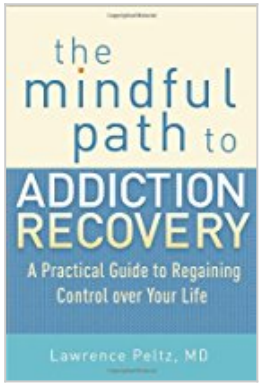

The Mindful Path to Addiction Recovery: A Practical Guide to Regaining Control over Your Life

By Lawrence Peltz

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Mindfulness, the quality of attention that combines full awareness with acceptance of each moment, just as it is, is gaining broad acceptance among mental health professionals as an adjunct to treatment. Because at the heart of addiction is the fear of painful emotional states, addicts compulsively seek drugs and alcohol to avoid or escape emotional pain. Mindfulness, on the other hand, helps us develop greater acceptance and ease with life's challenges, as well as greater self-compassion.

Here, Dr. Lawrence Peltz, who has worked as an addiction psychiatrist for nearly three decades, draws from his clinical experience and on the techniques of mindfulness-based stress reduction (MBSR) to explain the fundamental dynamics of addiction and the stages of the recovery process, and also gives us specific mindfulness exercises to support recovery.

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Editorial Review

Review
"A mindful and compassionate attention is the very ground of recovery from addiction. In this book, Lawrence Peltz offers a penetrating understanding of the nature of addiction, and the meditation practices that can help us find freedom from this suffering. Drawing on his rich clinical experience, Dr. Peltz shares the struggles of people who have found great healing on this path of recovery and transformation."—Tara Brach, PhD, author of *Radical Acceptance* and *True Refuge*

"Addictions are rooted in distress and suffering. Dr. Peltz shows us how practicing thoughtfulness, awareness, and acceptance can bring solace, relief, and happiness without resorting to addictive solutions."—Edward J. Khantzian, MD, Clinical Professor of Psychiatry, Harvard Medical School, and Associate Chief Emeritus of Psychiatry, Tewksbury Hospital

"This is a book that deserves its place among the very best of addiction recovery guides—both for practitioners who want to expand their treatment options and for those seeking change."—Howard J. Shaffer, PhD, Associate Professor, Harvard Medical School, and Director, Division on Addiction, Cambridge Health Alliance, a Harvard Medical School teaching affiliate

"A very gentle, compassionate, sensible, believable, readable, encouraging, and incredibly helpful book about overcoming a very powerful affliction. It is, in its broad thoroughness, a wise support for facing any major challenge."—Sylvia Boorstein, author of *Happiness Is an Inside Job*

"Larry Peltz gives a unique and enlightening view of addiction and provides a very clear way to change one's destructive habits. I highly recommend it."—Sharon Salzberg, author of *Lovingkindness* and *Real Happiness*

About the Author
Lawrence Peltz, MD, has worked as an addiction psychiatrist for more than two decades. He is the medical director of the Bournewood Caulfield Center, a drug and alcohol treatment facility in Woburn, Mass, and has been on the clinical faculty at both Harvard and Boston University Schools of Medicine. He is also a trained teacher of mindfulness-based stress reduction (MBSR), and he speaks regularly to mental health professionals about mindfulness and recovery.

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Addiction
I don't like you, but I love you.
Seems that I'm always thinking of you.
You treat me badly, I love you madly.
—Smokey Robinson
The essence of addiction is an attempt to manage an intolerable experience that we cannot avoid any other way. As we will see, people use drugs to change consciousness, which does work. However, once this mode of operating becomes a habit and then a way of life, changing consciousness transforms into avoiding

suffering. This happens outside of awareness. Before long, addiction is causing suffering and eventually *is* suffering. It is also, ironically, an attempt to heal, to seek relief via getting high, medicating feelings, escaping how things are right now. It is a process that attempts to change reality and control experience so that it is more acceptable, palatable, bearable.

Addiction can be a container for fear, disappointment, confusion, grief, or anger. It allows us to move forward in life with some hope that we might actually feel pleasure, even happiness. Of course, the happiness never materializes and the pleasure is more anticipated than realized. The addict becomes increasingly discouraged, unable to stand his experience as he digs a deeper hole. Abstinence, if considered, is quickly rejected. “I’m a total loser,” he tells himself. “Fuck it. My life is going nowhere anyway.”

