CASE REPORT

Utilizing kemetic yoga in the treatment of a case of substance use disorders

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ABSTRACT

This article details a clinical intervention utilizing Kemetic Yoga as a method to treat substance use disorders. Kemetic Yoga, or Kemetic (meaning the ancient spiritual/physical practice of the Kemetic, or ancient Egyptians) spiritual health system, combines physical movement (often within a deep listening/breathing context) with meditative and spiritual components. The clinician, a clinician social worker, utilized this culturally responsive intervention with an African American client who was abusing substances: cocaine and marijuana. The client showed marked improvement throughout the treatment, which lasted for 12 weeks. This article will explore the intervention and its outcomes. Finally, the included case study can be used by future clinicians to implement this intervention with their clients.

Keywords: Kemetic Yoga, substance use disorders

INTRODUCTION

Globally, it is estimated that 64 million people suffer from substance use disorders (SUDs).[1] This public health issue is the cause of negative outcomes for individuals, their families, and communities. As a major public health concern, there is an increased interest in designing effective interventions focusing on culture to improve treatment outcomes across culturally diverse groups. Culturally relevant interventions are defined as those interventions that are adapted and informed by a person's culture and that are characterized by the utilization of cultural beliefs, values, and practices (e.g., religiousness, spirituality, rituals, metaphors, images, myths, and legends) of the population targeted to enhance treatment processes, increase client engagement, and lead to a more authentic clinician-client relationship.[2] So, why would a health professional consider a culturally relevant intervention in the treatment of SUDs? Culturally relevant interventions remain crucial within all healthcare disciplines but are especially pertinent given the health disparities some marginalized groups experience in medical care.[3]

Historically, many efforts to treat SUDs have failed to consider the larger cultural contexts in which their participants live, leading to their failure or, at worst, their harm. Take the case of treatment versus care development and delivery: generic approaches to intervention delivery or standardized treatment programs might gloss over nuanced experiences that might be specific to racial and ethnic minorities, people who are low income or identify as lesbian, gay, bisexual, and transgender.[4] Notably, an abundance of research now demonstrates that many of these and other populations have multiple barriers to accessing standard SUD treatment care – often because of cultural stigma and discrimination, as well as culturally responsive care.[5] Additionally, robust evidence also continues to show disparities in treatment retention and engagement in care among SUD populations, suggesting that standard approaches to treatment might not adequately match the nuances of their needs.[6] This article will explore whether such a cultural intervention targets an improvement to SUDs and, more importantly, which outcomes beyond abstinence can be identified, as well as how individuals in culturally adapted programs experience the intervention. Hopefully, this will help usher in an important paradigm shift in SUD care that recognizes the need for cultural

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transformation of traditional and modern evidence-based practices.

BACKGROUND

The story of substance use among African Americans is inextricably linked to the nation's history, sociology, and culture. There are relevant and unique differences between the patterns of substance use reported by different demographics – partly because the specific circumstances of Black life, historically based on systemic inequalities, set people apart from other races and ethnicities.[3] At the same time, although opioid prescriptions declined substantially in the mid-2010s, substance use disorder in African American and all racial populations, including those involving alcohol, marijuana, and illicit drug use, continues at odds.[7] The trauma of slavery and racist institutionalization created psychological trauma and socioeconomic inequalities that still reverberate among African Americans today. Forced work and dehumanization in slavery created powerful psychosocial consequences that fueled patterns of substance use as a response to oppression.[8] Racism maintained through Jim Crow laws persisted after the freeing of slaves, depriving them of access to schooling, employment opportunities and health care.[9] Poverty and social vulnerability create perfect conditions for drug addiction to respond to these challenges.

