Mindfulness and Mandalas: Alternative Therapeutic Techniques for AOD Adolescents
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ABSTRACT
Mindfulness-based practices and mandalas are recognized for their healing properties. Recent academic literature supports the use of these alternative therapeutic techniques with the AOD (alcohol and other drug) adolescent population in preventing relapse and maintaining sobriety. The purpose of this project was to implement the techniques gleaned from research on the use of mindfulness-based exercises and mandala art directives through an existing drug rehabilitation/recreational program for AOD adolescents a drug and alcohol treatment facility in Columbus, OH. Participants engaged in three different mindfulness-based exercises and completed a mandala art directive following each exercise. Participants selected for this study were under the supervision of facility’s primary licensed clinicians, case managers, and recreational therapist, as well as the approval of a board certified art therapist. The implementation of these techniques with the AOD adolescent population was successful and should be considered in recovery treatment plans at additional facilities.

INTRODUCTION
The current treatment program at the drug and alcohol treatment facility that participated in this research is founded on the Alcoholics Anonymous (AA) 12 Steps. While at the facility, clients engage in “diverse treatment modalities...that address the teen’s unique needs and those of their family” (quoted from the facility’s literature). These include recreation and art therapy, psychological and psychiatric services, drug and alcohol counseling, and life-skills development group sessions.

Although the facility does not currently use mindfulness-based practices, recent studies promote the use of mindfulness meditation as an emerging therapeutic technique supporting positive treatment outcomes for individuals with addictive disorders (Marcus & Zgierska, 2012). Mindfulness meditation is an effective therapeutic technique in the treatment of addiction because it “limits experiential avoidance by promoting nonjudgmental acceptance of moment-to-moment thoughts and by interrupting the tendency to respond using maladaptive behaviors such as substance use” (Marcus & Zgierska). This therapeutic technique is applicable to the adolescent population as during this stage of development “adolescent thought transitions from childhood into more abstract cognition that applies hypotheses and deductive reasoning to provide an ability to grasp the complex concepts associated with mindfulness” (Montgomery et al., 2013). Although there is literature to support the use of mindfulness in the treatment of adolescents with addictive disorders, “only in the recent year have researchers begun to investigate the impact of mindfulness therapies on adolescent illness” (Montgomery et al.).

Mindfulness-based practices and the use of mandalas have been established as alternative therapeutic techniques with adolescents in residential treatment for addiction. The purpose of this research was to implement the mindfulness-based practices and the use of mandalas through an existing drug rehabilitation program for AOD (alcohol and other drug) adolescents.

The definition of mindfulness is often more easily stated in words than practiced. The literature concerning mindfulness presents a variety of definitions of the term, however, all woven from a common thread. Dankly and Stanton (2014) describe mindfulness as “paying attention in a particular way”. This type of attention requires that an individual pay attention on purpose, in the present moment, and non-judgmentally (Dankly & Stanton, 2014). According to Marcus and Zgierska (2012), attention is directed towards one’s awareness of “thoughts, feelings, and bodily sensations as they arise”. In addition to an awareness or attention to the present moment, mindfulness requires that the individual recognize and accept the impermanence of these experiences, refraining from attempts to suppress or modify them (Marcus & Zgierska). Lineman (cited in Dankly & Stanton) provided a more simplistic definition of mindfulness by using an analogy. Lineman described mindfulness as a skill that one acquires, that puts “you in the driver’s seat so that you are in control of your mind, rather than your mind being in control of you” (Dankly & Stanton).

