The use of mindfulness based interventions by Hungarian addiction counsellors: an interpretative phenomenological analysis

By

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Abstract

Mindfulness based interventions (MBIs) play an increasingly important role in the development of counselling practice, and also in treatment approaches in the substance misuse field; yet they have not been adopted by recovery services in Hungary. Addiction counsellors took part in an 8 week Mindfulness Based Cognitive Therapy course and were interviewed post-course about their experiences of learning mindfulness skills; and MBIs relevance to their work and to their clients’ recovery. Using Interpretative Phenomenological Analysis six themes were identified: experiencing a fundamental transition; increased ownership towards responsibility; learning mindfulness is challenging; increased capacities at work; prerequisites to use mindfulness at work; and innovative aspects of MBIs in substance misuse treatment. Implications for counsellors’ self-care, professional development and for the adaptation of MBIs in the Hungarian context are discussed.

Key words: Mindfulness based interventions, MBCT, substance misuse, counsellors’ well-being, burnout prevention
Introduction

This research project investigates counsellors' experiences of learning and applying mindfulness skills in substance misuse services in Hungary. Mindfulness based interventions (MBIs) have become influential in many areas in recent years, and this is also true for the addictions field. MBIs mainly originate from the US and the UK, and most research on application is also carried out in the Western Hemisphere. To my knowledge, no previous research on MBIs has been completed in Hungary on counsellors' mindfulness, or on the use of mindfulness in the substance use field. This research will explore qualitatively the use of MBIs in Hungary, by introducing it to addiction counsellors working in outpatient centres in Budapest. By teaching Mindfulness Based Cognitive Therapy to these professionals, the research will explore the application of MBIs by this service and how it may impact on counsellors' work and well-being. I do not have any prior hypotheses aside from the assumption that participants would have valuable and unique input about the subject.

Mindfulness practices and counselling have been equally important part of my personal journey. I've started meditating in the year 2000, and it was about two years later when I have enrolled on my first introductory course in psychotherapy. The insights learned from meditation practice and personal therapy have been invaluable, and for many years I did not think much about how these two could mix in my work. Coming from a family affected by addictions, I was drawn towards working with people with substance misuse problems, and I have been doing this now for the
best part of 10 years; residing and working at times in the UK (6 years) and in Hungary (4 years).

Throughout my life I have experienced a number of depressive episodes, accompanied by severe burnout relating to my work; mindfulness has been key in managing and recovering after these difficult times. It is perhaps most valuable for me in keeping things going and noticing the warning signs well before things could turn sour.

I have completed an 8 week MBCT course while studying at UEL for my post graduate diploma, and although I had been teaching mindfulness skills to my clients before, based on my personal knowledge and practice of mindfulness, learning about the integration of mindfulness and cognitive approaches has marked a very important point in my professional development. Enthusiastic about teaching MBCT to groups and individuals, and bringing it to Hungary, I have begun formal MBCT teacher training.

In the UK mindfulness is available to clients and staff at most substance misuse services; in forms of mindfulness groups; in skills training as part of relapse prevention; some services even offer specialist interventions such as Mindfulness Based Addiction Recovery (Mason-John and Groves, 2014). Mindfulness based interventions are little known in Hungary, this research is part of my efforts to introduce them to professionals and clients in my field of work.

I’ve decided to start by training addiction counsellors in MBCT, firstly because I know how difficult this work is, and how much support mindfulness be in managing it.
Secondly, I am hoping that this could have a greater reach on the long run; clinicians need to have direct experience with this approach, for it to be present and available in the field. Thirdly, those who engage with the approach on a personal level may begin experimenting with applying the skills in their work with their clients, just like I did, before starting my training. So exploring the application of this method with counsellors will hopefully support them in managing demands and pave the way to introducing MBIs to the services.
Literature Review

Research on mindfulness has become abundant in recent years. The growing popularity of MBIs is illustrated well via a search of the scientific literature using the term ‘mindfulness-based’ that yields 49611 published scientific articles. Yet, mindfulness-based interventions are little known in Hungary. A database search2 for scientific articles on MBIs carried out by Hungarian researchers yields 9 results; in terms of popular/self-help culture, there are only 5 books in publication and available from Hungary’s largest online book retailer www.bookline.hu. Currently, there are 9 practitioners in Hungary who have completed Mindfulness Based Stress Reduction (MBSR) teacher training3. There are few mindfulness groups on offer, either for people with chronic pain, or with eating disorders; it has not yet been part of counselling training, or offered to people who have or work with substance misuse problems.

For the purposes of this study I have identified the following areas for my literature review to focus on:

- Overview of the professional context in the substance misuse field
- Origins and development of mindfulness based interventions
- Mechanisms of MBIs
- Application of MBIs with substance misusing clients

1 Search via all EBSCOhost databases on 18.10.2015.
2 Search via all EBSCOhost databases. Search terms used: mindfulness with Hungary/Hungarian on 18.10.2015
3 Source: www.mbsr.hu – a website set up by Hungarian MBSR practitioners
- Professional development and MBIs
- Self-care aspects for counsellors
- Limitations, risks and adverse effects of MBIs

**Overview of the professional context in the substance misuse field**

Substance misuse affects a significant size of the global population. In Hungary the number of people with problematic drug use was last estimated at 24,000 (EMCDDA, 2015), while alcohol was linked to 27% of mortality among males in the age group of 35-64 (Józan, 2002). Helping people to recover from problematic drug and alcohol use is a huge task, which needs to be addressed by governments, healthcare professionals and communities.

In Hungary the substance misuse sector has experienced adverse changes in the past five years. A study carried out by a national umbrella organisation with services from non-governmental and governmental organisations found that service providers strongly criticised the national anti-drug strategy for being limited in terms of expressing opinions of health and social care professionals; also due to the lack of funding for research and monitoring there is little objective information available from the current state of affairs (KCKT, 2015). The study has identified alcohol use and the use of novel psychoactive substances (NPS - also commonly referred to as designer drugs or research chemicals) as the most dominant problem areas; the NPS leave professionals in a state of subjective powerlessness, due to their unpredictability and the inadequacy of regulatory reactions. The service providers of
outpatient facilities (providing case management and psychological counselling) reported that clients entering treatment often have dual diagnoses; their mean age is lowering; clinicians believe that their methods and tools are outdated; and funds for professional development are limited. The impact of this on clinicians is manifesting in high caseloads, the inability to meet demands and burnout. This is a cause for alarm, and the views of the participants are very bleak.

As mentioned above, the scarcity of up to date research further exacerbates the situation of the Hungarian substance misuse field. The last general population survey on the prevalence and attitudes toward drug use was carried out in 2007 (by Paksi). They found that Hungarians have unswerving negative attitudes towards drugs; nearly 80% of people strongly disagree with the use of any illegal drug, and drug users are the least tolerated social group (when compared to Roma people, ex-offenders, etc.) in Hungarian society. This is important in many ways for those working with substance misusers, considering the effect of these social factors on clients. As counsellors, we work with our client’s frame of reference, and we are affected by these social contexts; the stresses these realities create; their impact on the hopes and expectations of our clients, and on their chances to fully recover. Empathising with clients who are marginalised can be emotionally exhausting, having to face their pain and the hopelessness of their predicament. Exploring our feelings and reactions to this and identifying the ways this may affects us is an important task, if we are to remain healthy and effective as professionals.

It has long been recognised that counsellors in the substance misuse field are extremely vulnerable to burnout (Sorensen et al. 1989 and more recently Oyefeso et
al. 2008), and substance misuse agencies experience high staff turnover annually (Gallon et al. 2003, McLellan et al. 2003, McNulty et al. 2007). The high turnover has been related to emotional exhaustion due to work site factors, such as centralised organizational cultures (Knudsen et al. 2006); high work pressure and uncertain work policies, more so than in non-substance misuse specific services (Lacoursiere, 2001). Addiction counsellors often work in under-resourced clinics, have high caseloads and massive amounts of paperwork; they also have low level of prestige associated with their jobs; and work with clients who are typically difficult to treat (Oser et al. 2013, Shoptaw. et al. 2000). It appears that the way society relates to those who struggle with addiction, with stigmatisation, blaming and marginalisation, is somehow quite a similar encounter that we, therapists of this field experience.