The War on Drugs and Criminalization

The widespread uptake of recreational drug use in the 1980s, crack cocaine, prompted the "War on Drugs" policy response, with its extreme racism and Jim Crow architecture of mass incarceration, especially targeting the African American community.[10] Racial profiling and empowering aggressive policing helped to produce a cumulative process of criminalization in which recovery could be undermined and stigmatization of substance use reinforced.[11] Contemporary community substance use patterns of African Americans are closely intertwined with socioeconomic issues such as high unemployment rates, poverty, and poor physical and mental health services (access and quality).[12] As a result, the community has historically and currently been prone to poor coping strategies.[13] Higher rates of substance use disorders often develop in response to broader health disparities, which inhibit access to and quality of treatment. Stigma related to substance use continues to impact African American communities and hinders efforts to stop the cycle of shame and isolation.[14] Mental health challenges, often untreated because of stigma, are common and can compound SUDs.[15]

Treatment Accessibility

Treatment needs for African Americans must begin by expanding access to services and culturally competent care. Also needed are policies that expand access to community-based services and the delivery of mental health services.[16] For example, tackling substance misuse requires culturally tailored interventions that incorporate community values and norms in a context-specific manner.[17] A push towards harm reduction instead of punitive measures would make a difference in these communities: decriminalization of drug possession, regulating the illicit drug market, and replacing punitive measures typically with public health responses may relieve some of the systemic barriers to treatment.[18] These include discrimination by pharmacies, landlords, and insurance companies, as well as the destabilizing effects of arrest and incarceration for African Americans who seek help. In the US context, successful harm reduction must also include far-reaching education, greater access to safe consumption areas, and naloxone (which can reverse overdose and prevent death), where it is desperately needed – in the African American community.[19]

METHODS

Framework

This study's theoretical framework is grounded in African Self-consciousness. African self-consciousness is a self-awareness inflected by historical experience, rooted in cultural history, and world-theorized through the African worldview. African self-consciousness is not the only way for people of African origin to think about race. It is not the same as what scholars call ethnographic identity, which defines a person based on their relationship to a particular ethnic group. By contrast, African self-consciousness situates the individual as part of an identified minority and collective in the larger context of Africa's written and lived history, struggles, and hopes. African self-consciousness has been a widely held idea among scholars and thinkers. The claim that

such consciousness spurs Black empowerment, cultural recovery, and social justice has animated political uses of African self-consciousness.[20][21]

CBT and Substance Use Disorders

Substance abuse problems affect many individuals and families all over the world today, and this makes health outreach and community support systems so crucial. The use of substances has the potential to lead to dependency, affecting individuals, and society as well. The use of evidence-based interventions with SUDs potential risks might look contradictory. Cognitive Behavioral Therapy (CBT) however, as an evidence-based tool, has shown to be effective in addressing SUDs. Experts estimate the financial toll of SUDs in the United States exceeds $600 billion due to healthcare costs, reduced productivity and the cost associated with the criminal justice system.[22] Methods of treatment are constantly evolving, but they are leaning more towards pharmacological interventions. Both models have sufficient underlying research supporting their benefits in addressing SUDs. The effectiveness of CBT in treating SUDs has been extensively reviewed by Bo et al.[14] and Fordham et al.[23]

CBT is founded on the cognitive model of psychological distress, which firmly links maladaptive thoughts or core beliefs to emotional and behavioural responses.[24] Helping people recognize and challenge dysfunctional thoughts can change maladaptive behaviour patterns. It could thus also be a helpful, structured way pinning substance use. CBT's versatility is evident in its application as a personal treatment option. As part of group sessions and digital programs[24] these diverse approaches involve assessments of CBT effectiveness for different SUDs. For instance, Fordham and colleagues[25] found that individuals undergoing CBT for cocaine addiction experienced decreases in substance use compared with those in a treatment group with co-occurring substance use disorders and psychiatric conditions. CBT is recognized for treating disorders and SUD concurrently while improving functioning.[26]