Mindfulness and meditative practices are closely linked. Like mindfulness, meditation requires that the individual consciously “attempt to focus attention in a non-analytical way...attempt[ing] not to dwell on discursive, ruminating thought” (Young et al., 2011). Meditation has three primary types of practice: devotional, mantra, and mindfulness. Devotional meditation is most commonly used in Christian tradition (Young et al.). Mantra meditation may be further classified as either focused or unfocused. In focused mantra meditation the aspirant repeats a word or phrase, called a mantra, “for the purpose of keeping the mind occupied during meditation” (Young et al.). It is advised that focused mantra meditation be practiced “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” (Young et al.). On the other hand, in unfocused mantra meditation “the aspirant does not focus attention but repeats a mantra and mentally brushes away thoughts” (Young et al.). Mindfulness meditation, however, is a type of meditation in which the aspirant strives to find peace and happiness through the use of breathing exercises that can be practiced “both during and outside of meditation” (Young et al.).

Mindfulness meditation has its roots in Buddhist Vipassana (Marcus & Zgierska, 2012). Its development is attributed to Gautama Siddhartha (the Buddha) circa 500 BCE in India (Coholic, 2010). An ancient holistic philosophy, mindfulness meditation was originally used “as a holistic teaching whose purpose was to relieve human suffering, to increase compassion and loving-kindness among its practitioners, and to help individuals attain the peace of enlightenment” (Coholic).

Mandalas, like mindfulness meditation, provide an additional tool in which to focus one’s thoughts. The term mandala is the Sanskrit word meaning “circle” thought to have originated from “ancient Islamic beliefs concerning the importance of the center as a sacred space from which a cosmic power can enter a figure” (Buchalter, 2013). In addition, the sacred form of the mandala has been used by Hindus and Buddhists as aids in meditation (Buchalter). The Buddhist religion required that monks follow “strict and detailed instructions concerning how mandalas must be constructed and which colors must be used in which circumstances” (Buchalter).

Much like the impermanency of one’s thoughts in the practice of mindfulness meditation, the mandala represents a sense of impermanency in Buddhism, as the intricately detailed and time-consuming patterns are created only to be washed away by the ocean currents. The connection between mindfulness meditation and mandalas stretches across a variety of cultures, religions, and periods of time. The mandala serves as a tangible object in which to focus one’s inner thoughts, assisting in the difficulty of quieting one’s mind during the practice of meditation (Buchalter, 2013). Its tangibility aids in preventing wandering thoughts, keeping individuals engaged in the present moment (Buchalter, 2013). Many individuals experience a sense of “comfortability” when using mandalas. According to Buchalter, “Clients tend to feel more comfortable working within the circle because it is structured and defined” allowing them to “feel freer to reveal true feelings…and less likely to hide behind superficial images”. Using mandalas in the therapeutic process facilitates self-awareness as individuals may continuously refer to the object for knowledge and insight, ultimately prompting one towards positive lifestyle and attitude change (Buchalter).

While the use of mindfulness meditation and mandalas benefit a variety of individuals, the use of these therapeutic techniques is extensive with individuals suffering from addiction. The 12-Step Program, an addiction recovery plan used by Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), references the use of mindfulness meditation in its eleventh step. Young et al. (2011) elucidate this reference, which states, “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”. Although this step addresses the religious beliefs of Christianity, AA/NA acknowledge that “prayer and meditation...can be practiced regardless of one’s religion or spiritual background” as these are tools that are common across many religions (Young et al.). The use of meditative practices is not just unique to AA/NA, an organization that has implemented meditation techniques since the 1960s (Young et al.). Today, “meditative practices are used in a variety of health care settings and have been acknowledged as important components of addiction recovery” (Young et al.). Drug and alcohol treatment facilities frequently use this alternative therapeutic treatment technique. Young et al. noted a national survey of the frequency of alternative therapeutic treatments, with “58% of 139 addiction treatment programs us[ing] meditation as a component of treatment separate from prayer alone”.

