Swedish drug policy on an ideological level, and to its mainstream treatment methods treatment wise. In fact MBIs are based on a non-judging, accepting, and compassionate approach to the clients and their substance use issue. In this context relapses represent a normal aspect of the recovery process, and clients are deeply trusted and regarded as active agents able to fully navigate in their lives.

Within the framework of substance use disorders treatment with mindfulness and MBIs all that is required to the clients is the cultivation of an observational stance toward their own experiential field, thus learning to recognize their reactive and automatic tendencies, such as for instance substance use and abuse. Furthermore, this observational stance allows the clients to recognize how they are not their problems, thus creating a space of greater acceptance and control in the life of the client.

Then considering how foundational features of mindfulness such as acceptance, non-judgment, compassion, and its observational stance, are effectively applied within the Swedish system of substance use disorders treatment, stresses the relevance, effectiveness and current inclusion of traditional Buddhist thought within the framework of western clinical settings. Thus, the inclusion of mindfulness into clinical settings is primarily fostered by the practitioners' ability to embody the teaching of the Buddha. In fact, as it emerges from the last area of analysis, mindfulness does not merely display as a clinical intervention but as an overreaching life stance able to offer alternative vantage points if compared to our rationalist, third-person perspective for its practitioners, whether social workers or clients.

Yet the inclusion of mindfulness and MBIs in Western clinical settings is not problem free although the overall aims of both mindfulness as originally conceptualized and as therapeutic practices is the reduction of suffering. The fact that for the social workers mindfulness is more than a mere therapeutic tool represents a

challenge for their professional practice as it requires them to carefully balance their own take on it and its implementation as a clinical tool.

However, this thesis suggests that more concern should be directed not on mindfulness inclusion in Western settings per se, but on the scientific investigations used in order to validate such an inclusion. In fact, as we have previously noticed, the mainstream approach to the study of mindfulness and its clinical application is based on epistemological and methodological stances that allow only a partial investigation of the phenomenon.

2.1. Recommendation for future research

Concluding, this thesis suggests that phenomenology, and in particular Husserlian phenomenology, may be among the most promising approaches in theorizing mindfulness, and thus deserves to be accounted for as such in future research. Such a task seems particularly relevant considering how phenomenology offers the chance to study mindfulness from its own vantage point, from a first-person, experience-based perspective, contrary to the mainstream research on mindfulness and its clinical applications. Thus the phenomenological approach proposed not only contributes to fill the research gap previously underlined but provides an alternative methodology for the study of mindfulness in its clinical applications. In particular, exploring the notions of empathy and expressive unity in relation to the clinical application of mindfulness displays as an interesting task since it may allow us to further ground our understanding of mindfulness as it unfolds in therapeutic work and gain further insights on one of the foundational features of successful therapeutic work such as empathy.

Further research may be oriented toward the employment of post-colonial lenses, and in particular the concept of hybridity in relation to the study of, and attempt to further explore and discuss the processes of inclusion of mindfulness in Western clinical settings.

Finally, and of particular relevance in relation to the Swedish context, considering how the study on the employment of mindfulness in the treatment of substance use disorders is at its very beginning, exploring mindfulness and MBIs as plausible alternatives to the current mainstream treatment methods and their underlying ideology deserves further attention. This line of research could be pursued both accounting for phenomenological inquiries as the one here proposed, or designing studies aimed at explicitly evaluating and comparing mindfulness and MBIs with treatments as usual, such as randomized controlled trials.

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4. Appendix 1

4.1. List of abbreviations

ACT: act commitment therapy

CBT: cognitive behavioral therapy

CT: cognitive therapy

DBT: Dialectical Behavioral Therapy

IPA: interpretative phenomenological analysis

MBIs: mindful-based interventions

MBCT: Mindfulness-Based Cognitive Therapy for depression

MBRP: Mindfulness-Based Relapse Prevention

MBSR: Mindfulness-Based Stress Reduction

RFT: relational frame theory

RP: relapse prevention

UNODC: United Nations Office on Drugs and Crime