Cultural Limitations of CBT

Cognitive Behavioural Therapy is also the main modality used in SUD treatment and is historically the "gold standard" for substance use treatment which is empirically based and structured.[24] This approach to treating SUDs that is grounded in evidence and science. Yet results indicate critical disparities in treatment outcomes for Black individuals.[27] CBT is nevertheless grounded in a Eurocentric approach to psychology that fails to capture or address the cultural, social, and systemic factors that are germane to Black patients in the context of treatment, which could make CBT less effective.[28] CBT typically focuses on cognitive dysfunctions and behavioural reinforcement that are highly individualized and require central concepts of self and autonomy at their core.[24] The notions of identity held within Black communities are likely determined in large part by interconnected cultural values, social groups, and the impact of systemic experiences. Styles of family life, religion, and extended social networks may all be involved.[29] These can often be lost from traditional CBT out of a simplistic understanding of the core self, fostering feelings of alienation and dissatisfaction with treatment. For example, there's evidence that many Black clients approach therapy to address a problem for themselves not because of problems with their feelings but in the context of family and community motivation.[30]

Kemetic Yoga

Kemetic Yoga is based on ancient practices from Kemet (ancient Egypt), where meditative and spiritual practices accompany movements. Adding 'Kemetic' to the phrase 'Kemetic Yoga' evokes centuries and cultures of older forms originating from older people, Kemet.[31] Kemetic Yoga - in contrast to most popularized and contemporary interpretations of yoga, which are mostly about the asanas (positions) of the body, conceptualizes all aspects of yoga through movement, breath, and awareness. Kemetic Yoga adopts a philosophy of harmony, equilibrium, and union with the universe, rooted in some of the foundational principles of African-centric beliefs.[31] Research suggests that yoga practices can provide meaningful, reliable decreases in stress and anxiety and improve overall health outcomes, including for survivors of domestic violence, but specifically for Black women and children.[32] Kemetic Yoga seeks to cure today's spiritual ills by combining meditative movement, breath

control, and spiritual mindfulness, like calling upon the Metu Neter from ancient Egypt, benefiting those individuals who are marginalized due to the historical and present-day illness of slavery.[31] Grounding itself in historical truth and lived experiences, Kemetic Yoga can be seen as a conscious tool for coordinating physical action and ensuing spiritual and cultural reactions, a sensible means through which the practitioner can fully self-actualize. By integrating head, heart, and body, Kemetic Yoga reshapes the present – and the future – with ancestral tools, drawing fresh meaning from ancient wisdom.

CASE BACKGROUND

The intervention for this study, was implemented with a 24-year-old African American male named Jesse (his name has been changed for privacy). Jesse presented in the clinic with major depression disorder (MDD), which he was diagnosed with three years ago. An estimated 20-30% of those with MDD also exhibit a substance use disorder.[33] This interchange between MDD and SUDs manifests because people with MDD can start abusing substances to self-medicate (which often fails). At the same time, the neurobiological effects of protracted substance use – as well as the psychosocial impacts of living with an addiction – can trigger depressive episodes.[34] Since his diagnosis, Jesse has struggled with substance use; his substances of choice were marijuana and cocaine. Jesse reported using marijuana shortly after his diagnosis of MDD. After a year, Jesse reported "being in a bad place," which caused him to use cocaine. Jesse was using cocaine at least five times a week; he would smoke marijuana seven days a week. Jesses' symptoms consisted of self-isolation; feeling down, depressed, and hopeless nearly every day; little interest or pleasure in doing things nearly every day; feeling tired and having little energy, nearly every day; and trouble concentrating on things like work or watching television nearly every day.

