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A Proposal for a Compassion Based Recovery Program for Chemical Dependence

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A Proposal for a Compassion Based Recovery Program for Chemical Dependence

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Report

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Abstract

A Proposal for a Compassion Based Recovery Program for Chemical Dependence

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This report is a proposal for a compassion based recovery program for the treatment of chemical dependence. Chemical dependency is a growing problem with many individuals and families worldwide. Mindfulness and self-compassion are two new constructs in the new wave of positive psychology that have shown to be effective in alleviating many of the symptoms that are related to those whom are chemically dependent This report will list the current approaches to the treatment of chemical dependency. This report will also define mindfulness and self-compassion as well as give a basic framework on how a compassion-based recovery program might look as well as a basic design on testing the effectiveness of such a program.

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Chapter 1 Introduction

Currently, chemical dependency is a substantial health problem in the United States, one that has concerned family as well as health professionals and received attention from researchers. In this report, I want to accomplish three tasks. First, I will review the current approaches that are used in the treatment of chemical dependence. Second, I will define and discuss the newer psychological constructs of mindfulness and self-compassion. Finally, I will give a basic outline of how an innovative approach based on self-compassion might look, as well as how it's effectiveness could be tested.

In the first section of this introductory chapter, I will list the current trends nationwide on chemical dependency as well as the statistics. In the following section, I will list some of the characteristics of those suffering from chemical dependence that I believe self-compassion will help address. In the final section of this chapter, I will give the details of how this report will be presented.

1.1 Current Trends on Chemical Dependency

There are some very interesting facts as it pertains to drug use in our country. According to the National Institute on Drug Abuse (NIDA), in 2010, an estimated 22.6 million Americans over the age of 12, roughly 8.9 percent of the population, had used an illicit drug or abused some type of medication in the past month, which represented an increase from 8.3 percent in 2002 (NIDA, 2012). NIDA also revealed that also in 2010, 17.9 million Americans, or roughly 7 percent of the population, were dependent on

alcohol or had problems related to their use of alcohol. This number has remained relatively stable for a while, but is alarming nonetheless.

These numbers underscore that substance use and abuse is a major concern moving forward as these numbers are expected to continue to grow. The question then becomes one of how many individuals identified as abusing are getting treatment. In 2010, an estimated 23.1 million Americans, roughly 9.1 percent, needed to receive treatment for a problem related to drugs or alcohol. Of this population, only 2.6 million, or around 1 percent, were receiving treatment (NIDA, 2012), leaving over 20 million Americans needing help or treatment for their chemical dependency and not receiving it.

These numbers have alarmed. Without being treated, these problems and numbers seem likely to grow. The reasons for lack of treatment are several: finances, refusal of treatment, and of course the availability of effective treatment. One reason that may not have received enough attention is the type of treatment that is available. Most, if not all, of the treatments that are currently available have poor success rates, a characteristic that discourages those about to embark on one of the current treatments. Being told that most will not complete this program is not very motivating for the individual who is about to enter the treatment.

Since the beginnings of treatment with Alcoholics Anonymous to other current approaches used recently, treatment has followed relatively similar structure. With the success rates still very low my proposal is that it is time to breathe a fresh new perspective into the approaches that are currently being utilized. Taking a different approach to the treatment of chemical dependency by involving the constructs of mindfulness and self-compassion might be this breath of fresh air that is needed to help individuals who need treatment to get well.

1.2 Common Characteristics of the Chemically Dependent

There have been recognized common characteristics of those who suffer from chemical dependence. These characteristics can be addressed with the practice of self – compassion. Those who suffer from chemical dependence have been known to suffer from symptoms of anxiety, depression, avoidance, emotional dysregualtion, and PTSD. As will be mentioned in the section on self-compassion, self-compassion has been shown to treat and reduce all of these symptoms. Reducing these symptoms would thus reduce the need to self-medicate.

Chemical dependence is seen as the combination to the common symptoms listed above. Many may see these as the cause, but these symptoms can be manifested in many different ways. Some individuals may overeat, gamble, or engage in sexually deviant behavior. Many who suffer from chemical dependence may also engage in these other manifestations. If seen as the cause of the chemical dependence, the treatment should first address the symptoms and issues that are causing the symptoms. By approaching each symptom separately, this may bring most of the issues that the individual is suffering from to the surface and thus eliminate the need to self-medicate. Continued treatment of the symptoms and/or the disorder would then treat the dependence on chemicals.

Researchers might argue that the symptoms are the product of the substance abuse itself. That being that the prolonged and repeated abuse of the substance has caused paranoia, loss, grief, shame, worry, and anxiety. This may be true in many cases. Substance use over a long period of time will take its toll on the emotions and the biological aspects of the brain, primarily the reward system. In these cases, the first step would be to abstain from the substance use. Once the individual has been completely off

the substances for a while, a more accurate assessment of the remaining symptoms can be made. Acceptance of the responsibility for the damage that has been caused due to the abuse of the substance will be key in alleviating the symptoms. In these circumstances, the individual seems to remain in a sick cycle. The individual will use, and then he or she will feel guilt or shame. The individual will then use to cope with or mask that guilt or shame, thus building layer upon layer on top of an already shaky foundation. Peeling back these layers of the symptoms that were produced by the substance abuse will reveal if there are in fact any underlying symptoms to his or her chemical dependence.

1.3 Organization of This Report

This report is composed of five total chapters. The next chapter provides a review of current approaches to chemical dependence. The third chapter will define mindfulness and self-compassion, as well as list some empirical findings related to the two constructs. The fourth chapter will compare and contrast self-compassion with the current approaches to chemical dependence. I then conclude with a final chapter that provides a brief summary and a look more broadly to issues associated with chemical dependence.

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Chemical dependence is a problem that plagues our nation. But before progress can be made on treating the disorder, a better understanding is needed about the current approaches to chemical dependence. This is where I begin in the next chapter.

Chapter 2 Approaches to Chemical Dependence Treatment

In this chapter, the current approaches to the treatment of chemical dependence will be explored and discussed. The first section will cover the more traditional approaches to chemical dependence treatment, including the foundation of most treatment programs, Alcoholics Anonymous. The chapter will continue in the next section with exploring the secular-based programs, as well as their inception. From there, the next section continues with faith-based recovery programs, and the different types of programs within the model. Finally, the chapter will conclude with a final section that compares impatient and outpatient treatment including factors that determine which one is more suitable for an individual and what one might experience throughout each treatment.

2.1 Traditional Approaches to Chemical Dependence Treatment

In this section, the traditional approaches to chemical dependence treatment will be reviewed. The first approach to be discussed will be Alcoholics Anonymous, which is the foundation to most traditional approaches, and in some part, a piece in other approaches. The next traditional approach to be examined will be the Minnesota Model, which is the basis for most impatient treatment. The final approach to be visited will be outpatient treatment.

Alcoholics Anonymous and other 12-Step Approaches

The very beginning of Alcoholics Anonymous is rooted in another organization, The Oxford Group, which was a religious movement in the United States and Europe in the early 20th century that had an emphasis on self-improvement. Alcoholics Anonymous was formed in the early 1930's, but June 10th, 1935 is traditionally celebrated as the founding date of AA. Alcoholics Anonymous (AA) is a social support group that continues today, and is for people with a desire to quit drinking alcohol (Sharma & Branscum, 2010). There is but one primary purpose of AA, to help other alcoholics achieve and keep sobriety (Alcoholics Anonymous, 2010). AA, governed by its own principles, is not affiliated with nor has any alliance with any religion, sect, denomination, political viewpoint, or any other outside organization or institution. It has no outside support, and is supported primarily by the voluntary contributions of its members and supporters. The basis of Alcoholics Anonymous is the Twelve Steps and the Twelve Traditions (Butler, 2010). The following are the Twelve Steps of Alcoholics Anonymous:

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. 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.