The use of meditation is crucial for the recovery of individuals suffering from addiction. These individuals often experience similar symptoms and are frequently diagnosed with mental illness of psychological or physiological origin. Stress seems to be the most prevalent symptom for this population. Marcus and Zgierska (2012) acknowledged the relationship between stress and addiction: “Stress increases the likelihood of alcohol and drug use, and can precipitate relapses”. The use of drugs and alcohol to manage stress can “dysregulate the central nervous system” leading one to relapse (Young et al., 2011). In addition, many individuals suffer from depression and anxiety. Meditation is an effective technique in alleviating the symptoms of this population, aiding in the recovery process. Mindfulness meditation has been shown effective in preventing substance use through limiting “experiential avoidance by promoting nonjudgmental acceptance of moment-to-moment thoughts and by interrupting the tendency to respond using maladaptive behaviors such as substance use” (Marcus & Zgierska). Mindfulness meditation is a practical alternative to alcohol and other drugs as it teaches the individual “not to react automatically but respond with awareness” whenever the individual experiences intense cravings (Marcus & Zgierska). Research shows that mindfulness meditation can enrich neural structures in the brain, serving as a natural antidepressant, and “decreasing intense cravings that can lead to relapse” (Young et al.). Moreover,
mindfulness encourages the “recognition that stress, negative affect, and low distress tolerance are important triggers for relapse” and through “repeated experience of observing rather than reacting to one’s urges or emotional responses to eliciting stimuli may engender a greater sense of control over the actual decision to use” (Britton et al., n.d.). Special considerations must be taken when implementing mindfulness meditation with individuals suffering from addiction. Stage of development is an important factor to consider with the AOD adolescent population. According to Erikson’s theory of development, “adolescence is a period marked by the need to establish one’s identity and self outside of the familial context” (Montgomery et al., 2013). During this stage of development, adolescent thought transitions from childhood into more abstract cognition that applies hypotheses and deductive reasoning to provide an ability to grasp the complex concepts associated with mindfulness” (Montgomery et al.). In addition to stage of development, one should consider psychosocial factors before implementing mindfulness meditation with the AOD adolescent population. According to Bowen’s theory, enmeshed, or undifferentiated youths, engage in delinquent behaviors, such as drug and alcohol use “partly as a result of [the] individuals’ inability to differentiate themselves from the family” (Montgomery et al.). Other problematic factors include peers, school and the community, and without the support and participation of these systems, efficacious treatment of the individual’s symptoms is significantly decreased (Montgomery et al.).

A third consideration includes treatment location. Young et al. (2011) noted the importance of setting when implementing meditation in residential treatment: “Residential treatment 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”. In addition, certain medications, such as Methadone and Topomax “can cause increased sleepiness, making focused alert attention challenging for clients in detox” (Young et al.). Client stage of recovery is another factor to consider before implementing meditation. Young et al. denoted three primary stages of recovery: early, middle, and late, of which the latter two allow meditation to work best “because clients typically have some experience with abstaining from drug and alcohol use”.

When implemented at the correct stage of recovery, mindfulness meditation and the use of other alternative therapeutic treatment techniques yield beneficial results. One of the most compelling benefits of practicing mindfulness meditation is the limitation of experiential avoidance, “or an individual’s unwillingness to remain in contact with unpleasant thoughts and experiences” (Marcus & Zgierska, 2012). This specific benefit is crucial to the individual’s successfulness in recovery as an unwillingness to acknowledge and accept intense thoughts and cravings to use can ultimately encourage maladaptive behaviors. The benefits of mindfulness meditation extend beyond the physiological scope; they positively affect emotional and physical health. Mindfulness meditation improves emotional distress through its ability to increase self-esteem, self-awareness, and self-acceptance (Buchalter, 2013). Anger and stress management skills are positive effects from mindfulness meditation practice (Young et al., 2011). Recent studies have demonstrated mindfulness meditation as a contributing factor to “improvements in self-reported sleep disturbance” as well as improvements in “immune system functioning, allergies, asthma, cancer, depression, fatigue, heart disease, sleep problems and high blood pressure” (Montgomery et al., 2013; Buchalter). However, one of the most attractive benefits of mindfulness meditation may be its cost effectiveness in conjunction with, or supplemental to, other therapeutic treatments (Young et al.).