The chronic nature of addiction itself presents considerable difficulties to counsellors; the substance misuse sector has high rates of recidivism, clients are often dual diagnosed and have a range of social problems, such as lack of housing and employment opportunities (Oser et al. 2013). We are constantly facing relapsing clients, where our work seems to have gone nowhere. Working with people who are chronically ill due to blood borne viruses is exhausting, and the scope and complexity of presenting problems can be overwhelming. The aforementioned health and social problems can really invade the counselling room, and it can be quite difficult to keep up a hopeful and positive outlook in work; one almost has to bracket out the outside realities we live in.

Under the difficult climate as described above, introducing newly developed and effective measures can provide the means to improve the situation. Mindfulness
based interventions are playing an increasingly important role, both in terms of clinicians’ self-care and for treatment of clients with a range of issues, including substance misuse. In the following section I will review how MBIs have appeared as important additions in the helping field.

**Origins and development of mindfulness based interventions**

Mindfulness, while having its roots in Buddhism, and eastern spiritual practices was introduced to Western medicine by Jon Kabat-Zinn in the 1970s. It is described as “paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (Kabat-Zinn, 1994). The first treatment programme, Mindfulness Based Stress Reduction (MBSR) was also developed by Kabat-Zinn (1990) to help people experiencing chronic pain. MBSR is taught in a pragmatic and non-religious way, ensuring that the programme remains equally appropriate and relevant for people, whether they have a spiritual and religious background, or not (Kabat-Zinn, 2003). It has become influential tool, which is increasingly used in various adapted formats in psychotherapy. MBSR lead to the development of Dialectical Behaviour Therapy [DBT] (Linehan et al. 1999), Acceptance and Commitment Therapy [ACT] (Hayes et al. 1999), and Mindfulness Based Cognitive Therapy [MBCT] (Segal et al. 2002). Currently MBIs are used with a range of issues, from borderline personality disorder to recurring depression. The emergence of MBIs saw a change in the field of substance misuse treatments as well, as mindfulness-based therapies have emerged as an effective alternative to cognitive-behavioural treatments (Ziegerska et al. 2009).
MBCT was successful in preventing relapse/reoccurrence of depression, which was not adequately addressed by behavioural and cognitive methods or anti-depressant medication. As Segal et al. (2002) pointed out; the scope of the problem had changed from treating depression to including prevention of relapse of depression. The lessons on relapse prevention are important ones to consider in substance misuse treatment as well, i.e. learning to be with experience, as opposed to changing negative dysfunctional thinking into positive and functional.

As mentioned above, MBIs have built on eastern religious practices, such as Vipassana meditation, a form of Buddhist practice, developed in its current form by S.N. Goenka (Hart, 1987). The practice is based on the following assumptions: suffering is an inevitable part of life; most of that is caused by attachment to pleasant things, or avoiding unpleasant ones; it is possible to alleviate this suffering; by certain practices and attitudes. Attachment to the pleasurable and avoidance of the unpleasant, seems to correlate well with the difficulties that those with substance abuse problems face. We may view pleasure seeking (of euphoric or sedating effects), and avoiding unpleasant experiences (such as cravings, withdrawal symptoms, anxiety, or depression) as intrinsic parts of problematic drug use (depending on type of drug and severity) and conditions that are associated with it.

In recent years, a number of MBIs have been developed to treat people with substance misuse issues, such as Acceptance-Based Relapse Prevention [ABRP] (Vieten et al. 2010), Mindfulness Oriented Recovery Environment [MORE] (Garland et al. 2012) or Mindfulness Based Relapse Prevention [MBRP] (Witkiewitz, Marlatt, &
Walker, 2005). The latter two are based on and have incorporated the cognitive
behavioural approaches of MBCT. These interventions (and MBIs in general) are
similar in having an acceptance-based, rather than a control-based approach to the
regulation of negative affect, to awareness of relapse triggers, and to coping with
 cravings.

**Mechanisms of MBIs**

These ‘third wave’ cognitive-behavioural approaches (influenced by mindfulness)
have shifted the focus from changing maladaptive thoughts, moods and behaviours
to changing our relationship to them. These newer approaches generally aim to
change the cognitive processes rather than their content. The change is brought
about by treating thoughts as mental events; by developing the capacity to relate to
difficult thoughts, feelings and sensations differently; and by strengthening the
metacognitive capacities of observing one’s thoughts (Segal at al., 2002).

By observing one’s thoughts mindfully without intending to change them, one can
create the experience of recognising thoughts as both separate from oneself and not
necessarily reflective of any particular reality or truth. Recognising that thoughts and
emotions are transient and often insubstantial can empower clients to choose to give
up attachment to these mental/emotional constructs and begin considering
alternative ways of being. This non-striving attitude, accessible through a variety of
mindfulness techniques, reduces reactivity, thus providing a more reflective, less
disturbed, and more adaptive mode of consciousness (Brown et al. 2013).
The basic components of mindfulness have been proposed as self-regulation of attention and a quality of relating to experience with curiosity, openness and acceptance (Bishop et al. 2004). When practising mindfulness one lets go of expectations and goals, so as to de-condition the automaticity that typically dominates cognitive processing. There is an invitation to develop an accepting stance towards difficulties, i.e. to reduce pleasure seeking and avoidance. This acceptance or ‘being with’ difficulties allows for change by enabling the development of alternative responses to difficult situations, thoughts, feelings and bodily sensations, such as physical discomfort.

All MBIs have in common a bodily focus, bringing awareness to the interconnectedness of thoughts, feelings, and body sensations. The bodily signs of lowering mood and stress are felt before they can become known via intellectual means, thus providing an early warning system of negative thinking which could signal the need for preventative methods, or simply the acknowledging of such content (Nanda, 2010).

Mindfulness has been explored as a trait-like construct. Trait mindfulness is characterized by an attentive and non-judgmental monitoring of moment-by-moment experience (Baer et al. 2006). The mindfulness practice that one may develop through participating in a course or through learning via other means (web learning, books, retreats), involves techniques that produce the state of mindfulness, which may increase our metacognitive awareness, and our competence to consciously respond, rather than react, to challenging life events and experiences (Garland et al.
2012). Recurrent practice evoking the state of mindfulness is was found to promote the development of trait mindfulness (Kiken et al. 2015), which positively correlates with attentiveness, optimism, emotional intelligence, awareness of internal states, mental health and well-being, and negatively correlates with anxiety, anger, depression, self-consciousness, and impulsivity (Baer et al. 2006).

There is little emphasis on change; however, it is often a motivator to engage in a mindfulness programme. MBIs also support people to manage their expectations, trust the process, identify their motivations, and explore nurturing activities.

**Application of MBIs with substance misusing clients**

In Marlatt's (1978) study of common relapse predictors, negative affect emerged as the most common precipitant of lapse/relapse. The strong link between negative affect and relapse highlights the important role of distress tolerance in abstinence; MBIs work on enhancing affect regulation, and higher distress tolerance was found to correlate positively with MBIs (Hsin Hsu et al. 2012).

Negative affect is characterised by presence of negative emotions and a poor self-concept (Watson & Clark, 1984), and the avoidance of negative affect has been suggested to be a key motivator behind substance use and dependence, as drugs and alcohol act as negative reinforcements by providing relief from negative affective states (Baker et al. 2004). Avoidance based coping of distress has been linked to
self-medicating, whereby one learns to control suffering by using substances (Khantzian, 2003).

Increase in distress tolerance is brought about by developing awareness and acceptance of thoughts, feelings, and sensations (with a particular emphasis on cravings for this cohort) and using these skills to cope with the high-risk situations that elicit negative affect (Witkiewitz et al. 2005). Increasing mindfulness may weaken the link between negative affect and craving, indicating that mindfulness training may enable one to respond wisely and skilfully as opposed to reacting to cravings (Robinson et al. 2014 and Witkiewitz & Bowen, 2010).