12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Alcoholics Anonymous, 2010).

It is the practicing of the Twelve Steps that helps an alcoholic quit drinking and remain sober. This is done usually with a sponsor, someone who has already completed the Twelve Steps and has sufficient sobriety. AA members are encouraged to attend meetings regularly, and actively work the Twelve Steps with a sponsor. It is stated that the only requirement for membership in AA, is the desire to stop drinking.

There have been other 12-Step support groups that have been formed for other substance dependence, but are still based on the same Twelve Steps and Twelve Principles of AA. Those would be Cocaine Anonymous (CA) and Narcotics Anonymous (NA). The format is the same as AA for these groups, with only the word "alcohol" in the steps changed to "cocaine" for CA and "addiction" for NA. Members of all three

groups usually are encouraged to attend different types of meetings to find one that best suits them and their abuse problems.

There are many disadvantages and advantages to the 12-step approaches of AA and these other groups. The major advantage is that these groups are entirely free to their members, a loon to those with financial restrictions and limitations. Other advantages include that meetings are available worldwide with many available times, usually in the evenings, and even have online communities. A potential problem with AA lies in the spiritual message that is at the core of the program, which may discourage individuals from participation.

There has been mixed findings when it comes to the research on Alcoholics Anonymous and other 12-step approaches. A few years back, Ferri, Amato, & Davoli (2006) conducted a systematic review of randomized controlled trials for the Cochrane Database evaluating the effectiveness of AA and other 12-step facilitations (TSF). There were eight of these studies included in the final review, three of which evaluated AA programs. The conclusion was that "no experimental studies unequivocally demonstrated the effectiveness of AA or TSF approaches for reducing alcohol dependence or problem" (Ferri, Amato, & Davoli, 2006). Other studies have shown more positive results. One study showed "The preponderance of evidence supports the causal pathway that AA attendance leads to abstinence" (Kaskutas et al. 2009), and that, "12-step affiliation significantly enhances the odds of sustaining abstinence for multiple years among polysubstance-dependent individuals" (Laudet, 2008).

Many different reasons have been given for these mixed findings on the research done on Alcoholics Anonymous. AA studies suffer from the huge problem of high drop-out rates, which make accurate conclusions more difficult to derive. Also, given its naturalistic settings and the anonymity of the program, it is very difficult to conduct the

effective research needed (Sharma & Branscum, 2010). Other problems include that, as an organization, AA is uninterested in research. Also, Vaillant (2005) has stated that medical researchers have difficulty sometimes in assessing AA without being biased based on unconscious rivalry and ideological differences. Finally, there usually are several interventions being used simultaneously when treating an alcoholic, so it is difficult to conduct a truly controlled study (Vaillant, 2005). Until these obstacles can be overcome, accurate conclusions cannot be made.

Minnesota Model

The early treatment of chemical dependence typically involved a patient goes through an initial intensive treatment stage at an inpatient facility. This initial stage would then subsequently be followed by a second less intense stage in some sort of outpatient center or facility. The most widely used approach in these situations was and still is the Minnesota Model. The Minnesota Model is a chemical dependence treatment program that usually lasts 28 days and is a residential treatment program. This program was first developed at The Hazelden Foundation in conjunction with other similar residential treatment programs (Anderson et al., 1999; McElrath, 1997). The Minnesota Model originally evolved from the development of AA in Minnesota in the late 1940's and early 1950's. The Hazelton Foundation and The Pioneer House had begun employing recovering AA members as staff. Around the same time, Psychiatrists and Professional Psychologists from the Willmer State Mental Hospitals' alcohol treatment program began recognizing their limitations in treating their alcoholic patients and began asking for assistance from The Hazelden Foundation and The Pioneer House, and from there, the Minnesota Model was born (Borkman, Kaskutas, & Owen, 2007). The

Minnesota Model is based on the 12-step programs and the principles of AA. This basis also adds a more holistic approach of treating the patient as a whole, using various group and individual therapies showing attention to the mind, body, and the soul. In this treatment, the patient would undergo care for the duration of the 28 days, and then be referred to some sort of continuing care program, usually Alcoholics Anonymous. Additionally, the patient is in most cases suggested to take on some sort of aftercare plan or program. These aftercare plans can consist of individual and group therapy sessions to help with the sometimes challenging transition from being in a shielded inpatient facility back into the challenge of their normal lives, which will include many choices and temptations as they reintegrate.

Researchers have noted a few limitations to the approach using the Minnesota Model. The first thing that was brought up was the inflexibility of this approach, leaving very little room for alterations or adaptations to specific patient needs or unique characteristics. A second limitation of the Minnesota Model is the heavy emphasis and focus on the fundamentals, principles, and philosophies of Alcoholics Anonymous, which is accepted by some but not all substance abusers (McKay & Hiller-Sturmhofel, 2011). The spiritual, and sometimes viewed as religious component, does seem to deter some from adhering to the program of Alcoholics Anonymous, and thus would do the same for the Minnesota Model. Another limitation worth mentioning would be that the most effective residential treatment programs usually last for a period of not less than 90 days. The 28 days of the Minnesota Model is then too short, only allowing for the physical and mental detoxification of the substances from the abuser's body.

Outpatient Treatment

In the late 1990's, the first stage of treatment of having the patient go into a residential facility had been increasingly shifted to day hospitals or intensive outpatient programs (IOPs), both to save from the expensive costs of inpatient treatment and to make treatment less disruptive to the patient's life (McClellan & Meyers, 2004). Although the treatment is now on an outpatient basis, it still follows the Minnesota Model, which is basically the 12-step approach. Once the outpatient treatment is completed, just like the inpatient treatment, it is followed by some sort of continuing care that is usually provided by and at the same facility. Having the chemical dependence treatment on an outpatient basis is currently the most widely used approach. Residential treatment is still utilized, but is usually reserved for those with more severe addictions and/or medical problems and for those with psychiatric problems. The outpatient treatment usually Continues for one to two months and the patient usually comes in around three times a week. Once patients have completed the outpatient program, their continuing care plan involves them attending 12-step meetings and/or other self-help groups.

Coupled with the advantages of attending treatment on an outpatient basis comes the many disadvantages. First, a significant percentage of patients who take part in outpatient treatment continue to drink alcohol and/or use drugs (McKay et al., 1997). Second, it has been shown that patients who fail to maintain at least several consecutive weeks of drug and/or alcohol abstinence during their initial treatment stage have poorer long-term outcomes than patients who do remain abstinent (McKay et al., 1999). A third disadvantage worth mentioning is that most residential treatment programs have a three to five day detoxification process that each patient undergoes upon entering treatment. This medically monitored process allows the person to come off of the substances safely

that he or she has been abusing. A more successful outpatient treatment program might still add this process and might increase the patient's success.

2.2 Secular-Based Programs

In this section, the development and types of secular-based programs will be covered. The first programs to be introduced will be therapeutic communities and Synanon. These two programs will be coupled together as therapeutic communities were a product of Synanon. The next program to be examined and described will be harm reduction. This section will be concluded with examining SMART Recovery.

Therapeutic Communities and Synanon

Therapeutic Communities (TCs) is an approach usually seen as needed for addicts who were believed to require strict regulation and oversight that was labeled in the late 1960's and early 1970's and was rooted and staffed by ex-drug addicts and members of Synanon. Synanon was a therapeutic approach that was developed by Chuck Dederich, who was an alcoholic who had become sober in AA before starting Synanon in 1958 (Janzen, 2001). Dederich had become passionate about the idea that drug addicts could become clean and focused all of his efforts on helping addicts, many of whom had legal and criminal issues (Borgman, Kasutas, & Owen, 2007).