Roger completed day treatment after an alcohol detox and many years of drinking. He was committed to recovery and was able to stay sober until he became involved with a much younger woman he had met in the program. He relapsed with her, they ended badly, and he was back for another round of treatment, during which he learned something about his vulnerability in romantic relationships.

When Roger came back for a third time, it was not about drinking but gambling. He had been playing the slot machines regularly and, as a retiree on a fixed income, was courting financial ruin. Driving to the casino, Roger experienced the excitement and anticipation of winning, the fear of losing even more, the dread of facing his creditors, and a wish to escape what he eventually was able to identify as loneliness and desperation. His foray into gambling had begun much like his relationship with the young woman, his drinking, or any addictive process. Initially, he had a sense of power, a rigged game in which he felt in love, one up on everyone, no limits, totally in control of the situation.

Let’s focus on the experience of falling in love. At the outset the lover is perfect in looks, reactions, speech—a missing piece to complete us and fill us with the miracle of life and of our amazing fortune to have found this person. In fact, we often do fall in love with our opposite, or what Hal and Sidra Stone have called our “disowned part.”

Think of the attraction between the hard-driving, successful, somewhat obsessional man and the free-flowing, flirtatious woman. He loves her openness, creativity, ease with her sexuality, and she is drawn to his confidence, power, and organization. All is well until the honeymoon is over and it is necessary to engage in the business of life with the other person. Then, she or he is less perfect, annoying, and even impossible to communicate with at times. If mutual judgment proceeds unchecked, the couple will get further apart—not an uncommon outcome. But with time, patience, and maturity, differences can be accepted and love deepens. It is no longer fantasy driven and is far more enduring and workable.

When we fall in love with a substance like cocaine or alcohol, there is also a sense of feeling complete and perfected. Addicts have repeatedly described an experience of infinite power and of being “unstoppable.” Once the glow is gone, however, there is no negotiation and, suddenly, significant constraints. The drug, in a true bait and switch, now demands enormous attention and time. As the addiction proceeds, it brings diminishing returns in terms of pleasure and costs increasingly more in money, relationships, health, and safety.

Of course we know there is no hope of discussing or bargaining with a drug, but there is more here than meets the eye. A disease process has begun that is progressive and takes over our ability to think clearly. Much as HIV infection attacks the immune system that is needed to defeat it, addiction compromises our brain and emotional capacities. As the addictive process evolves, there is a progressive atrophy of maturity and clarity.

Responsibility

Roger is an intelligent man. He was in serious debt and understood the futility of his actions. However, once he entered a relationship with a woman who was not committed to recovery, began driving to the casino, or took the first drink, he no longer had the capacity to make a reasoned judgment or a choice.

This is the flaw in Nancy Reagan’s famous call to “just say no.” As the disease advances, the part of the

mind that might be able to abstain is less functional and there are so many conflicting agendas that a reasoned judgment is nearly impossible. The heart closes, and the addict is living with blinders or in a tunnel. The capacity for responsibility, the *ability to respond* intelligently and decisively toward well-being, has been seriously impaired.

The process is insidious, almost imperceptible at first. Getting high on opiates for manageable money becomes getting high for a lot of money, then just getting straight for even more. An obese person does not come to weigh four hundred pounds in a few weeks. It occurs over a long period and depends on much denial and rationalizing. The pursuit of pleasure or relief becomes an end in itself, and other consequences are pushed away until it is no longer possible to do so.

Even then help is often not sought. Addicts wind up broke, alone, in prison, mentally ill, physically sick, or dead. I often tell our patients in the Bournewood-Caulfield Partial Hospitalization Program (who come for the day while living at home, a sober house, or residence) that they are a select group. These people either choose to come to day treatment following hospitalization or come because their outpatient therapy has not adequately stabilized them. Clearly, there are patients who are coerced to come by the legal system, their spouse, their boss, or financial circumstances, but they still have to be willing to be there. There is no locked door. Many addicts would never come to treatment, preferring to withdraw, hide, escape as long as possible. Why is that? Why not seek help as an alternative to prison, illness, or death? I will give five possibilities, with considerable overlap among them:

- The person has lost the mental or emotional capacity to think clearly about his or her circumstances.
- He or she has become insulated from health-promoting information from the body or relationships.
- It is too painful to face the physical discomfort, fear, shame, or grief.
- There is a history of unreliable health providers or caregivers in general.
- There is a deep sense of unworthiness to accept or receive help.