Garland and his colleagues (2014) found that MBIs enhance the ability to regulate distressing emotions and increase the capacity for reappraising the meaning of challenging life events; this can be a powerful strategy to self-regulation.

MBIs when compared to regular substance abuse treatment programme (relapse prevention) has increased both awareness and acceptance of participants experiences, showed decreases in craving and substance use, and experiencing negative affective states were less likely to lead to craving (Witkiewitz & Bowen, 2010 and Witkiewitz et al. 2013).

**Professional development and MBIs**

Mindfulness of therapists can be considered a baseline trait. Acceptance, openness and compassion towards oneself and others are central to MBIs. This way of relating
shows comparisons to the elements of the humanistic core conditions (Rogers, 1980). However, mindful acceptance does not focus solely on the client, it is a more encompassing idea about accepting internal states, thoughts and emotions, as well as the present; i.e.: what the client brings into the room and how it manifests through the relationship. Research found that individuals higher in trait mindfulness attend to their negative emotional experiences in a less judgmental and more accepting way (Kimberly et al. 2010).

MBIs may offer therapists a tool to develop their capacity to be with their clients while staying ‘centred’. Mindfulness by promoting radical self-acceptance fosters authenticity; when purposefully cultivated, it leads to heightened awareness of inner and outer experiences through open, non-judgmental, focused attention in the present moment (Irving et al. 2009), allowing a therapist to sit with a client without an agenda.

When looking at empathy, mindfulness facilitates deeper compassion and acceptance of the clients experience, which in turn leads to clients feeling emotionally understood and safe to open up to the therapist (Razzaque et al. 2015). When investigating the relationship between MBIs and empathy, Shapiro and Izett (2008) found a significant increase in empathy when teaching mindfulness to counselling psychology students. They have suggested three means by which MBIs may facilitate empathy: (a) reducing stress, which is correlated with increased empathy, (b) increasing self-compassion, which many consider a precursor for other-empathy, and (c) loosening one’s identification with one’s personal subjective
experience and thereby being better able to perceive and accept the experience of others without judgment or defensiveness.

Studies with trainee psychotherapists found that mindfulness practice helped them being present with, and aware of what is happening to the client, while attending to their inner experience during therapist-client interactions, as well as remaining present with intense or difficult material during sessions (Caldwell et al. 2011, Christopher & Maris, 2010 and McCollum & Gehart, 2010). Other research found that mindfulness training helped trainees with self-care, professional development in intrapersonal skills, and confidence in their mindfulness intervention skills (Hemanth & Fisher, 2014).

Perhaps, most importantly, research also found that mindfulness is associated with better client outcomes – trainee therapists practising mindfulness had higher evaluations by clients on measures of therapeutic relationship, ability to solve problems and communicating clearly in sessions than trainees not practising mindfulness; clients of those practising mindfulness also reported greater symptom reduction (Grepmair et al. 2007).

**Self-care aspects for counsellors**

Mindfulness may offer important self-care strategies for those in the helping professions; I have described earlier the challenges those working in substance misuse services may have. It is both professionals’ and employers’ responsibility to
manage the effects of this work, and practicing mindfulness and creating mindful
working environments is one way of doing that. Mindfulness training delivered to
primary care clinicians was associated with reduced stress, anxiety, depression and
burnout, and was supportive of health and well-being (Fortney et al. 2013).

Mindfulness practice allows one to observe thoughts and feelings in a self-
monitoring manner, in similar conditions that are the foundations of talking therapies:
an accepting, open and non-judgmental atmosphere. The practice involves
developing an accepting stance towards content which is seen as unwanted or
undesirable, so one can learn to attend to, and “be with” experiences as opposed to
suppress, avoid or push away; this in turn may allow the development of positive
affect and a sense of profound equanimity (Christopher & Maris, 2010). Non-
reactivity may facilitate coping and affect regulation in face of emotions such as
anger, fear, and sadness; and mindfulness has been shown to alleviate distressing
symptoms and enhance emotional regulation (Chiesa & Serretti, 2009). These
capacities are very important considering the challenges counsellors face in their
work. MBIs can teach important self-care techniques that can help prevent burnout,
compassion fatigue, and vicarious traumatisation (Christopher & Maris, 2010).

MBIs can help finding the balance between the being and doing modes (McCollum
& Gehart, 2010). Instead of getting caught in our desire to have things unfold
differently – the doing mode – MBI participants work at making peace with things as
they are and embracing what is most meaningful in their lives in the present moment
– the being mode. Of course, both modes of mind are important and necessary, and
neither is better than the other; but being able to choose from them is just as essential in our personal life, as it may be for positive therapeutic outcomes.

Mindfulness can lead to outcomes such as intentional living, experiencing a sense of connectedness and deep gratitude, and inviting clients to live mindfully (Rothaupt et al. 2007). Trainee counsellors who practiced mindfulness reported increased compassion and acceptance towards themselves and their clients (McCollum & Gehart, 2010). Therapists with long term mindfulness practice felt that it helped them to be more present and aware, increased their sense of compassion and non-judgment, and allowed them to tailor MBIs to specific client needs (Gill et al. 2015).

Self-compassion and self-acceptance as integral part of mindfulness may help us as therapists to come to terms with our relationships to helping, improvement or redemption. A non-fixing mindful attitude and the capacity to relate to difficulties differently may be crucial factors in mediating work related stress.

**Limitations, risks and adverse effects of MBIs**

As with any therapeutic method, positive outcomes may not be reasonably expected without costs or risks to target populations. There is no minimum commitment of time that is required for benefits and positive change, but 30-60 minutes of practice daily seems to be advocated by most programmes (for example MBCT and MBRP), although the time investment seems to be compensated by improved sleep and efficiency (Kabat-Zinn, 1993). This amount of time may not be available without
giving up other important things, although this is mediated by advocating informal practices, such as everyday activities, that if done mindfully (mindful eating, walking or cleaning) can offer benefits similar to formal, meditative practices.

With dropout rates being high in substance use treatment (Chiesa & Serretti, 2014) it is important to highlight that achieving positive outcomes requires a high level of involvement. Some studies found that benefits are seen only among those who attended half of or more sessions (Amaro et al. 2014), which are typically 8 to 10 sessions, lasting 2 to 2.5 hours on a weekly basis. Hsin Hsu (et al. 2012) found a plateau effect after four months with a substance misusing population, which indicated the need for booster sessions to facilitate long term effects. However, research focusing on recurrent depression found that at 1-year follow-up levels of depression were mediated by mindfulness skills and self-compassion (Kuyken et al. 2010, van Aalderen et al. 2012).

Cognitive approaches such as MBCT need to be actively engaged with and require intensive participation; they perhaps are best suited to highly motivated clients (Skanavia et al. 2011). ACT was found to work well with involuntary clients who suffered from mental illness (Gaudiano, 2015 and Baer, 2015), yet the problems and motivations of mandated clients in drug services may be different. In Hungary treatment of drug users in lieu of punishment is part of the country’s drug and criminal policies. Treatment instead of punishment (TIP) is not only linked to crime related to drug use (i.e. acquisitive crime) but it is also the punishment for consumption-type criminal offences involving small quantities of drugs. By opting for TIP, a drug user can avoid having to stand before the drug user’s court where a fine,
suspended sentence or probation can be imposed (Rácz et al. 2008). In 2014 more than half (60%) of those entering treatment were doing it in order to avoid punishment (National Focal Point, 2015); meaning that their primary motivation is not necessarily getting help about their drug use, but to avoid criminal proceedings. This may pose a limitation to the successes of MBIs in Hungary.

Current acute psychosis might be a contraindication for intensive meditation training, the potentially negative side effects of mindfulness can be (although very rarely) the exacerbation of psychiatric symptoms, including depression and anxiety, altered reality testing and even psychosis (Allen et al. 2006). Cultivating mindfulness for individuals with severe psychological disturbance may be more difficult, but individuals with basic cognitive functioning should be capable of doing so (Brown et al. 2013).