Therapeutic Communities and Synanon borrowed many ideas and principles of AA. They were both programs focused on the importance of truth telling and the necessity for addicts to have a change of personality to maintain abstinence. They also utilized the value of telling one's mistakes to others, as in AA's fifth step, as well as

making amends, as in AA's ninth step. Finally, they focused on recovering addicts helping one another stay clean, as in AA's twelfth step (Glaser, 1981). The essential components of a TC can be seen as residents taking responsibility within the inpatient treatment setting, including the interpersonal, domestic, and treatment components. The group work and residential structures place an emphasis on open communication, involvement, participation, and shared problem solving, enabling staff and residents to make joint decisions, address conflicts, and hold each other accountable (Shuker, 2010).

Although TCs and Synanon were similar to AA in many ways, there were some distinct differences that separated them from AA. Dederich totally rejected all the references that AA made to God that were found in the 12-steps of AA. He believed that addicts and alcoholics did have to take full responsibility for their actions if they wanted to recover, but he substituted some secular writings as the philosophical basis of these ideas (Borgman, Kasutas, & Owen, 2007). The core of this therapy was a method first known as the "Synanon Game" later known as the *game* or *encounter group*. The Synanon Game involved eight to twelve residents and staff verbally addressing one resident who was placed in the middle or "hot seat" for several hours of intense confrontation regarding the resident's self-deceptions about his or her destructive drug use, behavior patterns, and lifestyle (Yablonsky, 1989).

TCs and Synanon, although very similar, differed in some key ways. TC's goal was to return the addict or alcoholic to productive roles in society, whereas Synanon's goal was to keep the addict maintained in an enclosed community. TCs did accept funds from outside organizations and public funding, whereas Synanon relied primarily on private donations. The final key difference was that the professional staffs of TCs were integrated and ex-addicts trained in the therapeutic skills, whereas Synanon's staffs were all informally trained by Dederich himself (White, 1998).

In recent years, there have been some significant changes in TCs since their early inception. TCs have multiplied in number and diversity adapting to the changing forces of society and what is known about the chemically dependent. They have also incorporated some day treatment service alternatives, rather than the residential treatment, and have expanded to include most special populations as well (DeLeon, 1995). TCs have become less hierarchical, and the confrontational encounter game has been modified in many programs (Sugarman, 1982). The biggest change that has taken place in TCs is probably the gradual inclusion of the Twelve-Step philosophy and the use of Twelve-Step meetings in their treatment regime, which has come about in response to shorter lengths of stay and is usually used as more of an aftercare support (Troyer et al., 1995).

The monetary costs of TCs and the lengths of stay are probably the two biggest drawbacks to the approach. As stated earlier, there have been some recent adjustments to TCs to make up for these deficits. There are some other treatments that have been proven more than or just as effective as TCs and do not require the cost or time of TCs. In general, there is no evidence to support superiority of TC over other more accessible and less costly types of treatment for drug use (Fiestas & Ponce 2012).

Harm Reduction

There is no agreement in the literature on addiction or among practitioners as to the definition of harm reduction. Riley et al. (1999) stated that some advocates consider law reform to be harm reduction, whereas others consider imprisonment of drug users for simple possession a form of harm reduction. Harm reduction is a public health approach to substance use and other high-risk behaviors that seeks, as its name implies, to reduce

harms associated with substance use. Harm reduction places the first priority on reducing the negative consequences of drug use rather than all together eliminating drug use or remaining abstinent (Riley et al., 1999). Unique to harm reduction, services are still provided to individuals who continue to use and abuse their substance. Riley and his colleagues also stated that harm reduction was initially born from different clinics around the world with the desire to prevent the transmission of HIV among drug users who used and shared needles. It is now seen as a viable option for some individuals who struggle with alcohol or drug abuse, and for whom twelve-step programs as abstinence based treatments are seen as not possible (Lee, Engstrom, & Petersen, 2011).

At its very core, harm reduction techniques and practices support any kind of steps, no matter how minimal, in the right direction. Even though harm reduction does not directly promote abstinence, abstinence is still seen as the ultimate goal. The harm reduction practitioner first wants to see where the client is in regards to his or her drug or alcohol use, as well as motivations for wanting to make changes. In this regard, the practitioner's goals can be viewed as secondary to what the client wants to get out of the sessions. Even though the practitioner may hold a particular opinion, he or she begins from a premise of respecting the client's decisions on change (Logan & Marlatt, 2010).

There are many different approaches to harm reduction, but most share similar characteristics. Most harm reduction practitioners will use a nonjudgmental but directive approach, such as motivational interviewing to explore with the client the reasons for wanting to change (Miller & Rollnick, 2002). The motivational interviewing aids in building rapport with the client, as well as allowing the practitioner to identify the discrepancies between what the client wants and where he or she is presently. The practitioner will also work with the client in breaking through any resistance to change, building the relationship necessary to enacting the change, and also giving support to the

client's self-efficacy. The client and the practitioner will also work together on setting small realistic but attainable goals practicing some different resistance techniques by identifying some alternate behaviors, and focusing on relapse prevention (Logan & Marlatt, 2010).

Although very similar, there is one key difference in harm reduction that separates it from 12-step programs or other programs of total abstinence, that is, what each one would consider success or a failure. For example, if after a month of therapy and/or treatment, the client is still consuming the substance to some degree, a program with the goal of abstinence would consider the client as having failed. This is important because if abstinence was a factor in attaining this treatment, the client would be turned away from any further treatment, which might include being turned away from housing if this was a service involved with his or her treatment. On the other hand, in harm reduction, if the client was consuming less of the substance at the end of the first month than at the start of therapy, this would be considered to be a step in the right direction, which is considered a success. Even if the client's original goal was to abstain, that he or she had lessened use would be considered a success (Logan & Marlatt, 2010).

When conducting research on harm reduction, researchers evaluate their findings with the same harm reduction goals. Logan and Marlatt (2010) tested and evaluated harm reduction techniques for alcohol use in several different settings: school-based, college students, and several other adult populations. They found that in school-based settings, harm reduction methods resulted in significant reductions in alcohol use in the short-term, but not prevention in the long-term. For college students, harm reduction did have long-term benefits. Finally, with other adult populations, such as the homeless, trauma centers, workplace programs, and for those with concurring disorders, harm reduction was shown to be effective for reducing alcohol use. Logan and Marlatt

concluded that harm reduction interventions were demonstrated and proven to be effective for alcohol and substance abuse in many settings across different populations.

SMART Recovery

In recent years, there have been other alternatives to the 12-step approach that have become increasingly popular. SMART Recovery (formerly known as Rational Recovery) has been suggested as an alternative to AA. Rational Recovery was derived from Rational Emotive Therapy, a mental health treatment with a cognitive orientation that was developed by Albert Ellis (Ellis, 1962). Rational Emotive Therapy generally is based on the premise that psychological difficulties are caused by irrational beliefs about oneself and can be better understood and eventually overcome without the use of existential or spiritual approaches. Ellis had some critiques on AA and this was reflected by his emphasis on rational self-examination rather than by religiosity (Ellis & Volten, 1992). The most prominent of these irrational beliefs he states is that unhappiness is caused by not having control of certain circumstances. In this regard, Rational Recovery takes issue with the first step of AA's Twelve Steps.