Addiction progresses toward an absence of emotional intelligence, receptivity, and self-compassion. It promulgates the delusion that we are alone in a unique engagement with emotional pain and alienation. It is a hole that has no bottom. As the addiction to a substance or behavior becomes the only game in town, self-judgment and guilt increase, with only one mode of relief, however transient. The addict moves through discouragement, despair, self-hatred, resignation— and the stories that emerge from these mind states only reinforce a sense of unworthiness of caring or help.

Many just die—in a hospital, a prison, alone, and via accident, violence, or suicide. Beyond the one hundred thousand alcohol-related deaths, there are half a million from nicotine each year in the United States. I have seen patients with chronic lung disease die on respirators, and it is not pretty. Did they know this would happen?

The answer is yes and no. I once encountered an ex-patient that I had cared for as a medical student outside the Hines VA Hospital in Chicago. He was finally being discharged after recovering from extensive surgery. As I chatted with him and his wife, I was aware of smoke coming through the fist of his right hand. As it became clear that he was hiding his cigarette from me, he smiled sheepishly, and I wished him well. All he was doing was enjoying a cigarette and his freedom after several weeks in the hospital. But somehow he was ashamed, caught by the “doctor.”

Who is the doctor really, in this case? I believe it is his mature energy that takes responsibility for his own self-care. That part wanted to experience a robust sense of well-being and knew that smoking was not moving him in that direction. Another part just wanted to feel relief, whatever the cost. These were clearly in conflict and underscore the problem of addiction. It is “normal” to want to relax and feel better. We do it all the time by reading the newspaper, having a cup of coffee, turning on the TV, calling a friend. How is smoking a cigarette different from these? When does “having a snack” turn into overeating or bingeing on food?

Why Do People Use Drugs?

If you are considering or coming to treatment for addiction, you are likely feeling some combination of exhaustion, confusion, powerlessness, despair, and shame. But what is good about using cocaine, for example? With some encouragement, people will say things like “The euphoria,” “I like the energy,” “I get focused,” “Sex is so much better,” “I am the man,” “I really don’t know, it’s pretty stupid,” “I think I am going to get high, but I just get paranoid.” Highlighting the initial motivation for using a drug is the beginning of a conversation on the pluses and minuses and the presence of a conflict. This will be discussed in more detail in the section on the recovery process. There are many reasons why people use drugs, but all of them fall into three categories:

- To get a feeling
- To get rid of a feeling
- To escape

Let’s look at these one at a time.

Get a Feeling

Generally we want the “positive” feelings noted in the cocaine example above—euphoria, energy, self-esteem, power. Some of these come directly from the use of the drug and can be particular to the individual or setting. Alcohol can facilitate a buoyant mood or a simple calming; opiates can bring deep relaxation or energy; cocaine provides intense stimulation or focus; marijuana can be experienced as a buzz or an enhancer of experience; hallucinogens can be speedy and a means to radically shift our perceptions.

Other feelings can come from the setting surrounding the drug. Heroin addicts come to methadone programs (and more recently buprenorphine providers) sick and depleted from years of hustling. Like professional athletes, many run out of gas in their mid- to late thirties, and the risks begin to outweigh the rewards. As medical director of a methadone program, I offered a deal —“We give you methadone, you come to treatment”—that was readily accepted. However, within three to six months, a significant number got depressed. This was partly because, for so many years, much of their energy, ingenuity, and creativity had gone into the street. It was a source of self-esteem and effectiveness, possibly providing an identity as hero, renegade, or desperado. Often the addict stayed in treatment to face the guilt, grief, and wreckage of her life. But there was a sense of loss at times manifesting in war stories glorifying the lifestyle or drug. People became attached to the adrenaline rush, the risk, the experience of efficacy, the needle, or any aspect of the experience.

Often teenagers begin to use drugs and alcohol in their peer group in order to feel part of something. It seems to me that there are two universal human needs: to feel good about ourselves and to belong. Some kids have never had either experience, and substance use, in one fell swoop, can appear to provide both. On the plus side, using together can create a bonding experience of fun, going outside the rules, and exploration or self-discovery. However, at some point the party is over, and if the person has not explored more mature modes of operating, he or she will either be alone or connect with another group of users.

In either case, the drug is likely to be the new vehicle for comfort, despite the fact that the original goal was to have friends. Sadly, addicts can also become quite attached to “negative” feelings of shame and alienation. Though these feelings may not appear to be much fun, they can become the new hiding place or refuge.