**Summary**

Working in substance misuse services is one of the most challenging fields in counselling. Addiction counsellors in Hungary are going through difficult times, and work in an unsupportive financial, political, and social environment. There is a strong need for new approaches and professional development. Mindfulness has been applied to a variety presenting problems, and has been shown to produce good results for both clinicians and their clients. There are numerous MBIs developed for the substance misusing population, many of these fuse mindfulness with a cognitive approach, and have been heavily influenced by MBCT. The use of cognitive
approaches such as Motivational Interviewing (Miller & Rollnick, 1991), Cognitive Behavioural Relapse Prevention (Marlatt & Gordon, 1985) have been dominant and widespread in addiction treatment, therefore it is safe to assume that addiction counsellors are familiar with these, and this should support the attainment of MBCT despite its’ obscurity in Hungary. Apart from the increased work related competencies, MBIs have been found to enhance the physical and psychological wellbeing of counsellors (Christopher & Maris, 2010).

To benefit from the self-care aspects and to further therapeutic skills, it is important to have the experiential understanding of mindfulness, before it is applied in clinical practice. Teaching therapists mindfulness skills seems like a valuable tool that supports safer and healthier practice and can improve therapeutic outcomes.

**Research aims and objectives**

1. Explore the application of MBIs in Hungary, where these methods are not yet in use in the substance misuse field.
2. Explore counsellors’ experiences of learning and using mindfulness skills after an 8 week MBCT course.
3. Explore how professionals and clients may benefit from using these methods and draw conclusions for successful strategies of adaptation in a Hungarian context.
4. Complement the mindfulness research centred in North America and Western Europe through an analysis of exploring use and applicability in Eastern Europe.
Methodology

Design

The design of the research is qualitative, as it is interested in people’s voices and attempts to give space for the participants to express their ideas and share their perspectives. Questionnaires or other quantitative methods are not appropriate for this study as it aims to find latent and underlying meaning in the data by exploring participants’ experience in an open-ended manner. To investigate mental states self-report questionnaires are inherently limited; in the case of investigating mindfulness this is even truer. The use of pre-existing measures and self-report statements may impose the researcher’s framework of meaning that may miss or distort the structures of meaning that participants would spontaneously generate. Previous research has argued that studying mindfulness qualitatively allows the researcher to explore experiences and reveal aspects of change that have not yet been captured in previous research (Christopher & Maris 2010).

I have conducted semi-structured interviews with participants from the first MBCT group that I have run for counsellors of substance misuse services in Budapest. This interview format allows the researcher and the participant to engage in dialogue in real time. It also gives enough space and flexibility for original and unexpected issues to arise, with the opportunity to investigate in more detail with further
questions. The oral narratives of interviews offer a unique avenue of inquiry that can help to reveal and qualify an individual’s or a group’s experience (Patton, 1999).

To produce a rich and detailed account of the interviews Interpretative Phenomenological Analysis (IPA) was chosen as the tool for analysis (Smith & Osborn, 2007). This method allows the research to be driven by my theoretical and analytical interest in the investigated area. IPA is different from other qualitative approaches that it simultaneously focuses on the unique characteristics of individual participants and on patterning of meaning across them (Smith et al. 2009). IPA is concerned with sense making, meaning and meaning-making; it allows the capturing of the lived experience of mindfulness as a “first-person” phenomenon, directly accessible only to the person who is experiencing it.

IPA is phenomenological in that it involves detailed examination of the individuals’ worldview; it aims to explore personal experience, perception and sense-making of an object or event, as opposed to trying to make objective statements about an object or event itself (Pietkiewicz and Smith, 2014). The meanings that individuals attach to phenomena are not accessible directly to a researcher, but acquired via a process of interpretation, which also takes into account the researcher’s sense making (Smith et al. 2009). During the whole of the research process, I sought to be aware of my assumptions and recorded my reflections in a journal, as well as having discussions with my supervisor and academic peers.
Participants

In line with IPA recommendations (Hefferon & Gil-Rodriguez, 2011) a small and homogenous sample was chosen; four participants were recruited, 1 man and 3 women, all addiction counsellors in recovery services in Hungary. According to Smith & Osborn (2007), this sample size for a research project at a post graduate level IPA allows sufficient in-depth engagement with each individual case while a detailed examination of similarity and difference is also possible. A bigger sample would have limited the depth of the analysis.

The participants’ age range were between 25 and 46 years of age, they have had or were working towards formal qualifications in addiction counselling (2), psychodynamic counselling (1) clinical psychology (1) and were educated at a postgraduate level. They all worked as addiction counsellors, providing one to one counselling to clients with substance misuse problems or behavioural addictions; and all but one were also facilitating therapeutic groups to the same client group. They have been working in substance misuse field between 3 to 9 years. The participants had no knowledge of MBCT in the form it was being taught, however, three of them had some personal experience of either hatha yoga or relaxation techniques, and one person was familiar with a range of meditational practices.
Materials

The interviews were based on 8 open ended questions (see below). The lengths of the interviews were approximated at 30-50 minutes each, to provide sufficient amount of material for the analysis. The questions and the interview protocol were piloted to test validity, structure and efficiency. After conducting a pilot interview, one additional question was included (question 6) and all original questions were kept.

The interview questions and protocol were designed to encourage the participants to elaborate on their experiences of the training; how it has impacted on their personal and professional lives; on the therapeutic relationships; and were asked to elaborate on applying mindfulness skills in therapy; teaching it to clients; and generally the appropriateness of MBI’s and their use in Hungarian substance misuse services.

Interview questions

1. What were your experiences of learning and developing mindfulness skills?
2. What changes have you noticed?
3. How applicable is mindfulness, if at all, to your work?
4. How being mindful may impact on your work?
5. How could MBIs be introduced at your service?
6. How would it fit with the approaches and methods currently in use?
7. What effect mindfulness may have on your clients’ recovery, or on making changes?

8. How do you feel about teaching mindfulness skills to your clients?

**Ethical considerations**

When finalising the design, I have consulted the BACP guidelines for ethical research, to investigate areas for concern. There were no significant risks identified, especially as I was to interview counselling professionals. I was ensuring that they had complete anonymity, and were fully aware of their right to withdraw at any time, without consequences. I maintained an awareness of beneficence and non-maleficence towards my participants throughout their involvement in this study.

All participants were known to me in a professional manner. I work at a recovery centre in Budapest, and the MBCT course was offered to counsellors working at either of the two centres run by my employer (Blue Point Foundation). I currently work as a recovery consultant, I do not line manage staff, neither was I being line managed by research participants. All the participants of the study were Hungarian nationals, like me. Given that I was interviewing my peers, our prior knowledge of each other, along with the possibility of future contact with each other, may have affected the openness of the interview.
The research gained ethical approval from the School of Psychology Research Ethics Committee at the University of East London (see appendix i), with suggestions for minor amendments. These were:

- Extend data collection period.
- Allow participants to withdraw up to the point of data analysis.
- Obtain a letter of acknowledgement of research from the proposed data collection site (Blue Point Foundation).
- Complete an official risk assessment for oversees data collection.

All the required amendments were made, before starting with the interviews.

**Procedure**

I offered an 8 week long Mindfulness Based Cognitive Therapy course, free of charge for addiction counsellors at a substance miscue organisation in Budapest. Participants came forward from two outpatient centres to attend the course, and were given the opportunity at the end of the course to take part in this research. They were not told about a study being made, or asked about taking part in it, until the 7th week of the course. The reason for this was to eliminate any possible interference with the learning process. Knowing about the study could have resulted in more motivation, but also could have led to experiencing pressure to conform to expectations attributed to the researcher.