Rational Recovery places an emphasis on the use of cognitive devices for achieving abstinence. Rational Recovery achieves this through a few different ways. The attendees openly discuss their compulsive thoughts to drink or use drugs in "cross - talk", which is an open exchange between participants in meetings. The members also use "Sobriety Spreadsheets", where they can log and journal the irrational beliefs about themselves that have and might propel them to engage in drinking or using. Rational Recovery also uses its own literature, *The Small Book,* which provides the member with help in achieving the right attitude towards sobriety. There is no use of a sponsor or

religious components in Rational Recovery, and meetings are usually weekly for ninety minutes and facilitated by a "coordinator" (Galanter, Egelko, & Edwards, 1993).

SMART Recovery, which was originally known as Rational Recovery, had an affiliation with a for-profit company owned by a man by the name of Jack Trimpey. In 1994, the non-profit ended their affiliation with Jack Trimpey because of conflicts with their board and Mr. Trimpey, and changed its name to SMART Recovery (Wiley & Sons Inc., 2009). SMART recovery stands for Self-Management and Recovery Training. Members of SMART are pretty adamant about saying that in way is SMART better or worse than AA. They feel that both programs are excellent, and that both are very good in helping people battle their addictions, but that the individual must find program that best suits them. SMART Recovery has about 450 ongoing groups worldwide, which pales in comparison to AA, who have around 90,000 ongoing groups worldwide (Wiley & Sons Inc., 2009).

There is very little research done on the effectiveness of SMART Recovery. Those involved with SMART say that the foundation that it's based upon does imply that changes and adjustments will be made to the approach as newer scientific evidence is discovered and revealed. In the study by Galanter, Egelko, & Edwards, (1993), they found that RR was a success in engagement with the chemically dependent and promoting abstinence among them while presentation of its cognitive orientation, but that it's utility in treating chemical dependence warrants further investigation.

2.3 Faith-Based Recovery

Although AA does include a spiritual component in its program for recovery, other Recovery programs promote stronger connections within specific religious perspectives. This faith based approach has its scientific support by the studies that show the role that spirituality has in addiction. Most alcohol abuse has been shown to begin before the age of 21, so it is definitely relevant that it has been shown that those who have spiritual involvement are associated with lower incidence of substance when they are adolescents (NSDUH Report, 2004). In a different study by Tsuang et.al (2002) with 100 sets of male twins, it was found that higher levels of spirituality were negatively associated with alcohol abuse. This spiritual component has proven effective in AA as mentioned, but there are a significant number of people with a strong religious background who would prefer to pursue their recovery within the confines of their own religion and thus take these faith based approaches (Brown et. al. (2006).

There has definitely been some confusion on whether or not the program is religious based or if it just has some spiritual components. To help clarify these confusions, the Working Group on Human Needs and Community Initiatives define four distinct faith based programs:

1. faith-saturated – that involves explicit, extensive, and mandatory religious content integrated throughout the activity
2. faith-centered – where explicit religious messages and activities are included but designed so that participants can opt out of them and still expect positive outcomes
3. faith-related – where no explicit religious messages or activities exist, although religious dialogue may be available to participants who seek it
4. faith-background – where no explicit religious content or materials are available

(WGHN, 2002)

There are particular examples that have representation across the country, Celebrate Recovery and The Salvation Army, and these are reviewed next.

Celebrate Recovery

The one program that exemplifies the faith-based approach is Celebrate Recovery. Celebrate Recovery was developed in 1990 through Saddleback Church in California by Pastor Rick Warren, who wrote the book *The Purpose Driven Life* in response to AA's "vagueness about the nature of God" (Celebrate Recovery, 2012). Celebrate Recovery utilizes the following "8 Recovery Principles":

1, R = Realize I'm not God; I admit that I am powerless to control my tendency to do the wrong thing and my life is unmanageable, "Happy are those who know they are spiritually poor"

2, E = Earnestly believe that God exists, that I matter to Him, and that He has the power to help me recover, "Happy are those who mourn, for they shall be comforted"

3, C = Consciously choose to commit all my life and will to Christ's care and control, "Happy are the meek"

4, 0 = Openly examine and confess my faults to God, to myself, and to someone I trust, "Happy are the pure in heart"

5, V = Voluntarily submit to every change God wants to make in my life and humbly ask Him to remove my character defects, "Happy are those whose greatest desire is to do

what God requires"

6, E = Evaluate all my relationships; offer forgiveness to those who have hurt me and make amends for harm I've done to others except when to do so would harm them or others. "Happy are the merciful" "Happy are the peacemakers"

7, R = Reserve a daily time with God for self-examination, Bible readings and prayer in order to know God and His will for my life and to gain the power to follow His will,

8, Y = Yield myself to God to be used to bring this Good News to others, both by my example and by my words, "Happy are those who are persecuted because they do what God requires"

(Celebrate Recovery, 2012)

Celebrate Recovery also incorporates weekly meetings with group discussion, and also utilizes the use and importance of having an individual sponsor. The leaders of these group talks and meetings are nor professionals, and thus give no clinical advice. This program has a huge emphasis on a religious commitment and places an emphasis on self-accountability and responsibility. Celebrate Recovery has spread to over 800 churches from many different denominations around the world (Celebrate Recovery, 2012).

Other Faith-Based Recovery Programs

Although Celebrate Recovery is the most widely known and used of these Faith-Based Programs, there are some other Faith-Based Programs out there. Another one of these Faith-Based Programs is the Faith-Based Recovery Home. This program is an intervention in which a number of recovering addicts reside together to aid in enhancing the emotional stability needed to help sustain recovery, all the while maintaining the

upkeep of the house or residence (Stevens et. al., 2010). It is believed and has been derived from other studies that when living within the confines of social support that it helps aid in recovery and helps individuals better manage their lives and interactions with society (Friedman, Bowden, & Jones, 2003).

Two examples of Faith-Based Recovery Homes are known as the Potter's House Restoration Ministries, one for males and one for females. The Potter's House is managed by a director who also resides in the home with the other residents. The director oversees the other residents, handles financial obligations, and manages the basic upkeep of the house, which is done by the residents. Most preference is given in to these homes to addicts who have recently completed some sort of inpatient treatment program. The residents can stay for up to a year, but must at least commit to three months, all the while attending religious functions, activities, and groups, including AA. The goal of the Potter House is "the sober individual making positive contributions to the community". The Potter House has many partnerships with other social agencies and ministries such as the department of mental health, employment commission, and other church auxiliaries. The residents share in household responsibilities and eventually are goaled to attain employment for transition in to a life outside of the Potter House (Timmons, 2011).

The Salvation Army

Another example of Faith-Based Recovery Programs is the Salvation Army. The Salvation Army was originally founded by William Booth and his wife Catherine in 1852, as a traveling minister who was converting those that the church rejected at the time: thieves, prostitutes, gamblers, and drunkards. He spread the work throughout London, reaching America in 1880. The mission of the Salvation Army is to preach the

gospel of Jesus Christ and to meet human needs in His name without discrimination. The Salvation Army now has a six month Adult Rehabilitation Center. It is usually seen as "the place that no other center or person wants". The clients are called "beneficiaries" and are required to strict rules of dress and conduct. They live in three to six-man rooms and our required to attend work therapy for 40 hours a week. This therapy usually includes maintaining the grounds, working in the retail stores, or taking care of the donations that come in through the warehouse. The beneficiaries are also required to attend one AA meeting and church weekly. They also participate in 10 weeks of Celebrate Recovery, and attend classes and individual therapy. The beneficiaries can stay up to one year, but the program is six months (Salvation Army, 2012).