Another alternative therapeutic tool, mandalas, produce beneficial results. According to Buchalter (2013), “Clients are better able to express feelings, thoughts, hopes, fear, and dreams when they create mandalas; their stress level and anxiety decreases”. Healing, insight, and the integration of an individual’s inner and outer worlds are further advantages of using mandalas in therapy (Buchalter). Mandalas facilitate the improvement of an individual’s creativity and concentration (Buchalter). A significant benefit of creating mandalas is their tangibility; clients can return to their mandalas, analyzing and reflecting upon what they have made. According to Buchalter, reflection and analysis of one’s mandala “helps clients learn coping techniques such as choosing one’s battles and focusing on the positive aspects of life instead of the negative...clients learn how to identify and avoid anxiety triggers...they focus on support systems and asking for help when needed”.

Based on the previous literature there is evidence that mindfulness meditation and mandalas are effective therapeutic tools for the treatment of individuals suffering from addiction. However, even though “the number of publications with ‘mindfulness’ in the abstract or keywords [has] grown...to over 350 by 2010”, the research on these techniques still is limited (Dankly & Stanton, 2014). According to Montgomery et al. (2013), “Only in recent years have researchers begun to investigate the impact of mindfulness therapies on adolescent illnesses. To date...there has been no synthesis of research on mindfulness therapies with adolescents”. Another limitation of the existing research is that the literature contains no measurement, or quantitative data, of the results of mindfulness over time; the current literature is qualitative in nature. Future directions for research in this domain includes experimentally varying the
“intensity of meditation” and dismantling “individual intervention components” to address the effectiveness of multiple treatment interventions when used in conjunction with mindfulness meditation (Britton et al., n.d.). Although the literature recognizes the benefits of mindfulness meditation and mandalas as separate therapeutic techniques with the AOD population, more research is needed to bolster literature concerning the combined use of these holistic based treatment interventions.

**METHOD**

**Participants**

The residential AOD adolescent boys’ unit was recruited as participants in this project. Participants were male, between the ages of 12 and 18 years, and currently in residential treatment for at least three months. Before recruiting participants, approval was granted by the site, adolescent treatment specialist, and registered art therapist. In order to participate in the project, participants were asked to sign a consent form and photo release document, of which the treatment specialist, art therapist, and student researcher signed. Participants were informed that all identifying information would be confidential and of the potential benefits and risks from participating in this project. There was no compensation for participating in this project. Participants were recruited from an outpatient and residential treatment facility for adults and adolescents with addiction and mental illness in Columbus, OH. The university’s Institutional Review Board approved using human participants in this research.

**Interventions**

The interventions used in the project were gleaned from the scholarly research concerning mindfulness-meditation and the use of mandalas with the AOD adolescent population. Three mindfulness-meditation scripts from Dankly and Stanton (2014) were implemented in this project: Mindfulness of an Object; Mindful Body Scan. In addition, the work of Buchalter (2013) was used in selecting appropriate mandala art directives to correlate with the mindfulness-meditation scripts. These mandala art directives included: Mindfulness Exercise, Release, and Body Scan.

**Procedure**

One mindfulness-meditation exercise and mandala art directive was scheduled each week, with the total project taking three weeks to implement. The order of the mindfulness-meditation exercises were selected based on level of difficulty and participant involvement, with each mindfulness-meditation exercise building upon itself the following week. Group rules were established during the first session, and repeated in the subsequent sessions. Before beginning the first mindfulness-meditation exercise, an introductory script was read by the student researcher explaining the concepts of mindfulness-meditation and mandalas and their usefulness in everyday life. Each session began with a review of mindfulness-meditation and mandalas. Participants were asked to engage in the mindfulness-meditation exercise and then complete a mandala representing their experience with the technique. During the first session, participants engaged in mindfulness of an object (leaf). Participants were then asked to draw their reaction to the experience through color, shape, objects, or figures. The second session required participants to engage in mindfulness of breath, visualizing what they breathed out during the exercise. Participants were then asked to draw what they breathed out, such as stress, anger, or fear, using size, shape, color, and texture. In the final session, participants were guided through a mindful body scan, focusing on any areas of tension in their body. Participants were then asked to divide their mandalas in half, drawing how they felt before the exercise on one half, and how they felt after the exercise on the other half. Group processing, discussion, and clean up followed each of the sessions.