MBCT provided the theoretical basis for the development of substance use specific MBIs, its format follows the traditions of MBSR (Kabat-Zinn, 1990), taught in group
over 8 weeks, in approximately 2 hour sessions. As participants were all from the field of addictions, their knowledge of substance misuse treatment approaches would enable them to combine the newly learned material with substance use specific content (such as relapse prevention). As clients of Hungarian services were found to often have dual diagnoses, and professionals felt exhausted and many nearing burnout (KCKT, 2015), using MBCT seemed an appropriate choice.

The MBCT course followed the model proposed by Segal, Williams and Teasdale (2002). I have translated the session handouts (containing the main concepts summarized and the homework assignments) and re-recorded the audio recordings in Hungarian. Translations of these, and the interview extracts were double checked by a native English speaker. As all the participants of the study were Hungarian nationals, the invitation letters, consent forms and all information were given to participants in Hungarian (see appendix ii for the English versions); the same language used in the interviews.

The average attendance among those who took part in the study was 6 out of 8 sessions, those who missed a session had the audio practices and hand-outs sent by email on the same day, and had the opportunity to discuss the material with me in person.

The interviews were carried out 2 to 3 weeks after the training ended. They took place at the participants’ place of work and in an open and friendly manner, to provide a stable and safe environment for the interview process. The interview style and the location can be an important feature as participants feel more at ease in their
place of work, than being interviewed in a psychology lab, which is unknown and less comforting to them (Charmaz, 2002).

All interviews were conducted successfully, following the previously devised structure. The total length of the collected material was around 140 minutes. The recordings were transcribed for analysis and upon completion destroyed, and all identifying information was removed from transcripts. The transcripts contained a verbatim account of all verbal and some non-verbal (e.g. pauses, changes of tone, laughter) utterances, to suit the type of analysis used. In addition the entire data set was checked against the tapes for accuracy.

**Reflexivity**

Inquiry is central to teaching MBCT, inviting participants to share their experiences with the group. The teacher uses mainly inquiring questions to illustrate the approach, the curiosity and openness towards one’s experience. Having this shared group experience with the participants has probably helped the interview process; the dynamic of supportive questioning was present throughout, just like in the weekly classes. As participants were all known to me, I was aware of the juxtaposition of my various roles that were present during interviews; the colleague, the MBCT teacher and the researcher. While embodying the latter, this overall familiarity allowed for intimacy, depth and at the same time lightness during the interviews. Interestingly there was a considerable amount of humour present and laughter often followed
statements about recognising something about oneself, or when talking about personal struggles.

**Analysis of data**

I diarised the process of analysis, making notes on emerging ideas, personal reflections similarities and differences to my experience. After reading and rereading the transcripts a number of times, I started making three types of comments: descriptive, linguistic, and conceptual (Smith et al. 2009). Emerging themes were formed by moving to an interpretive level of abstraction, linking the participants’ meanings to more abstract, psychological concepts, while still rooted in the particular details of participants accounts (Smith & Osborn, 2007). After preliminary data analysis I translated emerging themes and interview fragments to English, and from that point onwards I have worked with the translated material.

I combined the initial themes into groups based on similarity in meaning; this generated a list of superordinate themes, that are presented in the following section.
Results and analysis

Using IPA the emerging themes from the data were the following:

1. Experiencing a fundamental transition
2. Increased ownership towards responsibility
3. Learning mindfulness is challenging
4. Increased capacities at work
5. Prerequisites to use mindfulness at work
6. Innovative aspects of MBIs in substance misuse treatment

Throughout the text I illustrate the themes with participants’ interview extracts in italics, followed by participants’ codes (P1 for participant 1, and so forth).

1. Experiencing a fundamental transition

All participants described elemental changes in their lived day to day experiences, in terms of experiencing emotions. They have allowed their emotions to be present in their awareness more; regardless of whether their content was pleasant or unpleasant. They have related this to the open and accepting stance towards all experiences that is central to MBIs.

“It was a new approach (…) allowing our emotions and experiencing them, for me it was a very important point, and I’d felt that this is new and I can gain so much from this.” P1

This transition was experienced as deeply influential and powerful, marking a point of no return.
“There are days when I can’t be as effective, I can’t hold it that much, but I got infected by this enough, so that it has an effect on my day to day life.” P3

The new experiences led to exploring and placing higher values on life and the uniqueness of each moment. Aspects of everyday life that were not important or meaningful became appreciated through practice, conveying a sense of personal well-being and life satisfaction.

“One of its’ biggest messages is, I just thought of it, to learn to enjoy these minuscule little things. For example, like wow, I can breathe normally! Which seems so natural, yet a source of suffering for many people, so it’s not.” P2

This process was characterised by interest, challenging assumptions, and looking at the world differently. This has resulted in a positive appraisal of ordinary experiences, as well as increased alertness.

“I have started to pay attention to my body a lot more (...) that did not occupy me earlier. I have marvelled at things that I found banal before (...) like how perfectly constructed the human body is (...) I have noticed that how sensitive I am to sounds, which has not appeared to me before.” P2

As our mindfulness starts to develop, we may start noticing how ‘mindless’ we are. One participant shared how becoming aware of the continuous thought processes has affected the time spent at college. The experience was described as awe inspiring and approached with openness to change.

“Change started when I recognised that how can I sit in a lecture, and spend an hour and a half, without being there? It was not a scary, but an uncomfortable feeling. Why am I there then?” P1
This increased awareness of the present moment is the attribute of the ‘being mode’. For many, this experience of stopping from being engaged in thought and mental events most of the time (the ‘doing mode’) was quite radical and challenging.

“It was like being hit in the head, that I shouldn’t run all the time.” P3

“A wholly other operating mode, and there is a big gulf between the two … which is difficult to … start with this.” P1

Sustaining the conscious awareness of the moment requires practice and effort; participants seemed to be highly motivated and showed a strong commitment towards this change:

“I have started to be aware of this, like: Hey stop! Live in the present, not in the past, not in the future, in the present! And this is bloody difficult for me (...) but recognising it, is the first step!” P2

2. Increased ownership towards responsibility

Illustrating the recognition of the effective ways of dealing with difficulties by changing our relationship to them, all interviewees have talked about an increased ownership towards responsibility for problems or difficulties. Some talked about this in the context of managing feelings at work through awareness and reappraisal, which also suggests increased tolerance towards negative emotions and thoughts.

“It is very important to feel that this upsets me, but then to be aware, that these kind of people upset me or not, or is it only him (...) first I have to know what feelings are aroused in me.” P1
This approach to difficulties communicates a strong sense of self-acceptance that may lead to improvements in emotional regulation, coping strategies, as well as better interpersonal functioning.

“I look for the solution in myself, because the way it affects me, at the end, is about me.” P3

Reduced reactivity, and a more reflective and adaptive mode of consciousness was reported. Approaching thoughts as not necessarily reflective of reality or truth is shown in a participant’s account about transforming feelings of blame that one may experience towards clients.

“If something bothers me, or gets to me, I don’t blame him, a client for example, but I look for it inside me, what it is that bothers me about his behaviour. So I am more of the starting point.” P2

Taking responsibility for our emotions was linked to increased empathy and authenticity. This lack of pretence is a form of self-disclosure, possessing the totality of our experience in counselling sessions.

“On my part, I think it can enhance authenticity. If I can formulate my feelings about him, and not pretend as though… that probably helps the relationship a good deal, and creates an honest atmosphere. And it helps empathy that I can pay attention to my client.” P1

Being able to contain clients’ emotions more was also reported. The increased capacity to self-monitor, and suspend judgement, creates a space where one can overcome self-biases, and labelling.

“I believe if I can sit with a client and allow the content to flow through me, that will have an impact on him and even on my reactions (…) I get shocked
sometimes, even if I don’t show it. But if you can sit in that [mindful] state, if it becomes familiar, this labelling happens less.” P4

Openness towards feelings such as insecurity or self-consciousness was seen as something that helps developing self-awareness and self-acceptance.

“So I can detect, that new client, new situation, I expect that I will want to live up to my expectations, and then I can catch that. So I don’t react from that feeling.” P1

There was a sense of radical acceptance of shortcomings, approached with the attitude of self-compassion. This possibly highlights the notion of perfectionism as a culturally dominant factor; the unrealistic expectations may contribute to the burnout of clinicians, and make recovery a struggle.