Most beneficiaries from the Salvation Army have tried unsuccessfully through other programs of recovery. The beneficiaries also work with a chaplain to help with their spiritual recovery. If the beneficiaries are facing any legal issues, a specialist works in conjunction with the district and municipal courts where individuals would be participating in the Salvation Army and completion of the program would be a requirement of their sentence from the court. There is also a specialist assigned to aid in taking care of any medical or dental needs that the beneficiary might have.

Like SMART Recovery there is not a lot of scientific research on the Faith-Based Recovery Programs. There is a definite need for research in these approaches, especially so that the directors of these fields can see what is and what is not effective in these programs. Until the research is done on these Faith-Based Recovery Programs, their true effectiveness is unknown.

2.4 Comparing Inpatient and Outpatient Care

Now that all the current approaches to the treatment of the chemically dependent have been discussed, it is time to examine why one might choose inpatient treatment rather than outpatient treatment and the factors involved in that decision. Also, it is important to distinguish between the benefits of both types of treatment and finally what it might look like to be in inpatient treatment or outpatient treatment.

Factors in Choosing Inpatient vs. Outpatient Treatment

There are several different factors involved when one might be choosing between entering inpatient treatment or enrolling in outpatient treatment. The biggest factor might be the legal implications. Some judges will make it a condition of probation or other type of sentence that the individual enter impatient treatment. This is usually contingent upon this individual's prior drug-related offenses, and/or the individual's compliance with their current programs or stipulations. In this circumstance, the individual has little input on what type of treatment they can enter.

The second biggest factor that goes in to the decision on the type of treatment is the costs of the program. Many individuals' insurance will not cover the cost of an inpatient program, if the individual even has insurance. Inpatient treatment costs can be very high and thus some will enroll in outpatient services, which will allow the individual to make payments on a class-by-class basis. Right along with the monetary costs is the costs that a family might endure if their primary bread winner is the one who needs the treatment. In this case, outpatient treatment would be more suitable as it will still allow the individual to attend and maintain employment.

Another huge factor to consider is the extent of the dependence that the individual might have. Inpatient treatment allows the individual to be completely away from his or

her surroundings and in most cases, takes away from any option that the individual might have in consuming their substance. One of the biggest drawbacks to outpatient treatment is that he or she will have access to whatever their substance is. Those with less control or will power might be more prone to engage in their substance use, thus hindering their recovery. The latter would be best suited in an inpatient facility.

Inpatient and Outpatient Experience

Although very similar in their curriculum, the inpatient and outpatient experience differ greatly in the experience that one will encounter in each. In an inpatient program, an individual will usually first go through a detoxification process. This can last anywhere from three to five days, based upon the substance and the time it takes to safely detox. The individual will have twenty four hour monitoring, and will have their vital signs checked every couple hours. During this time, the individual will primarily only leave their bed to eat and go to the restroom. After the detox, the individual will be assigned a case manager and/or counselor, and will start attending group counseling sessions, classes, and one-on-one therapy. In addition to the counseling and therapy sessions, the individual will start attending 12-step meetings in the facility or sometimes with the group to an outside meeting. The counselor or case worker encourages the individual to use these meetings to get better acquainted with the 12-step program and meet other people in the fellowship and possibly even attain a sponsor. The transition from inpatient treatment back in to society can be very challenging. Upon graduation, it is suggested that individuals move in to a sober house, which is a house for recovering alcoholics and addict, to ease this transition. In most inpatient programs, there is an aftercare group that meets once a week to help the individual stay on track.

The outpatient experience can be different altogether for the individual. In outpatient treatment, he or she will usually come to the center three to five times a week, with the sessions lasting anywhere from four to six hours for anywhere from 6 to 12 weeks. The curriculum is usually the same for the individuals in outpatient treatment as in inpatient treatment. The outpatient treatment will have a primary focus on the group sessions, with one-on-one sessions scheduled outside of the regular classes. The individual will be expected to attend 12-step meetings in addition to their outpatient treatment, and have homework assigned between classes. As was stated earlier, the biggest drawback to outpatient treatment is that individuals will have access to their substances between classes. This can lead to high dropout rates as well as individuals showing up to the classes intoxicated.

No matter which approach an individual chooses to enter, recovery form chemical dependence is a long treacherous journey. Each approach does have its positive aspects and drawbacks. The important thing to remember is that although there is not ever going to be a program that has one hundred percent recovery rate. But that does not mean that the ones that are already in place cannot be modified or combined to make recovery more possible for everybody in need.

This chapter took a look at the current approaches in the area of chemical dependency. From its early days in the Oxford Group and AA to the more recent approaches of SMART Recovery and Harm Reduction, the treatment of chemical dependency has had its successes, but the current approaches definitely need some fresh new perspectives. In the next chapter two newer constructs will be defined and explored, mindfulness and self-compassion.

Chapter 3 Mindfulness and Self-Compassion

This chapter examines two different constructs that ate still relatively new in the area of psychology. The first section will examine *mindfulness*, giving a definition and its origins, as well as explaining how it is practiced and taught to others. The second section will cover *self-compassion*. This section will define self-compassion, tell how the tool to measure self-compassion was first developed, and review some of the research on self-compassion.

3.1 Mindfulness

In discussing mindfulness, I want to address first the origins and definitions of mindfulness. Next, I will address the components that comprise mindfulness. This section will follow with discussing some of the psychological constructs that are related to mindfulness. Some of the different approaches to practicing mindfulness will follow, and I will then conclude with the research and implications of mindfulness

Origins and Definition

The vast importance of the quality of consciousness for the maintenance and enhancement of personal and social well-being has been shared by many spiritual, philosophical, and psychological traditions throughout history (Wilber, 2000). One of the attributes of consciousness that has been receiving more and more attention in recent

years is mindfulness. Rooted in Buddhist philosophy and other traditional meditative practices, mindfulness is most commonly defined as the state of being attentive, aware, and present to and in the moment (Brown & Ryan, 2003). Others have called mindfulness, "The clear and single-minded awareness of what actually happens to us and in us at the successive moments of perception" (Thera, 1972), and "keeping one's consciousness alive to the present reality" (Hanh, 1976).

Components of Mindfulness

To describe the concept of mindfulness and the components that are involved, it is imperative to define consciousness, awareness, and attention in terms of its relate parts of. Consciousness encompasses both awareness and attention (Westen, 1999). Awareness itself has been defined by Westen (1999) as the overall radar or background of our consciousness, constantly keeping track of what is going on around us and the thoughts that are being produced inside of us. A person can be aware that something is going on without having to focus attention on that particular stimulus. Attention can be described as a process of actually focusing your conscious awareness on to a particular stimulus, providing a higher sense of sensitivity to a limited range of experience (Westen, 1999). Both of these work together, as an individual scans inner and outer worlds and processes what is going on.

It can easily be said that attention and awareness are normal for everybody on a day-to-day basis, and that each of us uses these functions of consciousness without even thinking. Here is where the concept of mindfulness becomes important. Mindfulness can be described as taking these common functions of consciousness and enhancing them by

more increased attention and awareness. One core characteristic of mindfulness has been said to have some open receptive awareness and attention that can be shown by sustaining these open conscious functions for prolonged events and experiences (Martin, 1997). Martin defined mindfulness as a "psychological freedom that occurs when attention remains quiet and limber, without attachment to any point of view" (p.291).

Mindfulness was said by Martin (1997) to mean more than simply paying attention or attention without distraction. He added that the defining characteristic of mindfulness was its nonattachment to any particular view or stance (Martin, 1997). It is taking that step out of the normal self or point of view and the world and observing with a quiet nonjudgmental state of mind. Without this mindfulness, one would be lost in their own perspective, seeing no alternatives, nor any way to return to their perspective once another is discovered (Martin, 1997).

