Using Meditation in Addiction Counseling

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Meditation has been studied as a way of reducing stress in counseling clients since the 1960s. Alcoholics Anonymous, Narcotics Anonymous, and new wave behavior therapies incorporate meditation techniques in their programs. This article identifies meditation's curative factors and limitations when using meditation in addiction settings.

According to the Substance Abuse and Mental Health Services Administration (2009), an estimated 22.2 million people in the United States ages 12 years or older were classified with substance dependence in 2008. Of those, 3.1 million were classified with dependence on or abuse of both alcohol and illicit drugs. Furthermore, the World Health Organization (1999) described addiction as a worldwide public health problem. Given the growing need for trained and effective professional counselors in the field of addictions, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP; 2009) placed a heavier emphasis on addiction issues in their 2009 CACREP Standards, requiring counselor preparation programs to pay increased attention to addiction-related issues across the curriculum for all students.

For decades, counselors working in addictions have recognized the "long-standing marriage" (Morgan & Cashwell, 2009, p. 34) between addictions counseling and spirituality. For example, 12-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous are widely used (Priester et al., 2009) and are considered to be effective (Kaskutas, 2009; Project MATCH Research Group, 1997) models for the treatment of drugs and alcohol addiction that also have spiritual elements heavily embedded in their message. Seven of the 12 steps reflect spiritual themes of relinquishing control to a higher power to overcome addictions. It is an article of faith in the 12-step community that the perception of God and spirituality can make the difference between relapse and recovery (AA, 1976; Johnsen, 1993).

Spirituality can be described as one's personal experience of a higher power, as opposed to religion, which describes the social bodies that promulgate scriptures, rites, and rituals of a particular faith. According to AA, prayer and meditation are important to the recovery of the addict and can be practiced regardless of one's religion or spiritual background. Similarly, other writers have noted that prayer and meditation are the generic spir-
tual tools that are common to all religions (Roach & Young, in press). For the purposes of this article, we focus solely on the use of meditation as a spiritual method for supporting recovery.

**Meditation in Addiction Treatment**

Meditative practices are used in a variety of health care settings (Baer, 2003) and have been acknowledged as important components of addiction recovery (Pruett, Nishimura, & Priest, 2007). Meditation is specifically referenced in AA’s 11th step, which reads, “We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out” (AA, 1976, p. 71). Moreover, meditation is a tool that is frequently used in drug and alcohol treatment centers. In a national survey on the frequency of prayer, meditation, and holistic interventions in addiction treatment centers, Priester et al. (2009) found that 58% of 139 addiction treatment programs used meditation as a component of treatment separate from prayer alone. Meditation has also been shown to help increase anger management skills (Vannoy, 2005), strengthen recovery motivation, bolster detoxification, manage stress, increase self-confidence, and boost personal well-being (Lohman, 1999; Snarr, Norris, & Fahrion, 2001).

In his landmark book, Glasser (1976) described meditation as a “positive addiction” that is associated with greater psychological balance and well-being. Researchers have supported this notion with the hypothesis that meditation is a practical alternative to alcohol because it results in the same positive consequences, including decreased tension and increased relaxation (Marlatt & Chawla, 2007). Research has also supported the idea that meditation is an effective, low-cost supplement to existing treatments for addictions with the potential to reduce substance use and improve interpersonal and psychosocial functioning (Gelderloose, Walton, Orme-Johnson, & Alexander, 1991; Marlatt & Chawla, 2007). Before discussing the benefits of meditation, we need to first look more closely at issues about addiction to understand how treatments such as meditation might be effective.

**What Is Addiction?**

The American Society of Addiction Medicine defines addiction as a primary, chronic, neurobiological disease that is influenced by genetic, psychosocial, and environmental factors and that is characterized by strong cravings, compulsive use, and a lack of control to stop despite the harm it may cause (Graham, Schultz, Mayo-Smith, Ries, & Wilford, 2003). Research has revealed that people who suffer from addictions often have higher rates of depression and anxiety (Schuckit & Monteiro, 1988), trauma histories or posttraumatic stress disorder (PTSD; Vallejo & Amaro, 2009), anger management problems (Clancy, 1996), family and relationship problems (Campbell, 1986), poor self-awareness (Verdejo-García & Pérez-García,
2008), poor self-control (Baler & Volkow, 2006), low self-esteem (Taylor, Lloyd, & Warheit, 2006), and low self-efficacy (Condiotte & Lichtenstein, 1981). Because these issues are not resolved during the periods of addiction, they resurface during relapse, creating emotional responses that increase the likelihood of relapse (Witkiewitz & Wu, 2010).