“Why are we afraid of fallibility!? To allow this in client work, that yes, you have made a mistake… and not put it away into a corner, or something, but to understand this. So it has some emotion and some form.” P1

The importance of identifying and acknowledging personal motivation, and maintaining an awareness of intentions was also noted.

“Every work like this is about the relationship, and if I sit here, and I say that this is important to me, then I try to be here with my being… and express it.” P2

3. Learning mindfulness is challenging

In mindfulness programmes it is important to help participants develop realistic expectations and acceptance towards their own inconsistent practice. Mindfulness
may bring a range of positive changes, as described above, but requires considerable amount of effort to maintain an on-going practice and to change cognitive patterns, such as approaching difficulties with openness. This initially may seem as exhausting. MBIs are designed to support those in this learning process, yet from the interviews emerged a sense of struggling in terms of making sense of the experience:

“I understood this intellectually… But when observing it during practice, and linking it to an experience, that was hard. To find that experience. Like practising a handstand, but having no idea of what a handstand is.” P1

The data was convergent about the difficulties of developing and applying the newly acquired knowledge. Despite the challenge inherent in this transition of becoming mindful, a sense of commitment to this was present.

“I find this feeling of stiffness. When you know you could already do it better, but you are unsure when trying, that you’re not going to be worse off, than doing what you used to, which is not as good. There is ambivalence between these two states. It’s difficult to get over this, to allow myself to experiment, which may lead to something better.” P1

Persistence and commitment towards increasing self-directed attention was seen among all participants. The laborious efforts were compensated by improvements in well-being and self-monitoring.

“I try to do a body scan, which is very hard for me, and I envy those who say they don’t drift off (...) But when I can stay in it, just for a little bit of time, then it’s very, very, very good. And it gives me confidence and I can pay attention to myself better, and feel better.” P2
Despite offering practices that incorporate movement, the majority of the exercises require stillness. One participant found the stationary aspect of the method a challenge.

“I can and like to do this when I am feeling ok, it calms me and I find myself. But when I’m nervous or upset, it is even more frustrating (...) being still, like I am locked up.” P4

MBIs are time consuming and require effort. One participant mentioned that the amount of time investment suggested by the method was daunting, and found that it initially discouraged regular practice.

“First I got scared by having to practice 50 minutes daily, like that’s… well not that much, but it seems so much, and that scared me. And then I did not even go near it.” P2

To take part and fully engage in an intensive 8 week course requires considerable amount of effort and resources from participants.

“Investing my energy into this thing … is difficult … especially the everyday practice. I haven’t found a way for it yet. That is very funny, because in reality this is what I work with.” P1

4. Increased capacities at work

Despite talking about how exhausting confronting our difficulties and maintaining a regular practice can be, participants have described the benefits of enhanced capacity and attention. This increased capacity was related to improved efficiency in structuring time and work related tasks.
“I need to manage so many things, so for me, this came at the perfect time, because I can structure my days much better (...) and while I’m doing something I don’t meander in a thousand directions. So it was a really big gift for me.” P3

Participants demonstrated improved affect tolerance, which helped mediating the impact of client work. Mindfulness was increasing their ability to manage difficult emotions that arise in counselling.

“What I take home is easier… I experience it differently… so I don’t push it away. If I have taken over someone else’s pain, I might as well experience it, or allow it to recede, so I don’t push it away from myself (...) So I am not reacting from labelling it as bad, and that I should do something about it. It somehow passes away.” P1

Increased affect tolerance was also linked higher work related competency.

“The anxious states… to allow those too… like, it comes, it goes, and passes away. This gives me a sense of competency.” P4

This increased capacity has enhanced self-efficacy, and mental focus. It was felt to allow more depth in client work.

“I can direct my attention to one person’s life (...) I can think, prepare for these clients and evaluate better in myself. When I write case notes, I write in more length and depth.” P3

Higher in session self-awareness and attentiveness to clients was also reported.

“I pay attention better, to the conversations, I notice more if I have drifted off, and escort it back more.” P2
Increased openness and capacity allowed maintaining an awareness of one’s intentions in client work. One participant found that being aware of personal motivation helped creating a mindful counselling environment.

“To be conscious of this, that someone is coming to see me … and what do I want then? Do I want to help? What do I want? To have this (...) tuning in.” P1

Learning a new approach also resulted in feeling more resourceful and competent, by being able to choose from a wider range of treatment options.

“It’s a great feeling that I have another thing up my sleeve.” P3

5. Prerequisites to use mindfulness in work

This theme is based on two subthemes, the importance of personal practice, and of clients’ motivation. Participants were not asked or expected to teach mindfulness interventions to clients, although knowledge and personal practice of mindfulness may enable one to share the components of this approach, such as meta-cognitive awareness, acceptance or the practices themselves.

Two out of the four participants talked about a lack of confidence to start including mindfulness interventions in their client work.

“I don’t find my knowledge safe enough so that I could share it. Because I need a lot of practice with this.” P2

On-going practice and substantial experience and understanding of the approach were noted to be key elements to share mindfulness with clients.
“I think if someone can’t ride a bike, can still teach someone to ride a bike. But it’s a bit like riding a tandem. We can’t ride a tandem it if either of us knows it that well. Personal experience has a greater role here.” P1

Another participant talked about the necessity to be able to share personal experiences of mindfulness practice. In the substance misuse field it is fairly common that persons in recovery become recovering helpers, and in their work their personal journeys and experiential knowledge become important building blocks. For these professionals their own mindfulness experiences may have more play in client work than knowledge or understanding of concepts and theory.

“I think in order to have a positive effect on someone’s recovery I need to be able to show exactly, what I’m talking about. That I do this, I practise this. I can talk about its’ positive effects on my life. It may be uplifting for the other person, that I do these practises too, because I also have difficulties in my life.” P3

Participants’ accounts diverged on the ways of sharing MBCT; in terms of the approach and the practices as a whole package, or sharing only some of the components. Some felt that that it needs to be delivered in a well-structured format, similar to the course they have attended.

“I need to digest this, think about it. Get more personal experience (...) I look at it as a whole, with transforming thinking, and learning the techniques, so I couldn’t just tear out a bit, and share that.” P2

Another participant talked about sharing it with a sense of readiness, focusing more on the cognitive-relational aspect.
“With this I think it is the approach that is important… I think it is totally deliverable, and I really look forward to use this in work, because I’m curious about how it will go.” P4

Any treatment programme requires adherence and engagement for success. In the case of MBIs it is class attendance, time spent on daily home practice, and learning the exercises themselves. Motivation and involvement were reported by interviewees as a key factor in learning MBIs. When thinking about application in their work, participants agreed that using this approach with involuntary clients may be challenging.

“Those who are not that into their treatment [involuntary clients], I don’t think that they would like to do it.” P2

Some stated that for successful delivery, motivation is ideally aided by capacity and openness, so that clients may benefit from the approach.

“It is for those, who are here really voluntarily, and is a person with better resources, and openness.” P1

There was some divergence about this, too. Another participant noted that the philosophy of mindfulness is something that can be learned implicitly, or through modelling. This may offer a way for reluctant clients to still benefit from MBIs.

“I think if I can do it right, or use it, it’s even transmitted intersubjectively, if you work with someone long enough. Like being non-judgmental, one can just get it.” P4
6. Innovative aspects of MBIs in substance misuse treatment

The final theme was formed around the aspects of the approach that were seen as innovative and important additions to the array of treatment tools currently in use by participants’ services. There was a fair amount of divergence about the particular aspects of the approach which were noted as important advances, however, the data converged on the overarching theme.

Enhancing the ability to explore the complexity of concurrent mental and emotional states was noted as an especially relevant part of MBIs.