Mindfulness has also been related to emotional responses and intelligence. Corcoran, Farb, Anderson, & Segal (2010) conducted a study to investigate how mindfulness affected emotional regulation in the brain. They found brain-based evidence that those trained in mindfulness processed emotional information differently, and theorized that it also promotes metacognitive awareness while enhancing attention capacities and decreasing rumination.

Although the use of mindfulness approaches has been ongoing for several decades, not until the last few years has it been examined as a psychological construct that can be operationally defined with elements and processes. Shapiro et al. (2006) proposed that the elements of mindfulness include the components of those attitudinal formations, attention, and intention, and that all are interconnected and simultaneous. Bishop et al. (2004) had defined attention as a broad focus, with the ability to switch this

attention from stimulus to stimulus. He defined intention, or intentional attention, as the self-regulation of shifting attention.

Psychological Constructs Related to Mindfulness

In addition to the Eastern philosophies and practices, mindfulness has been shown to be related to other psychological constructs. One of these constructs is emotional intelligence, which has been defined as having perceptual clarity about one's own emotional states (Salovey et al., 1995). This type of clarity is related to what mindfulness involves as having the clarity about one's own psychological states. The acknowledgment of the processes that may be going on within one's own psychological state would be this heightened mindful awareness. Another construct that bears some resemblance to mindfulness would be the work of Langer and his colleagues on "wakefulness" (Langer, 2000). Langer speaks of wakefulness as having an open, assimilating approach to cognitive tasks, but his wakefulness is limited to a focus on what is going on externally, whereas mindfulness combines both what is going on internally in conjunction with what is going on externally. So, although mindfulness is associated with these other constructs, it is unique in its focus as well.

William James once said, "Compared to what we ought to be, we are only half awake" (James, 1924). Many researchers and scholars share this same point of view. Mindfulness carries with it a heightened state of consciousness that exhibits clarity and vividness of the current moment and experience that is the very opposite of being half awake, the automatic functioning of the day-to-day habits of most individuals. Mindfulness can be accessed to help break these automatic monotonous thoughts and

habits that sometimes produce unhealthy behaviors and patterns and help in regulating these patterns and behaviors thus enhancing one's own life and experiences (Ryan & Deci, 2000). In doing so, it would produce a happier, healthy lifestyle for the individual in a most direct fashion.

There have been several theories of self-regulation that place this same emphasis on the enhancement of attention and awareness. One of these theories is self-determination theory, which states that an open awareness may be very valuable in helping with the choice of behaviors that will remain consistent with one's values, needs, and interests (Deci & Ryan, 1980). In this case, it would be safe to say that mindfulness is this open awareness, and that mindfulness will allow the person to fulfill their own psychological needs in a way that would be the healthiest to their lives. This careful assessment and special attention that the individual would pay in making choices is much different than the automatic responses and mindless reactions that most use in their everyday lives. Some have argued that this automaticity is very beneficial in our lives and that it frees up the mind to tackle more important tasks, but others see that this type of behavior and thought patterns can inevitably lead to some sort of problematic situation or consequence (Maddux, 1997). There has been some evidence that heightened conscious attention can override unwanted responses, and is also linked to better well-being, emotions, and behavior (Baumeister, Heatherton, & Tice, 1994).

Mindfulness-Based Approaches

In recent years, the use of mindfulness-based interventions that teach individuals mindfulness skills to utilize in their daily lives to help with their psychological well-being and health has been increasing (Burke, 2010). Mindfulness training was primarily used

in adult populations, but has since spread to adolescents and children. The most commonly used mindfulness-based approaches are mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), dialectic behavior therapy (DBT), and acceptance and commitment therapy (ACT). They vary in how they approach teaching mindfulness, with MBSR and MBCT using meditative practices, whereas DBT and ACT use mindfulness techniques that are nonmeditative (Baer & Kristenmeyer, 2006).

MBSR was started sometime in the 1970's as a group intervention that lasted for a period of eight weeks. It was designed for individuals who were experiencing many different medical problems, including chronic pain, and was housed within a university-based medical center (Kabat-Zinn, 1990). Eventually it was adapted for aiding in the prevention of relapse in adults suffering from depression and incorporated into MBCT (Segal et al. 2002). Both MBSR and MBCT utilize an array of meditations, including body scanning, sitting, moving and walking, as the core curriculum, with practice at home and weekly meetings. The weekly meetings include guided meditation practice by a teacher, as well as psycho-education that can be modified to adapt to the particular group of participants. These teachers must also have some extensive personal experience with mindfulness practice, as well as the attitudinal foundations of mindfulness: non-judgment, acceptance, trust, patience, nonstriving, curiosity, and kindness (Shapiro et al., 2006).

Acceptance and commitment therapy (ACT) and dialectic behavior therapy (DBT) differ from MBSR and MBCT in the fact that they take more of a behavioral standpoint. ACT is a behavioral therapy that intertwines mindfulness, acceptance, cognitive defusion, and other techniques to modify the behavior with one's own personal values (Hayes, Stosahl, & Wilson, 1999). It is intended to aid in the person's capacity to

stay in the moment, and based on what is happening in the moment, modify behavior to attain one's goal. ACT is based upon a pragmatism known as functional contextualism (Biglan & Hayes, 1996). The noted components of functional contextualism are: focus on the whole event, sensitivity to the role of context in understanding the nature of the event, emphasis on a truth criterion, and specific goals with which to utilize that truth criterion (Hayes, 2004). The method involves analyzing a past or present behavior or circumstance, identifying what the intended goal was, specifying why it was the proper goal to have, and determining the healthiest way one could have, or can now act, to attain it.

DBT is an approach to treatment that was developed originally for those patients who suffered from borderline personality disorder with a particular interest in reducing their impulsive and destructive behaviors (Linehan, 1993). It is mostly used with individuals who seem treatment resistant, and its focus is on relentless problem solving with an attitude of acceptance through the applications of behavior science, mindfulness, and a dialectical philosophy (Kruger, 2012). A goal of the approach is to move from acceptance to formulating and instilling change in one's lives. The core elements of DBT, as discussed by Kruger (2012) are: (1) A biosocial theory of disorder that emphasizes reciprocal transactions over time between the client and their environment. (2) A development framework consisting of pretreatment and four treatment stages. (3) A hierarchy of behavioral targets within each treatment stage. (4) Acceptance, change, and dialectical strategies utilized to achieve behavioral targets. (5) An overall dialectical framework of therapy.

Mindfulness skills are taught in DBT primarily in the skills training groups. The other skills taught are interpersonal effectiveness, emotional regulation, and distress tolerance. The mindfulness skills are considered to be core or central skills necessary for

the performance of the other three that are taught. Within the mindfulness skills training, two other sets of skills training are taught: "what" skills and "how" skills. The three "what" skills are observing, describing, and participating while the "how" skills are nonjudgmentally, one-mindfully, and effectively (Robins, 2002). Although mindfulness skills are just one part of DBT, the approach emphasizes that such skills are essential for utilizing the other skills that are taught.

Research and Implications

There has been some significant research on mindfulness and its implications in different settings. Shennan, Payne, and Fenlon (2011) conducted a review on mindfulness-based interventions in cancer care. They reviewed thirteen papers and four conference abstracts that they identified had met their criteria for their review. What they found was that mindfulness approaches are a promising intervention in cancer care, potentially across cancer trajectory.