**RESULTS**

The content of the participant’s artwork was related to the mindfulness meditation exercise. Each exercise was designed to build in level of difficulty and participant involvement and the complexity of the artwork increased with each session. The first mindfulness meditation exercise, mindfulness of an object (leaf), resulted in drawings related to nature. Participants chose to depict trees, leaves, and relaxing outdoor settings, such as the ocean. Many participants traced the leaves they selected for the exercise on their mandalas. The second mindfulness meditation exercise, mindfulness of breath, required participants to draw what they breathed out. This exercise resulted in more diverse artistic expressions. Content included drawings of a face, nature scenes, a rainbow of marker scribbles, and images of events the participants had experienced earlier in the day, such as a difficult group session. The final mindfulness meditation exercise, mindful body scan, asked participants to divide their mandala in half, drawing how they felt before the exercise on one side, and how they felt after the exercise on the other. These mandalas depict images that contrast in nature -- happy and sad smiley faces, opposing elements of weather, detailed drawings versus chaotic scribbles.

Similar to the content of the artwork, participant receptiveness to the techniques varied. Although the participants were quiet and respectful of others during the mindfulness meditation exercises, most of them used the opportunity to sleep. Only a few participants actively participated in the exercises, paying
close attention to the directions and noticing their sensations and thoughts as they arose. The receptiveness of the participants depended on their level of alertness as well as their mood. Less participant involvement was evident on days when participants were lethargic and had negative attitudes related to interactions with other participants or staff members. With this population, the processing of the art was kept to a minimum. Many participants present with ADHD and other psychological disorders that impede their ability to concentrate. In addition, discussion focused on general aspects of the art to prevent any participants from feeling uncomfortable about sharing the images they chose to represent, or from arousing any adverse feelings about past experiences.

**DISCUSSION**

The results of this research project corroborate the evidence supporting the usefulness of mindfulness meditation and mandalas as alternative therapeutic treatment techniques. Whereas previous studies highlight the distinct significance in implementing these alternative therapeutic treatment techniques, this research project furthered the existing literature as it focused on the conjunctive use of mindfulness meditation and mandalas. The receptiveness of the participants to these techniques is evident through the completion and content of their artwork. Moreover, this research project enhanced the literature concerning the use of alternative therapeutic treatment techniques with the AOD adolescent population. To date, Britton et al. (n.d.) remains the only study to focus on mindfulness specifically with adolescents; however, Britton et al. used mindfulness as a behavioral sleep intervention for substance abuse.

Although this research project was innovative in its implementation, its design was qualitative in nature, and therefore, did not allow for quantitative results to be obtained. With no experimental variable or control variable, the research project was unable to measure the change or growth of individuals engaged in these alternative therapeutic techniques over time.

The extensive research and planning that this project involved support the successful outcomes of its implementation. The receptiveness of the participants to the alternative therapeutic techniques and the quality of the art incorporated into the collaborative piece confirm its success. From this research project I gained a greater understanding of the AOD adolescent population, a population with which I someday hope to work. Future directions and improvements include extending the mindfulness meditation exercises over a longer period, increasing the number of exercises and directives from three to five. In addition, to allow for quantitative data to be collected, the residential boys unit could be divided into two groups, with one group participating in the alternative therapeutic techniques and the other serving as a control group in which to compare the effectiveness of these techniques. Finally, surveys or questionnaires could be distributed before the participants’ exposure to the therapeutic techniques, as well as after the completion of the techniques, providing a qualitative personal description of the participant’s feelings about their experience in this project.

**REFERENCES**