“Experiencing that there can be more feelings present at the same time (...) I think this is a really good tool to explore that (...) because you work with these in the here and now.” P2

Being able to support clients in improving their metacognitive capacities, to be present with and observe their thoughts, was noted as a progressive and useful tool.

“Teaching, showing that there is this experience that you are present to what is going on, and you are not in a thought bubble.” P1

Some identified metacognitive awareness as essential for addressing problematic substance use.

“Like, I am inside too, but continually looking out, moving back and forth between perspectives. This is important and can really support recovery… That I won’t get consumed by what’s going on in my head, as there is a continuous in and out linking.” P4

The development of coping skills made possible by the use of the approach was noted. Overcoming polarisation and dissolving extremities were suggested as
milestones in recovery. This may be helped by a less judgmental, open an accepting attitude, and the capacity to reappraise meaning.

“The recovering addict gets stuck in things all the time, and gets sucked into these stories more and more. Especially in the beginning of recovery, labelling is really at work; these extremities of good, bad, black and white. This may help staying sober short term, but it’s so important not to get stuck in this. This [MBCT] is such a good approach for that.” P4

The non-verbal aspects of MBIs, such as sitting with silence and focusing on sensations arising from the body, which are inherent to these approaches, was also noted as offering diversification in services that offer predominantly talking therapies.

“Sometimes it is so needed, to be able to offer something more, beyond mere verbalisation.” P3

The above aspects of the approach were found supplementary to the recovery tools currently in use, adding variation and choice opportunities.

“I think it can really enhance clients’ competencies about their lives. To see that how much they have at hand. I don’t think we have everything in our hands, but we have a lot of tools and opportunities. It’s like a recovery smorgasbord.” P3
Discussion

The aim of this study was to explore application of mindfulness based interventions in Hungarian substance misuse services by investigating counsellors’ experiences of learning and using this approach. In this section I will review the main themes of the analysis in light of existing literature and the study aims.

1. Experiencing a fundamental transition

This process was about moving from mindlessness to mindfulness; becoming aware of mental and emotional contents and allowing them to remain in awareness. A mindful approach to life may be very different to what one is used to; relating to difficult thoughts, feelings and sensations with acceptance is quite the opposite of what is common; approaching these with aversion (Segal et al. 2013). This change in relating to experience with curiosity, openness and acceptance; and developing self-regulation of attention was accompanied by increased positive affect, life satisfaction and intentional living. Previous research also found these reported by those learning mindfulness (Christopher & Maris, 2010, Rothaupt et al. 2007).

Becoming aware of ‘mindlessness’ led to commitment to work towards mindfulness and towards balancing the ‘being’ and ‘doing’ modes of the mind. This balancing was found as an important factor on therapeutic presence and feeling comfortable with silences (McCollum & Gehart, 2010). The participants talked positively about this change, and showed enthusiasm towards continued use of the approach.

These outcomes, such as increased positive affect and well-being, are especially relevant in terms of mediating work related stress.
2. Increased ownership towards responsibility

Participants’ accounts suggest changes in self-acceptance, increased affect tolerance and capacity to handle responsibilities. These can be linked to the heightened awareness of inner and outer experiences and the attitudes openness, curiosity and acceptance as also reported by previous studies (Brown et al. 2013, Irving et al. 2009). Interestingly, the increased responsibility was not communicated as an added burden to an already high workload or as pressure on oneself. Quite to the contrary, reflexivity and self-regulation of attention were found as beneficial and supportive on both personal and professional levels.

The interviews touched on self-awareness of labelling, bias, self-expectation and perfectionism; which may relate to the social context, the highly stigmatising attitudes towards drugs and drug users (Paksi, 2007). This means that the non-judgemental attitude of MBIs may be a useful support for professionals to maintain an awareness of how these can be present in a counselling relationship. Previous studies point towards this (McCollum & Gehart, 2010, Razzaque et al. 2015); counsellors who practice mindfulness reported increased non-judgemental attitude, compassion and acceptance towards both themselves and their clients.

Reflective practice was present throughout the interviews; exploring motivation and managing expectations were reported in context of MBIs, as also mentioned by previous studies (Christopher & Maris, 2010 and Hemanth & Fisher, 2014). The attitude of radical acceptance allowed participants to increase ownership of responsibilities, with a sense of being capable to handle them.
3. Learning mindfulness is challenging

The challenge of this transition is adapt our set ways, behaviours and functioning in order to become more mindful. This was the experience of participants; however they were not discouraged by the difficulties, and have had sufficient practice to feel that their time and effort was rewarded; they showed commitment towards developing their mindfulness skills. Working with substance misusing clients is characterised by high caseloads and emotional exhaustion (Oser et al. 2013, Shoptaw et al. 2000, Sorensen et al. 1989) and the current situation in Hungary is far from ideal (KCKT, 2015); this may have had an impact on finding the resources that were required to take part and fully engage in an 8 week course and adhere to daily practice. Perhaps regarding MBIs as measures of burnout prevention, creating mindful work environments, or allowing time off for practice could be ways of how employers can help counsellors work towards a healthy work-life balance.

The inertness which is part of most MBIs, while also incorporating mindful movement, was also noted by one participant as difficult. Perhaps assessing this before and during teaching and including less stationary practices could work well with those who have lower tolerance for this.

4. Increased capacities at work

As substance misuse workers are under high work pressure (Lacoursiere, 2001) and extremely vulnerable to burnout (Sorensen et al. 1989, Oyefeso et al. 2008), a positive change in self-efficacy, affect tolerance and attention are important outcomes. These findings support previous research that a non-striving attitude
reduces reactivity and provides a more reflective, less disturbed, and more adaptive
mode of consciousness (Brown et al. 2013, Chiesa & Serretti, 2009).
The study found that bringing awareness to the experience and the emotions helped
counsellors’ ability to tolerate their own feelings and to create an emotional container
for the client’s difficult emotions, as also noted by Christopher and Maris (2010). This
was linked by participants to authenticity and deeper empathy towards clients.
Participants’ mindfulness lead to increases in metacognitive awareness, in line with
previous research (Garland et al. 2012), which suggests developments in trait
mindfulness (Kiken et al. 2015).
These outcomes can help professionals to manage difficulties better and feel more
competent and capable at work, which may have positive effects on their well-being
and positively influence treatment results.

5. Prerequisites to use mindfulness at work

There was deviation on confidence to use mindfulness interventions, and in terms of
subjective ability to begin incorporating parts of the approach into client work. Other
research, particularly those teaching MBIs to trainee counsellors did not emphasise
this finding (Hemanth & Fisher, 2014, Christopher & Maris, 2010). Perhaps as the
researchers were also counselling course leaders, they were able to work with their
participants long term; providing support and supervision in application of MBIs
longer than 8 weeks. Also the time between the completion of the course and data
collection is an important factor. Continuing support in learning and applying
mindfulness interventions seems ideal.
Participants highlighted the importance of experiential practice of mindfulness to
understand it, experience its' benefits, and use it with clients in a congruent way. The
importance of on-going practice for those wishing to work with MBIs has been noted elsewhere (Christopher & Maris, 2010, Hemanth & Fisher, 2014 and Segal et al. 2002), this was also confirmed by this study. Personal experience or knowledge is an important factor in the substance misuse field, as there are number of professionals, especially those working with 12 step programmes, who have experienced substance misuse issues and bring this into their client work (Rácz et al. 2015).

Therapists’ modelling of the approach from the depth of their own practice was found of importance previously, in helping clients to get over obstacles in learning (Garland et al. 2012), this was also touched on by participants; but it was also suggested that modelling may also have an effect without delivering explicit mindfulness training.

Participants felt that MBIs are best suited to highly motivated clients as it was theorised elsewhere (Skanavia et al. 2011). As drop-out rates are particularly high for this cohort (Chiesa & Serretti, 2014) and services experience a high percentage of involuntary clients (Rácz et al. 2008), it seems necessary that treatment regimens address this issue. Providing ample information and offering motivational work may need to precede treatments incorporating mindfulness.