Get Rid of a Feeling

Attempting to get rid of a feeling is what we have come to call “selfmedication,” a term popularized by one of my early mentors, Edward Khantzian, a psychiatrist and researcher at the Cambridge Hospital. Dr. Khantzian’s clinical experience demonstrated the association of certain drugs with particular intolerable mood states—opiates for rage, cocaine for depression, alcohol and benzodiazepines for anxiety. One important discovery was that a number of cocaine users were treating poor attention and were actually able

to focus and calm down on cocaine. Nicotine has the ability to either stimulate the mind or reduce anxiety depending upon the smoker's level of arousal. Appetite can be suppressed with nicotine and stimulants, enhanced by cannabis.
We do not like being bored, disappointed, agitated, depressed, angry, or in pain and want to change our consciousness. This is normal, and substances have been used for this purpose for millennia. (It is notable that for some diseases, drugs are all that Western medicine has to offer.) Also available to us are food, sex, shopping, gambling, work, exercise, and many other modes that can alter an experience that feels intolerable.

Escape
Escaping has some similarity to getting rid of a feeling but is more global and possibly more unconscious. Did you ever not know what to do with yourself and either open the refrigerator or turn on the TV? Again, it is normal to take refuge in an ice-cream cone, a movie, a book, a bath, a nap, or a beer after a long day. There is a fine line between a moment of pleasure that makes life feel livable and a pattern of dissociating or checking out.
A good high, a good low, adrenalized or lethargic states transport us to another realm away from our fear, boredom, or self-doubt. In one astonishing example, a heroin addict was unable to tell me almost anything about the decade of his life between twenty and thirty. He had literally dissociated from his experience for ten years as he went about his business of acquiring and using the drug.
Escaping our feelings has pluses and minuses. I have noted a tendency in myself to leave just enough time to get to my destination. This gave me the opportunity to get one more thing done and to experience some adrenalin as I drove. The downside was that I felt stressed, was late at times, and got a couple of speeding tickets. If I leave plenty of time, I am more relaxed and do not miss my plane, but I lose the sense of efficiency and of being on a roll. I also might have to wait for someone or be aware of unpleasant feelings. The heroin addict I mentioned above took a radical approach to changing consciousness with enormous cost. However, the costs of not using may have appeared greater. These two examples, using heroin to escape vs. scheduling my life too tightly, while quite different, I hope suggest a continuum between a bad habit and an addiction, which we will now explore.

Habit, Substance Abuse, and Dependence

Tom is a college student who smokes marijuana on Friday and Saturday nights with his friends. He enjoys the camaraderie and laughter; the enhancement of music, movies, and conversation; as well as the eating that seems to happen every time. Tom is a serious student who works hard and looks forward to his weekend ritual, which he will skip only at crunch time, late in the semester. He will also get high during the week, but sporadically and never jeopardizing his work or his ability to get up in the morning for a class. Invariably on Sunday, Tom is able to hunker down with his studies, reestablishing his rhythm and producing good-quality work.
Tom has a habit. He would likely agree and say he is enjoying it for now, with an idea that he would change this behavior at some point after college or graduate school. For now, he is having fun, not hurting himself or his future prospects. If asked if this was substance abuse, he might acknowledge that it is technically illegal but otherwise not a problem. His parents would likely disagree, but Tom could counter that his behavior is no different from their having a few drinks and getting tipsy.
The most recent diagnostic manual for psychiatry, the DSM-IV, would back him up. According to its criteria, the diagnosis of substance abuse requires recurrent use resulting in one or more of the following:

- Failure to fulfill major role obligations in work, school, or home
- Physical hazards (driving a car or operating a machine when impaired)
- Recurrent substance-related legal problems
- Persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

Now, if Tom began not getting out of bed on Sundays, rationalizing that he only had enough energy to watch football games, not studying, and getting poorer grades, he would qualify for the diagnosis of substance abuse. His parents would now be more justified in reading him the riot act, stating that he could watch football at home and attend a community college for a lot less than $50,000 per year.

In either case, Tom is in a good position to change. His marijuana habit will likely shift with maturity, having a girlfriend who does not want to use, having a job where he will be drug tested, or merely moving on to a new place and group of friends. If it had gotten more serious, the wake-up call from his parents might have been sufficient for him to give it up. Once he stopped smoking pot, Tom would likely miss the drug and the good times, rationalize using again, and wonder if he were an addict. However, there is little evidence that he is at this point.