The inability to effectively deal with stress is one of the strongest predictors of drug craving, relapse, and continued drug use (National Institute on Drug Abuse, 2002). Stress comes in many forms and can manifest as general tension or traumatic life experiences (i.e., childhood abuse) in the form of PTSD. Numerous studies have examined the relationship among anxiety, stress, PTSD, and substance abuse and have concluded that people with addictions have higher incidences of these disorders when compared with the general population (Courtois, 1988; Herman, 1992; Pekala, Kumar, Maurer, Elliott-Carter, & Moon, 2009; Ross, 1989). Moreover, symptoms of depression, anxiety, and stress disorders have been correlated with a person’s risk of relapse. For example, in their longitudinal study, Gil-Rivas, Prause, and Grella (2009) found that lifetime trauma exposure, along with symptoms of depression and anxiety, was associated with an increased likelihood of substance use 6 to 12 months following residential substance abuse treatment. One of the reasons meditation is considered to be an effective component of addiction treatment is because it has been shown to decrease these common symptoms of depression and anxiety (S. L. Shapiro, Schwartz, & Bonner, 1998; Toneatto & Nguyen, 2007) while simultaneously training the meditator to manage stress more effectively (B. Carlson & Larkin, 2009; Goleman & Schwartz, 1976; MacLean et al., 1997; Plasse, 2002; Vannoy, 2005). This notion of meditation as an emotional palliative, or emotion-focused coping, might be an attractive way to introduce meditation to the person in addictions treatment.

What Is Meditation?

Despite its origins in spirituality and religion, meditation has been extracted as a secular technique and studied widely since the 1960s as a tool for enhancing mental health and overcoming mental disorders (Field, 2009). It has been used in a variety of therapies, including mindfulness-based stress reduction (Kabat-Zinn et al., 1992), mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002), dialectical behavior therapy (Linehan, 1993a), and acceptance and commitment therapy (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Although meditation has been practiced in the East for over 2,500 years, it has only begun to influence Western therapy in recent years (Walsh & Shapiro, 2006).

There are several disciplines of meditation (e.g., transcendental meditation, Zen meditation, and Vipassana meditation) that are often mistakenly lumped in the same category. Therefore, a clear definition of meditation is necessary (S. L. Shapiro, 2009). For the purposes of this article, we use D. H. Shapiro’s (1980) definition that “meditation refers to a family of tech-
niques which have in common a conscious attempt to focus attention in a non-analytical way, and an attempt not to dwell on discursive, ruminating thought” (p. 14). In general, the aspirant sits in a comfortable pose and with relaxed attention pulls away from external distractions and bodily sensations and especially from thoughts (R. Singh, 1998).

There are various categories of meditation practiced within both secular and spiritual traditions. In general, they can be broken into three groups: (a) devotional meditation, which is often associated with the Christian tradition; (b) mantra meditation, which can be focused or unfocused; and (c) mindfulness meditation. Priester et al. (2009) explained that devotional meditation involves contemplation on a particular prayer, positive thought, or biblical passage and is often encouraged by 12-step programs as a daily morning practice. Mantra and mindfulness meditations are described as follows.

Mantra meditation. A mantra is a word or phrase that is repeated for the purpose of keeping the mind occupied during meditation. This phrase can be a name of God or any other word, such as One, Peace, or Shalom. In most cases, the aspirant is advised to use the mantra throughout the day, not just during sitting meditation, to keep the mind from running into the past or the future and to bring it under control (Benson, 1975). In the unfocused type of mantra meditation, such as Maharishi Mahesh Yogi’s popular transcendental meditation (Roth, 1994), the aspirant does not focus attention but repeats a mantra and mentally brushes away thoughts. Transcendental meditation was used in many of the early studies on meditation, including Wallace and Benson’s (1972) pioneering research showing physiological changes from practicing meditation. Herbert Benson, then at Harvard University, published a popular account of his research in his book, The Relaxation Response (Benson, 1975). Benson had extracted a secular version of transcendental meditation because, at that time, he felt that the primary effects were due to stress reduction. Later, Benson concluded that a spiritual attitude potentiated the effect of this mantra-based meditation, prompting a new book, Beyond the Relaxation Response, in which he touted the faith factor (Benson, 1984).