6. Innovative aspects of MBIs in substance misuse treatment

Participants found certain aspects of the approach as especially important and novel additions to the array of treatment approaches that they currently use in their client work. MBCT was seen as a useful tool for a safe exploration of mental and emotional contents. Reduced reactivity, a more adaptive mode of consciousness and non-judgmental monitoring may be responsible for this, as it was found as possible
outcomes of MBIs in previous research (Brown et al. 2013, Christopher & Maris, 2010).

Increased metacognitive awareness was also discussed as a beneficial aspect of the approach for those with substance misuse problems, as confirmed elsewhere (Chiesa & Serretti, 2009, 2014). Metacognitive monitoring, and a less rigid and more adaptive mode of mind were mentioned as important tools required for a recovery journey; participants noted that MBIs could help developing these essential skills. The capacity to reappraise meaning and move away from all-or-nothing thinking has been linked to MBIs and managing substance cravings by previous studies (Garland et al. 2014)

Further findings

Increased psychological wellbeing of counsellors was evident throughout the interviews, hopefully on long term it will result in reduced stress, anxiety, depression and burnout as found elsewhere (Fortney et al. 2013). Increased positive affect was reported, but there was little information on changes in negative affect. This may be because the 8 week course did not have an effect on this; or participants focused more on recounting the positives, and talked about the negative emotions in terms of allowing them to be experienced, without discussing changes in the volume of negative affect.

Despite a body of research detailing the difficulties of working in the substance misuse field, this was not evident from participants’ accounts. Firstly, this may be because of the obvious, that they were not asked directly to elaborate on this. Secondly, due to the proximity of the researcher to the participants, it may have been
self-evident for participants that this is part of our shared reality, and therefore there was no need to bring it up in the context of MBIs.

Validity and reliability

Throughout the data analysis I have maintained an awareness of my personal bias towards results; it is my interest to see MBIs become more available in Hungary. This research is a part of those efforts as well, and its’ central aim was to produce credible and transferable results. Throughout the analysis, I have tried to maintain a balanced view of my intentions, motivations and my personal difficulties while being immersed in the sense making of the participants. In order to ensure validity and reliability while accounting for both convergence and divergence, I used rigorous note taking and journaling while working with the data. Following the analysis, I have engaged with peers to get feedback and opinion to reduce researcher bias; and have involved participants in validation; I have shared the results and analysis with them to review whether the findings adequately reflect their experiences; this they have confirmed. As Interpretative Phenomenological Analysis uses double hermeneutics, these steps helped to develop valid interpretations of participants’ sense making.

Strengths and limitations

This study was concerned about applicability, and the qualitative design made exploring this a possibility. The semi structured interviews have allowed participants
to elaborate, think and talk freely about the topics of investigation. For the analysis, IPA allowed more depth and individual variation, than other qualitative measures would have; and the sample size was also adequate for this method. It also allowed my personal and professional experiences to be instrumental in the process. A definite strength of the research was its’ participants; they were not trainee therapists, who are predominantly the subjects of MBI studies, but practitioners with considerable amount of experience. I already had a relationship with them prior to the study, which became deeper and more trusting during the 8 week MBCT course. This relationship allowed for openness and honesty in the interviews.

The interviews took place 2-3 weeks after the course has finished. This may have been a limitation of the study in assessing the effect of MBIs. If participants maintain some personal practice, and begin incorporating the approach in their work, the result probably would have been altered, especially if continuous support were provided. Perhaps a quantitative or mix method study could incorporate investigating changes in trait mindfulness pre and post MBI training.

Another limitation of this study, that it has not involved clients; therefore participants had to make assumptions about what they think might be useful for their clients’ recovery. Involving clients was out of the scope of this project, but hopefully the effect of the training provided will extend to them.

My roles as researcher, colleague and MBCT trainer may also have interfered with the interview process in a negative way. If the interviews were carried out by someone in a less known and more neutral position, that could have allowed for different content and maybe more critique, and possibly different themes.
Conclusion

There were no previous studies on the use of MBIs by counsellors or in substance misuse services in Hungary. The research objectives were wide; this study was mainly concerned about applicability of the approach. Participants collectively felt that MBCT was beneficial for counsellors’ self-care, professional development and for supporting clients in their recovery.

In terms of well-being and self-care, participants found that MBCT increased their capacity to regulate their attention and balance being and doing modes; which was accompanied by increased positive affect, self-acceptance, life satisfaction and intentional living.

In relation to their professional development they have experienced increased self-efficacy, attention, capacity to tolerate their own feelings and to create a holding space for their clients’ difficult emotions. MBCT supported the exploration of personal motivation, awareness of biases, labelling and self-expectations.

These outcomes, such as increased positive affect, self-care and well-being, are especially relevant in terms of mediating work related stress, and helping to prevent burnout. The participants of the study found MBCT as important and innovative addition to the range of treatment approaches.

Readiness to use was mixed; half of the participants have already tried and incorporated aspects of the programme, the other half felt overwhelmed by the complexity of the approach, and felt that they needed more time for personal practice and to digest all that has been learned. The 8 week MBCT course is demanding and covers a broad range of specific topics. Other researchers have offered MBIs to
professionals in other formats such as 1 hour sessions for 10 weeks (Christopher & Maris, 2010), and found that this allowed sufficient time for the exercises, but not for the didactic parts of the course. These didactic elements cover the cognitive approach, which are central to using MBIs with substance misusers. It seems that a fusion of the 8 week course, on-going practice and supervision would be ideal for feeling confident to use mindfulness interventions in work.

Implications for practice

Is it possible to teach mindfulness, without practicing it? Probably yes. However, it has been the tradition of MBI trainers to be experienced practitioners (e.g. Kabat-Zinn 1990, Segal et al 2013). When it comes to MBCT, its’ authors are quite specific: “… teachers who use this approach need skills as qualified and trusted professionals in their own field, but they also require the depth of practice and perspective that comes only from knowing, from the inside, what mindfulness practice is and what is not” (Segal et al 2013, p6.). Although other MBIs, such as ACT or DBT hold that if a practitioner has experienced and understood the concepts sufficiently, continuing practice is not needed.

There is a widely accepted notion that reflective practice requires counsellors to be highly aware of their own internal processes and how these affect their work. The use of MBIs may require not only clients to practice mindfulness, but counsellors, supervisors, and counsellor educators as well. Incorporating MBIs as part of continuing professional development, setting up mindful work environments could benefit professionals and client alike.
The potential difficulties of using the approach with involuntary clients were present in the findings, as expected. Tailoring mindfulness influenced interventions especially to this sub-group could be of value, so that it focuses on both providing ample pre-treatment information and offering motivational work prior to treatment. Perhaps given the flexibility, openness and the effort that are required to engage in MBIs, combining these interventions with Motivational Interviewing (Miller & Rollnick, 1991) could be the way.

**Suggestions for further research**

As this was the first study of MBIs in Hungary in a counselling context, further research could evaluate the use of the approach by counsellors who have had more time for practice and application. On-going support in learning and applying mindfulness interventions would be ideal, and further research assessing the application of mindfulness interventions with participants of this study would be of value.

There are numerous studies of the effects of MBIs on substance misuse, it would be important to investigate uses of the approach with clients who are in treatment instead of punishment.

Further research could examine the aspects of the program that are most difficult to adhere to; such as class attendance, time spent on daily home practice, or the exercises themselves.

Controlled studies on the effects of therapists’ mindfulness are rare; this could shed light on effects of therapists’ modelling of mindfulness to clients.
Personal reflection

This project and especially the analysis were very challenging. It was a novel approach for me, with no previous attempts with the method. I found it enjoyable and exhausting in the same time, and probably would not have been possible without guidance.

My personal practice of mindfulness has been fundamental in managing ups and downs, and I found my practice broadened by this project. As I was focusing on the self-care aspects of my work, my self-care has improved; I have engaged in complementary therapies during the process, and became more conscious of my physical health by beginning to exercise more regularly. Due to other demands in my life, it was very challenging to manage this study, and I found a lot of support in reflecting on self-compassion.

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