Louise is a young woman in her midtwenties who came to our day treatment program following a "devastating" break-up with her boyfriend. Though nearly forty, he was fairly immature, and Louise knew the relationship was likely not to work. But they smoked weed together and watched the Red Sox, which felt cozy. Louise had a history of daily use since the age of sixteen, largely to control her anxiety. Over the years, she needed to get high more often in order to relieve her symptoms. At the time of admission to the program, she was smoking three to five times per day, getting increasingly withdrawn and depressed and calling in sick to work.

Louise's parents divorced when she was five, and her childhood was hectic, with frequent moves, little opportunity to develop stable friendships, and limited contact with her father. Smoking weed had been a way to have a peer group and experience a sense of inner stability via numbing her chronic tendency to worry. There were times when Louise knew she should stop, but when she tried, the anxiety was disabling. Her relationship, however problematic, had a routine she found soothing. With the breakup, troubling thoughts threatened to frighten and overwhelm her, leading her to use more frequently, perpetuating a vicious cycle of increased anxiety, depression, and marijuana use.

Louise is clearly dependent upon cannabis for her functioning. The diagnosis of substance dependence according to DSM-IV criteria requires "a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following in the same twelve-month period":

- Tolerance (a need for increased amounts of the substance to achieve intoxication or the desired effect)
- Withdrawal (a substance-specific syndrome due to cessation [or reduction] of substance use that has been heavy and prolonged)
- The substance is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance or recover from its effects.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.
- The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Louise meets the criteria, but what is most notable is her sense of desperation in the face of her anxiety and worry, and the need to escape it.

Substance Dependence and Addiction

It is clear that Tom is not dependent upon cannabis and Louise is. But is Louise also an "addict"? The term *addiction* was replaced with *dependence* by the DSM-III-R committee in 1987, the latter appearing to be

more neutral. Dependence, however, is closely related (and limited) to the physical and behavioral manifestations of tolerance and withdrawal. *Addiction,* in my opinion, is a term capable of carrying psychological meaning as well.

Lance Dodes, in his book *The Heart of Addiction,* makes the distinction between "physical addiction" and "true addiction," which is emotionally driven. An example of the former is nicotine dependence. Although smokers can become strongly dependent upon nicotine, the revelation of serious health consequences secondary to smoking during the 1960s caused many to stop. Whether the ones who continued were "true addicts" or just physically dependent is not immediately apparent and would have to be understood case by case. Also, patients with postsurgical or chronic pain who are given opiates will become physically dependent if treated long enough. But most of these patients will never become psychologically addicted. Dodes, who is a psychoanalyst, makes a persuasive argument that the addictive process, what he calls true addiction, is driven by helplessness and the rage against it. Addictive behavior is seen as a substitute action (or displacement) for the need to reverse or escape the experience of helplessness or powerlessness.1 What the person experiences that directly leads to substance use—desperation (in Louise's case), loneliness, or grief—almost invariably has a sense of powerlessness at its core. We will see how treatment, including mindfulness practice, allows patients to hold these experiences without reacting and find other, more effective alternatives.

Once in treatment, Louise smoked pot less often and did initially feel more anxious. Her mindfulness training, however, helped her to feel more grounded, living more in the body, less in her thoughts. So she was able to experience anxiety as a physical experience independent of all of the stories associated with it. In other words, she could be anxious without "freaking out." This was a major step that allowed her not to immediately run with the first flicker of anxiety.

Then Louise was able to work more effectively with both her physiological and psychological dependence on the drug. This raises the question of whether someone can be addicted without being physically dependent.

Frank owns a successful construction company. He is able both to be the boss and to be respected by as well as have a sense of closeness with the guys. He does, however, have more problems in one-to-one relationships where there is no clear hierarchy.

Frank comes home from work every evening and has three or four drinks. He never develops tolerance (needing more and more to get a buzz) or withdrawal (shakes or inner tension requiring a drink to stabilize). He does not appear intoxicated, but his wife, Marjorie, knows when he is over the line. She tries to speak to him around the time of his first drink, because after that he is largely inaccessible for the remainder of the evening.

Though he doesn't realize it, Frank's behavior is causing Marjorie to feel abandoned and alone. The driving force behind his drinking is the fear of intimacy, and his addiction (facilitated by alcohol) is the compulsion to escape that fear. Not everyone will agree with me, but I believe that Frank is an addict. If he does not face his vulnerability in relationship, his wife may leave him, though he left her first without knowing it.