A second kind of mantra meditation is the focused type. Here, the meditator keeps his or her inner vision at a single point, generally at the third or single eye, which is between and behind the two eyebrows. The meditator focuses the attention in a relaxed but penetrating way in the middle of the darkness and repeats a mantra or some name of God. Practitioners of this type of meditation report experiences of inner light and sound as well as feelings of happiness and joy (R. Singh, 1998). Focused meditation is practiced by many groups, especially by millions in the Sant Mat Path, which originated in northern India (K. Singh, 1961).

Mindfulness. Thich Nhat Hanh, a Vietnamese Buddhist monk and one of the most acclaimed practitioners, explains that mindfulness involves learning to be nonjudging and nonattached to one’s thoughts in order to achieve peace and happiness (Willis, 2003). When practicing mindfulness,
the aspirant exercises intentional awareness and focuses the attention on breathing while striving to become keenly aware of what is happening in the present moment, both during and outside of meditation. Psychological and health researcher Ellen Langer (1989) believed mindfulness has important implications for health and survival and defined the term as the process of paying attention in the present moment without judging.

Jon Kabat-Zinn, a pioneer in mindfulness meditation, began using the practice with patients in 1979 for a stress reduction program at the University of Massachusetts Medical Center to help treat a range of physical and psychological disorders (Bishop, 2002). Now, mindfulness meditation is used in more than 240 hospitals and treatment centers throughout North America and Europe (Kabat-Zinn, 1998). It has also been shown to have similar beneficial effects on health care professionals, including decreased burnout and increased empathy (Krasner et al., 2009).

Curative Factors in Meditation

In her review of mindfulness as a clinical procedure, Baer (2003) identified and defined the underlying curative mechanisms that might be at work in mindfulness, namely, exposure, cognitive change, self-management, relaxation, and acceptance. Although Baer is describing mindfulness, it is likely that these factors are also present in other kinds of meditation. They are described briefly in the following sections.

Exposure. Mindfulness interventions use exposure when clients are asked to face their thoughts and feelings without judging or avoiding them. During mindfulness activities, the participant does not fight or get stuck on these thoughts but allows them to slide off the Teflon mind (Linehan, 1993b). For a client with addictions, this can also be called urge surfing, a term used to describe how one can use one’s awareness as a “surfboard” to “surf the urge” by allowing it to rise up and decline without “wiping out” and giving into the urge (Marlatt & Chawla, 2007, p. 452).

Cognitive change. Cognitive change can occur when clients realize that the labels they are giving to thoughts and feelings may be inaccurate. Through mindfulness, clients begin to recognize that thinking a negative thought does not make it true (Carrington, 1998).

Self-management. Clients may be learning self-management from mindfulness training because, as they observe themselves in the present moment, they are learning to focus away from depressing or anxiety-producing thoughts. Clients who are aware of their thoughts and are not avoiding them may also be more sensitive to potential relapse risks.

Relaxation. Relaxation has been repeatedly found to increase during and after mindfulness practices. Relaxation is seen as a by-product of meditation and can aid in stress-related disorders (C. R. Carlson, Bacaseta, & Simanton, 1988).

Acceptance. Acceptance is both a goal and an activity of mindfulness practice. Clients benefit from acceptance when they recognize that it might not
be possible to change all of the unpleasant symptoms they are experiencing. For example, when a person with an addiction encounters an intense desire to use during mindfulness meditation, the goal is to exercise acceptance of the urges, not to fight them (Marlatt, 1994; Marlatt & Chawla, 2007). Baer (2003) stated that it is easier for people to accept that they may only be able to reduce their symptoms as opposed to trying to eliminate them all together. Therefore, acceptance of symptoms is the first step in treating them through mindfulness.