Jesse reported that his symptoms were too "challenging for me to manage," and he turned to marijuana as a maladaptive coping skill. Cognitive distortions, along with other negative thinking patterns and maladaptive coping strategies that are so common among those suffering from MDD, can increase susceptibility to substance use as a form of self-medication.[35] Jesse stated that substance use reduced some of his MDD symptoms; however, he reported that the next day after smoking marijuana, he would feel more depressed than when he wasn't smoking. About a year after smoking marijuana, Jesse reported that a close friend of his offered him cocaine. Initially, Jesse rejected the offer, citing that he didn't want to use such a "hard substance like cocaine." Eventually, Jesse's symptoms increased, and he decided to call his friend to obtain the cocaine. Jesse reported that his cocaine use at times was "out of control" and that he would "blow hundreds of dollars just to get high." Jesse was enrolled in a substance use program after being caught by law enforcement with about three and a half grams of cocaine. He reported that the substance use program he was enrolled in was not effective. Jesse started using heavily during and after the program, citing his mental health was impacted by joining the program.

INTERVENTION

Cognitive Behavioural Therapy (CBT

Jesse was evaluated and screened for anxiety, depression, and other risk factors. Jesse denied any suicidal ideation or self-harm. Jesse's clinician suggested CBT for his MDD and SUD. Jesse initially hesitated to engage in treatment; he stated, "I'm fine, it's not a problem. I got this". After a few weeks of rapport-building, Jesse reported being open to treatment. The clinician began a 12-week CBT program that would focus simultaneously on Jesse's depression and substance use. CBT is considered the first-line treatment for both MDD and SUDs. There is empirical evidence to support the application of CBT to tackle both conditions, as it helps one to develop strategies to deal with and overcome cravings and triggers that increase substance use.[24] as well as negative thought patterns that might hinder any treatment outcome. For patients with co-morbid diagnoses, contingency management and motivational interviewing are critical therapeutic approaches that enhance treatment readiness, motivation, and adherence to treatment programs.[36]

As the weeks went on, Jesse's clinician tracked his treatment progress and observed that Jesse's substance use increased. Jesse would complain about feeling sad, alone, having crying spells,

and wanting to "go to sleep and not wake up." The clinician and Jesse discussed his participation in services. Jesse reported not completing any assignments outside the session because he thought they were a waste of time. He also stated, "I can't relate to this [treatment]. People would think I'm crazy if they knew I was doing this." The stigma of mental health treatment was one reason why Jesse was reluctant to engage. Stigma related to both substance use and mental health compounds the issue. Black people might be more vulnerable to social stigma related to SUDs (defined as the attitudes that lead individuals to experience shame and to feel embarrassed and afraid to seek treatment).[25] For example, Black people might be more vulnerable to the perception that they are failing or are "messed up" because of their use of illicit drugs.[37] Immediately after the session, the clinician, through observation and reflection, used his clinical judgment to alter the course of treatment – with Jesse's permission. Jesse and the clinician decided to use a more culturally aligned intervention for Jesse that would strengthen his identity and self-awareness about his issues and how to deal with them.

Integrating Kemetic Yoga:

While many studies link the treatment of MDD and SUDs to mindfulness and yoga practices,[38][39][40] there is a gap in the literature around culturally appropriate interventions utilizing Kemetic Yoga. Since there was no literature on utilizing Kemetic Yoga in treatment of SUDs, the clinician explored similar studies on yoga and mindfulness practices to inform a new theory that supports clients in treatment. Grounding this theory in African self-consciousness, the clinician engaged Jesse in breathwork, body movements, and meditation over 12 weeks. The clinician tracked the efficacy of treatment after each session. The clinician observed marked improvement within the first two weeks of treatment compared to using CBT. In fact, as mentioned earlier, utilizing CBT increased the client's substance use.

The implementation of this intervention targeted the client's self-image, which was distorted through the client's substance use. Instead of exploring cognitive distortions and negative thoughts, integrating Kemetic Yoga into treatment focused on developing the identity of the client. Research has shown that social identities can serve as a pathway out of addiction.[41] Thus, developing the client's multiple identities (race, ethnicity, gender, sexual orientation, etc.) through an African self-consciousness lens honors his cultural and ancestral roots as a Black-identifying individual of African descent. After three weeks of treatment, the clinician observed that the client's self-talk became more positive, that he was happier, and that he reported feeling "energetic and focused." The clinician and Jesse discussed these new feelings, and Jesse reported that he was feeling less depressed from the work they were doing in session; his marijuana use decreased from seven times a week to five times a week. During weeks six and seven of treatment, Jesse began to decompensate due to his not engaging in treatment because of a death in his family; this was a traumatic experience for Jesse because he was with the family member when they passed away.