Is Addiction a Disease?

The dictionary defines *addiction* as "a state of physiological or psychological dependence on a drug liable to have a damaging effect; to devote oneself habitually and compulsively." It derives from the Latin *addicere,* meaning "given over, awarded to another as a slave." This is clearly resonant with the experience of helplessness in the face of our desires, a theme that appears in the first step of Alcoholics Anonymous: "We admitted we were powerless over alcohol."

The addiction psychiatrist Richard Sandor, in his book *Thinking Simply about Addiction,* calls addiction a "disease of automaticity." Automatisms, he says, are developments in the nervous system that cannot be eliminated but can be rendered dormant. Sandor points out that *doing* something (using a drug) is often confused with *having* something (an addiction), that is, the behavior is confused with the disease. He goes on

to say:
What begins as a choice to drink or use a drug may later become something else, something no one chooses—a psychological reaction that has a life of its own—an addiction. At that point, the addict's drinking or using behavior has become the manifestation of the disease, not the disease itself. He may look like he is making choices, but where it really counts, something else is in charge.2
The subject of choice is a complex one that is taken up in greater detail in chapters 2, 3, and 8. Some relapses clearly begin with a choice and others do not, as the addict operates more in the realm of reaction or reflex. Sandor's "disease of automaticity" and Dodes's "rage against helplessness" both speak to the issue of addiction as a disease, but they disagree about what sort of disease it is. How some of us have this mind-body tendency to develop an addiction and others do not is also a source of some mystery.
It may help to acknowledge that we are all flawed in some way, even those who seem to get more than their share of intelligence, talent, or beauty. Addiction is just one of the possible flaws, manifesting in a given human being via a combination of biological, psychological, social, behavioral, and possibly spiritual factors. A full discussion of this subject is beyond the scope of this book, but as suggested in the section above called "Why Do People Use Drugs?" some of us may have a particular vulnerability toward the compulsion to grasp on to feelings, get rid of feelings, or escape.
How much of that is hereditary? In clinical practice, it appears that addiction runs in families, but so does speaking Portuguese, rooting for the Chicago Cubs, or appreciating Beethoven. No gene has been discovered for alcoholism. However, studies of twins and adoptees, which have been able to separate the effects of genetics from those of environment, have overwhelmingly demonstrated that there are hereditary factors determining who becomes an alcoholic and who does not.
That being said, our clinical task with an individual is to make some sense of an overwhelming situation, and what we see in families is widely variable. In some families, "everyone" is an addict, but in many cases the manifestation of alcoholism and drug addiction is more sporadic. In other scenarios, family history of addiction is absent, and emotional, developmental, or sociocultural factors will predominate.
We are talking about human beings, and there is a lot we do not know. Our task is not so much to solve the puzzle of addiction as to open to the physical and emotional manifestations of whatever is causing a person pain and suffering. The truth is in the experience. Once it is seen, our path becomes clearer and we are able to move forward with greater vision and confidence.

A Brief Introduction to Mindfulness

However you are sitting, notice your feet touching the floor or wherever they are landing right now. Feel the backs of your legs and your thighs, buttocks, and back as well as your hands and arms making contact. Give your full attention to each one, one at a time. You might also be aware of contact points around your mouth (lips, teeth, tongue) or your eyes, if closed, or the touch of breath at your nose. Simply direct your attention to the touch points, slowly moving through them or coming to rest in one place. Stay with this for about a minute.
What did you observe? Often, people notice sounds, energy moving in the body, physical sensations, thoughts, or emotions. Were you thinking as much as usual? If not, what was that like?
The practice of regularly checking in with our touch points gives us an immediate gateway to the present moment and the experience of embodied awareness. You might like practicing this as you read and throughout the day.

Users Review

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Edward Grimes:

What is your hobby? Have you heard which question when you got college students? We believe that that problem was given by teacher for their students. Many kinds of hobby, Every individual has different hobby. And you know that little person including reading or as reading become their hobby. You have to know that reading is very important in addition to book as to be the issue. Book is important thing to provide you knowledge, except your personal teacher or lecturer. You get good news or update in relation to something by book. Numerous books that can you go onto be your object. One of them is niagra The Mindful Path to Addiction Recovery: A Practical Guide to Regaining Control over Your Life.

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