Finally, one of the curative factors that may be effective in addictions treatment involves meditation's reputed capacity to produce positive emotional states such as peace and feelings of well-being (Alterman, Koppenhaver, Mulholland, Ladden, & Baime, 2004). In her chapter on meditation and positive psychology, S. L. Shapiro (2009) stated that the goal of meditation is to expand the mind’s capacity for empathy, happiness, awareness, and insight, leading to “total liberation” (p. 602) from suffering. In other words, meditation is used not only used to decrease negative thoughts and emotions but also to build a reservoir of positive ones (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Smith, Compton, & Beryl, 1995).

**Mindfulness and Cravings**

Kabat-Zinn (2005) hypothesized that drugs, alcohol, and stress dysregulate the central nervous system and that mindfulness meditation can act like an antidepressant enriching the brain’s neural structures. Moreover, for a person with addictions, mindfulness can help decrease intense cravings that can lead to relapse. Groves and Farmer (1994) asserted that “mindfulness might mean becoming aware of triggers for craving. . . and choosing to do something else which might ameliorate or prevent craving, so weakening habitual responses” (p. 189).

In their article on mindfulness-based relapse prevention, Witkiewitz, Marlatt, and Walker (2005) explained how mindfulness may disrupt the intense craving cycle. Basing their assertions on a cognitive behavior model, they pointed out that craving responses are made up of environmental cues and rigid cognitive responding, which elicit strong motivations for engaging in addiction behavior. When people with an addiction then engage in substance use, their negative withdrawal symptoms subside, and as a result, they experience positive reinforcement for continued use. Witkiewitz and colleagues argued that mindfulness meditation disrupts this cycle by ushering in curative mechanisms in the form of nonjudgmental, nonreactive awareness and acceptance of the craving response, thus acting as a form of counterconditioning that can serve as an alternative to addiction.

Moreover, in new wave behavior therapies, such as acceptance and commitment therapy (Hayes et al., 2006), the accepting attitude is seen as a way around the internal struggle associated with other cognitive therapies. By focusing on gentle acceptance of their urges, clients are less likely to wage an exhausting and unpleasant internal battle in an attempt to defeat their
cravings. There is no doubt that craving is a complex and daunting issue in research and treatment (Tiffany & Wray, 2009), but there now seems to be enough evidence to recommend further research on the efficacy of meditation in craving reduction.

**Counseling Implications**

Before using meditation with a client, the counselor should examine several factors, including timing, training, client stage of recovery, treatment setting, client schedules, and medications (Pruett et al., 2007; Vallejo & Amaro, 2009). Counselors have an ethical responsibility to receive appropriate training before practicing meditation with clients, should present it as a helping technique (not a cure-all), and should use it with clients who are open to meditation and who remain committed to the recovery process (Pruett et al., 2007). Furthermore, as in most counseling settings, a counselor should seek to understand a client's cultural identity before using meditation with the client. Although meditation is considered acceptable in many cultures and religions, it may not be appropriate with clients from every culture (Pruett et al., 2007). For example, some fundamental Christians associate meditation with a purely Eastern point of view and may not be comfortable with learning a technique that may not be acceptable to their religion.

In this same vein, a counselor should adhere to ethical and competent practice guidelines such as those promulgated by the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC; 2009). These revised ASERVIC Spiritual Competencies recommend that counselors who introduce meditation or any spiritually oriented treatment should be competent in six general areas. Counselors should (a) have a firm understanding of the client’s culture and worldview, (b) be knowledgeable about their own biases and beliefs, (c) understand stages of religious and human development, (d) be able to communicate with the client in a sensitive and accepting way, (e) be adept at gathering crucial information about the client's beliefs and problem areas, and (f) use the knowledge that they have gained to develop a treatment plan that is consistent with the client’s system.

Furthermore, understanding and identifying a client’s stage of recovery is an important consideration. For the purposes of this article, we operate from the belief that there are three broad stages of recovery: early recovery, middle recovery, and late recovery. Meditation tends to work best in the middle and late stages of recovery because clients typically have some experience with abstaining from drug and alcohol use. In early recovery, however, people with addictions are seeking to accomplish abstinence. Abstinence is a necessary condition for successful meditation because it is the first step toward a healthy physical, psychological, and spiritual lifestyle. This is the stage when clients are learning the skills to help them abstain. Physical withdrawals are often a by-product of initial detoxification and
can greatly hinder a person’s ability to focus or be still, two conditions necessary for meditative practice.