To regain treatment progress, the clinician engaged the client in additional sessions throughout the week to support him during his time of grief. During this time, Jesse admitted to using more cocaine and smoking excessive amounts of marijuana. The clinician utilized motivational interviewing to get back on track, promoting client reflection and exploring thoughts and feelings.[42] By validating the clients' emotions and strengths, the clinician reinforces the client's potential for change. Once Jesse completed his reflection, he reported that he was using excessive substances due to his loss. The clinician validated Jesses' feelings about his grief. After regulating Jesse, the clinician continued their Kemetic Yoga exercises for that session. Weeks nine and ten started to solidify Jesse's progress in treatment. He reported using marijuana four times a week and using cocaine only once a week. After reflecting on his improvements, Jesse reported that using Kemetic Yoga affirmed his identity and cultural background. Week twelve, the last week of treatment, was a success as the client reported that he stopped using cocaine and now smokes marijuana three times a week when feeling stressed.

OUTCOME

How did Jesse (client) improve his substance use? First, treatment was conducted in a

culturally competent manner. When CBT was ineffective at reducing the client's symptoms, the clinician pivoted and utilized an intervention that aligned culturally with the client. Further, this intervention was grounded in African self-conscious theory, allowing for the exploration of the client's identity to uncover linkages to one's ancestral roots and their traditional practices. Second, Kemetic Yoga was crucial to helping the client cultivate mindfulness, supporting his goal of reducing substance use. The client reported that through his Kemetic practices, was more aware of his substance use, and at times when he felt the urge to use, he would engage in Kemetic breathwork and movement until the sensation subsided. Thus, Kemetic Yoga was a critical factor in the client's recovery. Third, when the original treatment plan was ineffective, the clinician rightly changed course to help support the client in a way CBT could not. CBT's omission of a specific cultural component is a limitation of the model. CBT claims universality, but in reality, the modality was disenfranchising the client, provoking him to engage in high-risk behaviours. Fourth, the clinician worked closely with Jesse especially when treatment wasn't effective. Instead, of imposing treatment on Jesse, the clinician collaborated with him to create a treatment plan that honored Jesse's autonomy and lived experiences. Fifth, treatment focused on African American values of social connection, communalism, and restoration of the client's cultural connections. Finally, Jesse has been in recovery for the past year. His MDD symptoms have reduced. He reports using marijuana one day a week to help him sleep. He denies any cocaine use and reports that he still utilizes his Kemetic Yoga when feeling the urge to use substances or when he is dealing with other mental health issues.

CONCLUSION

The reported results indicate that Kemetic yoga may be a potentially useful complementary intervention to aid in the reduction of substance use, it extends the possibility of utilizing Kemetic yoga as a tool for promoting healing among those with substance-use disorders, particularly among those who are socially marginalized. The reporting of these results is of value as they help illustrate the effect of Kemetic yoga in SUDs and reveals that cultural nuances need to be built into the design of evidence-based interventions (EBTs). Kemetic yoga is an embedded and spiritually laden method for treating substance use because it provides release from the systemic, intergenerational traumas imposed on people in marginalized communities who bear the brunt of addiction.

In conclusion, we hope our research, and research like ours, will continue to advance the development of culturally sensitive, holistic approaches to treating addiction. Helping to inject a dose of curiosity about culturally and spiritually embedded influences on addiction and healing into mainstream addiction treatment. More broadly, this work contributes to the ever-growing literature championing mindful, adaptable ways of implementing evidence-based practices. Showing that traditionally situated, culturally embedded approaches to health and wellness can contribute to culturally sensitive modes of healthcare, healing, and recovery.

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