Research on the effectiveness of MBSR reported that participants who had MBSR training had a decrease on rumination scores (Ramel et al., 2004) and also had lower scores on psychological distress, depression, anxiety, and physical illness (McKim, 2008). For health care providers and therapists, mindfulness training has been shown to increase empathy (Walsh & Shapiro, 2006), self-compassion (Shapiro, Astin, Bishop, & Cordova, 2005). Such training led to some considerable positive effects on their counseling skills and therapeutic relationships, including being more attentive to the therapy process and more attuned to themselves and their clients (Newsome, Christopher, Dalen, & Christopher, 2006).

Finally, there have been a few studies on mindfulness as it relates to chemical dependence and substance use. Dakwar, Mariani, and Levin (2011) investigated mindfulness in individuals who were entering treatment for chemical dependency using the Mindful Attention Awareness Scale (MAAS). They concluded that deficits in mindfulness are common in the substance use population, and that mindfulness may be a suitable focus for the treatment of the chemically dependent. Bowen et al. (2006) tested the use of Vipassana meditation, which is a Buddhist mindfulness-based practice, on a population of incarcerated inmates and found that it significantly reduced alcohol and drug related problems. Mindfulness-based Relapse Prevention (MBRP) was tested on chemically dependent individuals after they had been intensely stabilized. It was concluded that MBRP showed reductions in substance use after a four month follow-up by influencing cognitive and behavioral responses to depressive symptoms (Witkiewitz & Bowen, 2010). Although the results look very promising, there needs to be more research in mindfulness as it relates to the treatment of the chemically dependent.

3.2 Self Compassion

In this, section I review the literature on the construct of self-compassion, first discussing its origins and definitions, followed by considering what Neff (2003a) calls the three "faces" of self-compassion. Next I examine the development of measures of self-compassion, before moving to the research that has been done on self-compassion. This chapter closes with the practices that might best help raise self-compassion.

Definition and "Faces" of Self-Compassion

Like mindfulness, *self-compassion* has its roots in ancient Eastern philosophies. Self-Compassion has been gaining increased interest over the past decade, introduced most cogently by Neff (2003a) as a healthy alternative to self-esteem and to those with other identity and issues with the self. Self- compassion, as defined by Neff, is a non-resistance to one's own suffering and the suffering of others, recognizing that pain, inadequacies, and failures in this shared human experience are an inevitability, thus enabling ourselves to "alleviate one's suffering and to heal oneself with kindness" (Neff, 2003a). Self-compassion is meant to remove the harsh judgment that one may place against the self, thereby ameliorating interactions with others. It also is meant to heal these harsh judgments with kindness, as to eliminate the negative feelings and self-talk that one experiences.

Neff (2003a) described three basic components as being essential parts or "faces" of self-compassion. Theses three "faces" of self-compassion include self-kindness, common humanity, and mindfulness. She described self-kindness as extending understanding and kindness to oneself rather than by showing harsh judgments and self-criticisms. Common humanity refers to an individual seeing himself/herself as part of this shared human experience in contrast to seeing oneself as alone and isolated. She defined mindfulness as the practice of holding one's own thoughts and feelings in balanced awareness, instead of overly identifying with them. Each face seems to hold a definite distinction, but they all work together to help enhance growth.

Measuring Self-Compassion

In order for self-compassion to be examined empirically, Neff (2003b) designed a self-compassion scale, aimed at measuring levels of self-compassion by evaluating each different "face" of self-compassion: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. The scores for each face are summed, and the resulting score becomes the individual's overall level of self-compassion. In the development of the self-compassion scale, Neff (2003b) found that self-compassion was correlated negatively with anxiety and depression, and positively with life satisfaction and psychological well-being.

Research on Self-Compassion

There has been a recent surge of interest in the area of self-compassion, with the construct receiving significant empirical findings. Self-compassion has been found to be positively correlated with positive affect and negatively correlated with negative affect (Leary et al., 2007; Neff et al. 2007a). Self-compassion does have a relation to emotional intelligence and emotional regulation. Emotional intelligence can be said is the understanding and acceptance of feelings in order to regulate one's mood. Neff (2003b) found that the face of mindfulness in self-compassion was correlated with emotional intelligence. It was also found that students who had high levels of self-compassion were less likely to suppress their emotions after failing and more likely to use positive coping mechanisms such as acceptance to deal with failure. (Neff, Hsieh, & Dejitterat, 2005).

There has also been some research on the relationship between self-compassion has and specific cognitive patterns. Self-compassion was found to be negatively correlated with rumination in a study conducted with undergraduate students (Neff, 2003b). Neff and her colleagues (2007b) also found that students showing increases in

self-compassion also showed decreases in thought suppression, a finding in line with Neff (2003b). It was also found that for students who had recently failed a midterm examination, self-compassion was negatively correlated with avoidance mechanisms such as mental disengagement and denial (Neff, Hsieh, & Dejitterat, 2005). Self-compassion was also found to be negatively correlated with avoidance strategies (Thompson & Waltz, 2008).

Leary and Tate (2007) along with their colleagues conducted five different studies on self-compassion and the implications that treating oneself kindly would have in the context of real life events. In the first study, they found that self-compassion was consistent in its association with having fewer negative thoughts, pessimism, and self-criticism. It was also shown in the first study that self-compassion was negatively related to feelings of negativity, including anxiety, sadness, and self-consciousness. In the second study, they found that self-compassion acted as a buffer against feelings of negativity when imagining some distressful social event. In the third study, they tested individuals' reactions after receiving feedback on a videotaped presentation they gave about themselves. The participants received either more positive, neutral, or more negative feedback from an observer. They found that self-compassion was a moderator for negative emotions after receiving the feedback, particularly for those who had low self-esteem. In the fourth study, it was found that these same participants who had exhibited low self-compassion also undervalued their presentation relevant to the observers. In the fifth and final study, they found that self-compassion allowed individuals to acknowledge their roles in negative events without being overwhelmed with feelings of negativity. Overall, the researchers concluded that the studies suggested that "self-compassion attenuates people's reactions to negative events in some ways that are distinct from and, in some cases, more beneficial than self-esteem".

Adams and Leary (2007) conducted a study with college women to see if inducing self-compassion might help with their diet. This study had three different conditions: non-dieters, dieters not receiving self-compassion induction, dieters receiving self-compassion induction. All three groups received a "preload", and that is, consuming food that would break a diet. The dieters who received the self-compassion induction reducing their food intake after the preload, and reported increased positive affect without increasing any negative affect. The dieters who did not receive the induction ended up eating more and did have increased negative affect and decreased positive affect. This study showed that with a brief induction, self-compassion can be increased and can also influence affect and behavior.

Barnard and Curry (2011) reviewed findings from personality, social, and clinical psychology research related to self-compassion. They concluded that the research findings support the call for interventions that can raise self-compassion. Barnard and Curry also concluded that self-compassion is a construct that is distinct from other self-themes and is associated with psychological health.

MacBeth and Gumley (2012) conducted a systematic research on self-compassion and its relationship to psychopathology. They conducted a primary meta-analysis on all identified studies reporting associations between compassion and psychopathology. They observed a large effect size for the relationship between compassion and psychopathology; demonstrating higher levels of compassion was associated with lower levels of mental health symptoms. This association provides empirical evidence for the importance of self-compassion for developing well-being, reducing depression and anxiety, and increasing resilience to stress.