In their article on adapting a mindfulness practice for addiction relapse prevention, Vallejo and Amaro (2009) noted several challenges clients faced while attempting to meditate in early recovery. They noted that the stillness required to do seated meditation was extremely difficult for people in the early stages of recovery, because some clients’ bodies were too hyperactive. Also, certain drugs prescribed to clients to aid them in recovery induced sleep or gaps in attentiveness any time clients closed their eyes, even for a few moments. Furthermore, they found that the “loud mental noise” (Vallejo & Amaro, 2009, p. 194) present in early recovery was amplified by meditation, making peace and serenity difficult.

Simple preparation and explanation of meditation practice can be a powerful intervention at this early stage. Mel Ash (1993), an author and Zen teacher who is also a self-described recovering alcoholic from an abused childhood, sees meditation as a tool to help clients live in the present moment or one day at a time. With mindfulness practice, he explained, things that previously seemed overwhelming and unmanageable in a person’s life can become more manageable. He compared mindfulness to a sharp knife that becomes dull and rusted from substance abuse. Through continuous mindfulness practice, he stated, people are able to overcome their fears, doubts, and resentments that feed into their addictions. This may be due to the fact that during meditation, one’s focus is on the present moment, not on one’s cravings, past difficulties, or worries about the future.

One cognitive behavior technique to use at this stage is known as the chocolate meditation. Singer (2006) developed the exercise for patients in detox because it allowed them to experience and overcome a less serious craving through focusing their attention to the here-and-now. This group exercise consists of touching, smelling, and placing chocolate between a person’s lips without the person putting it in the mouth. Group members are asked to focus their attention to their thoughts and sensations throughout the exercise, noting any reactions such as a salivating mouth or an intense desire to bite the chocolate. Group members are then asked to return their focus to their breathing until any urges subside. This exercise is a gentle way to help a client become more aware of thoughts and bodily sensations during cravings while fostering increased self-awareness and self-control.

In the middle stage of recovery, clients begin attempting to restructure negative cognitive beliefs about themselves and the world around them. It is also a time for clients to repair some of the damages in their lives caused by their addictions. This is a stage when clients are typically more comfortable in abstinence and are focused on ways to make changes in their lives emotionally, spiritually, socially, and physically. Middle recovery ends when a person achieves peace and balance in these areas. Still, a person in middle recovery has his or her own set of challenges when attempting to achieve a meditative state. For example, Vallejo and Amaro (2009) noted that for
some clients, sustained attention placed on previously abused parts of the
body during the body scan can lead to unpleasant memories of abuse that
are retraumatizing.

To acquaint clients with body sensations at a slow, safe, respectful pace,
Vallejo and Amaro (2009) used mindful Hatha yoga and meditation classes
within recovery. In this type of yoga, participants are urged to take re-
sponsibility for listening to their bodies and to resist making the body go
beyond what feels comfortable. The overall goal of the practice is to help
people in recovery identify and adapt their practice in a manner that re-
spects their bodies’ needs. Transformation occurs when clients are able to
track how their thoughts and feelings affect their bodily sensations (Vallejo
& Amaro, 2009).

During late recovery, the focus is largely on relapse prevention. The goal
of relapse prevention is to teach individuals who are trying to change their
behavior how to anticipate and cope with the problem of relapse. For a
person recovering from addiction, social pressure coupled with poor self-
efficacy, poor-self awareness, or an inability to effectively cope with stress
can set off triggers that elicit an intense desire to use (Marlatt & George,
1984). To maintain sobriety, a person in recovery needs stability and secu-
rity to continue dealing with emotional and physical triggers in a healthy
way. Self-awareness is an important tool during this stage, because it can
be used to defuse potential relapse triggers (Marlatt & George, 1984). In
the program developed by Vallejo and Amaro (2009), clients were taught
mindfulness skills to bring about moment-by-moment awareness whenever
their mind would dwell in the past or the future. Through continued
meditation practice, a person in recovery is better able to effectively man-
age the barrage of thoughts, feelings, and urges that may have preceded
previous relapse episodes (Marlatt & Marques, 1977).

The setting in which treatment takes place is a factor to consider when
prescribing meditation for clients in recovery. For example, residential treat-
ment centers tend to enforce stringent schedules and medication routines.
This may prevent a client in this setting from having a regular time set aside
for meditation unless it can easily become part of the schedule. Moreover,
certain medications, such as Methadone or Topomax, can cause increased
sleepiness, making focused, alert attention challenging for clients in detox.

Limitations

Although a number of therapeutic frameworks have been created to lend
organization and logic to meditation practices in recovery settings (Curtis,
Martin, & Shelley, 2002; Marlatt & Gordon, 1985), there are still limitations
when attempting to adequately address the multidimensional nature of
addiction through meditation (Pruett et al., 2007). One of the difficulties
in arriving at conclusions about meditation research is that there is no
standard form of meditation treatment and little agreement about length
of treatment. Another concern is in the breadth of conditions and subjects treated with meditation, making it difficult to present blanket statements about which type of addiction meditation benefits clients the most.

Also, the strength of meditation treatments varies considerably. There is some indication that longer periods of meditation and more consistent practice increase the potency of the treatment (Wachholtz & Pargament, 2005). Yet, the length of time one meditates, the length of the instruction, and the amount of homework assigned have not been standardized for research purposes in counseling or addictions treatment. However, mindfulness-based stress reduction (Kabat-Zinn et al., 1992) appears to have become the standardized treatment in medically based research.

Finally, in most studies, meditation has been stripped from its religious and spiritual context to appeal to Western participants. In several studies, there is evidence that incorporating spiritual and religious beliefs into meditative practice can substantially increase the power of the treatment. This fits with the notion in both Eastern and Western mysticism that meditation is intertwined with a lifestyle of self-control, peacefulness, and right conduct, none of which are required in the Western approaches. Thus, its potency and potential as a life-changing experience as claimed by traditional practitioners may be diluted or lost in clinical trials in which only the technique is tested and the aims are different. For example, mindfulness-based stress reduction is popular among researchers, yet it is not purely meditation in the spiritual sense because its goal is stress reduction rather than spiritual fulfillment. Therefore, including meditation in total lifestyle change as endorsed by 12-step programs has support from traditional meditation systems but may be lacking in meditation-only programs.

Conclusion

Counselors working in addictions have consistently recognized the link between addictions counseling and spirituality. Although there is limited empirical evidence to support the efficacy of any one method of meditation for addiction-related issues, meditation in general has been shown to be an effective tool in treating stress and distress that surface during recovery.

Meditation has been studied widely since the 1960s as a spiritual, religious, and secular tool for enhancing mental health and overcoming mental disorders and is defined by D. H. Shapiro (1980, p. 14) as a “family of techniques which have in common a conscious attempt to focus attention in a non-analytical way, and an attempt not to dwell on discursive, ruminating thought.” Evidence seems to suggest that using meditation as a spiritual intervention and in conjunction with a 12-step recovery program may be the most effective approach because this has been shown to decrease symptoms that are correlated with relapse, including depression, anxiety, anger management problems, poor self-awareness, poor self-control, low self-esteem, and low self-efficacy. Future research should focus on the direct
effects of meditation-based approaches on decreasing craving and relapse and increasing positive emotional states that broaden and build coping resources (Frederickson et al., 2008).

Devotional meditation, mindfulness meditation, and mantra meditation are all practices with underlying curative mechanisms that can aid a person in recovery, including exposure, acceptance, self-management, relaxation, nonjudgment, awareness, and cognitive change. Meditation seems to work best in the middle and late stages of recovery because clients typically have some experience with abstaining from drug and alcohol use. Meditation can be challenging for clients in the early stage of recovery, specifically for clients who have not completed detoxification, and therefore specific practices may need to be adapted to meet the needs of the client. Finally, counselors should receive training before using meditation with clients and should present meditation as a technique that can aid relapse prevention, not as a cure for addictions. Counselors are encouraged to consult ASERVIC's (2009) Spiritual Competencies to ensure ethical and sensitive treatment when using any spiritually oriented method.

References


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