Several therapies have been shown to raise self-compassion in individuals. Compassionate Mind Training (CMT) was originally developed to aid patients who were experiencing high levels of self-shame and self-criticism (Gilbert & Irons, 2005; Gilbert & Procter, 2006). Gilbert and Irons (2004) stated that the mind has two separate pathways, one that is self-judgmental and the other that involves self-kindness, one blocking the other. Lee (2005) stated that CMT focuses on the enhancement of the self-kindness pathway. The aims of CBT are to help patients build a more compassionate understanding of their stresses, a healthier concern for their own well-being, and a more mindful tolerance for their thoughts and feelings (Barnard & Curry, 2011). One study of CMT conducted by Gilbert and Procter (2006) measured changes in six different patients who had a broad range of psychiatric diagnoses. After receiving twelve two-hour group CMT sessions, all six patients showed significant reductions in self-reports of depression, anxiety, shame, submissive behavior, inferiority feelings, and the frequency of the power and intrusiveness of self-critical thoughts. Another report involved a series of three cases studies of CMT with patients who had been diagnosed with schizophrenia (Mayhem & Gilbert, 2008). This study showed that patients who had received twelve one-hour sessions of CMT showed prepost decreases in self-reported degrees of depression, anxiety, psychoticism, paranoia, obsessive-compulsive symptoms, and interpersonal sensitivity, although only one individual showed an increase in self-compassion.

Another approach that has shown success in raising self-compassion is Mindfulness-Based Stress Reduction (MBSR). Shapiro and his colleagues conducted two separate studies to test the relationship between MBSR and self-compassion (Shapiro, Brown & Biegel, 2007). The first study consisted of healthcare professionals, and the second study consisted of students in a counseling program. The professionals

who received MBSR showed reduced stress and increased self-compassion, whereas the students showed an increase in mindfulness, positive affect, and self-compassion, and a decrease in rumination and anxiety. Another study on the relationship between MBSR and self-compassion was conducted by Moore (2008) on clinical psychology students. Moore found in a pre-post design significant increases in the all faces of mindfulness and self-kindness, but not on overall self-compassion, suggesting that MBSR may raise self-compassion or at least some of its components.

There are two other approaches, also discussed in mindfulness, that may aid in raising self-compassion, Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT). There are no published studies that test the relationship between DBT and self-compassion but there are some studies that have linked DBT and ACT to mindfulness, which is one of the faces of self-compassion. Nicastro et al. (2010) examined the increase in mindfulness for 82 patients who had been diagnosed with bi-polar disorder and received four weeks of intensive DBT. They found that the patients showed increases in mindfulness also to include increased abilities to describe, accept, and observe their experiences nonjudgmentally. Forman et al. (2007) conducted a study on 101 outpatients who were diagnosed with severe to moderate anxiety or depression. The patients received either ACT or cognitive therapy for fifteen weeks on average. Results showed increases in aspects of mindfulness and acceptance, and these increases seemed to mediate treatment gains.

More recently, Neff and Germer (2011) developed and evaluated the effectiveness of an 8-week workshop designed to train individuals to be more self-compassionate. Their workshop consisted of 2 hour meetings once a week for 8 weeks. The meetings were facilitated by two clinical psychologists with extensive practice in both personal mindfulness mediation and professional experience with mindfulness-based and

acceptance-based therapies. Each session would focus on a specific topic. The first session was a general introduction. The following sections would focus on (2) mindfulness, (3) application of self-compassion in everyday life, (4) developing a compassionate inner voice, (5) living in accordance with core values, (6) dealing with difficult emotions, (7) challenging interpersonal relationships, and the final session (8) discusses how to relate to positive aspects of oneself and one's life with appreciation. The program also consists of a retreat that lasts four hours between sessions four and five that has various meditations. The program consists of various small groups where individuals can share good practices and homework assignments and practices are given and informal practices are also taught. The aim is to keep a warm and friendly atmosphere in the group and the participants are encouraged to discuss and share comfortably about their lives in a group setting.

Neff and Germer (2011) ran participants through their workshop to test its effectiveness. The participants were given scales measuring their self-compassion, mindfulness, connectedness, happiness, life-satisfaction, depression, anxiety, stress, and response to the program itself. They found that the workshop showed gains with the participants in self-compassion, mindfulness, life satisfaction, and happiness, and decreases in depression, stress, and anxiety. They also found in a separate study increases in self-compassion, mindfulness, and well-being versus a control group who were waitlisted for the workshop. The results of these studies suggest that the workshop is effective in increasing self-compassion, as well as mindfulness and compassion for others.

These are just some of the practices that might be associated with raising one's self-compassion. There may be more out there, but it is clear that there needs to be more

research done on these and other practices to determine which may be the most effective in increasing self-compassion.

This chapter took a look at more the more recent constructs of mindfulness and self-compassion. As most studies have stated on these concepts, there definitely needs to be more research so that accurate conclusions can be deduced. In the next chapter, the overlaps between the current approaches to chemical dependency treatment and these new constructs will be discussed as well as how a compassionate treatment program might look and how its effectiveness might be tested.

Chapter 4 Compassion Based Approach

In this chapter, a link between current approaches to chemical dependency treatment and mindfulness and self-compassion will be explored. In the first section, the overlap between the current approaches and mindfulness and self-compassion will be discussed. In the following section, I outline a basic framework for what a compassionate based treatment recovery for chemical dependency might look like. In the final section, I present a design for testing the effectiveness of a compassion based recovery program.

4.1 Current Approaches vs. Mindfulness and Self-Compassion

In this section the current approaches to chemical dependency treatment are compared to mindfulness and self-compassion. The section starts with a look at similarities before detailing the differences between the two. In discussing these similarities and differences, my goal is to bring innovation to the current approaches that would involve mindfulness and self-compassion.

Similarities

There are some notable similarities between current approaches to intervention treatment of addiciton and mindfulness and self-compassion. Probably the better way to look at these similarities would be to compare aspects of the current approaches to the "faces" of self-compassion, as one of the "faces" is mindfulness itself.

The first "face" of self-compassion is self-kindness, most easily aligned with Steps 4-7 of AA as well as Principles 5 & 7 of the Celebrate Recovery's "8 Recovery Principles" In these steps and principles, individuals are taking an honest look at their character and actually writing their defects down. These defects of character are usually areas within the individual for which he or she has been using harsh judgment that hinders self-kindness. Getting these defects to the surface allows the individual the understanding to accept these defects, thus allowing the self-kindness to begin. In harm reduction, the goal is not always abstinence, so lessened use of a substance is considered a success. Usually when an individual cannot achieve complete abstinence, he or she would respond with harsh judgment or self-criticism of the perceived failure. Harm reduction allows for a person to use self-kindness for achieving smaller goals. In SMART Recovery, self-kindness can be exhibited through the "Sobriety Worksheets" for which recovering addicts can actually see these harsh judgments on themselves, again bringing them to the surface to eliminate them and allow self-kindness to begin.

The next "face" of self-compassion to examine would be common humanity. This is a feature where the biggest overlap can be seen with current treatment. In all the current approaches to treatment the individuals are surrounded by other addicts and alcoholics who are sharing in their suffering of chemical dependency. Seeing others similar to themselves makes it very apparent for individuals to see that they are not alone or isolated in their suffering but are part of a greater humanity sharing in their struggles. This can easily be argued as being the foundation of most of the current approaches.

The final "face" of self-compassion to examine would be mindfulness. This can be compared to Steps 1 and 4 of AA, Principles 1 and 4 of Celebrate Recovery, and the "Sobriety Worksheets" in SMART Recovery. In all of these areas, awareness is the focal point. Without this awareness, it is easy for a person with addiction to over identify with these "unmanageability's" as well as the "defects of character". When these areas are again brought to the surface, their acceptance and the actions needed to alleviate this over-identifying can begin. This can also be seen in the "Synanon Game" of therapeutic communities, in which others can help bring this awareness to the individual to allow him or her to see how over identifying with these traits or labels is triggering a cycle of substance abuse.

Differences

Although they are significant similarities between the current approaches and mindfulness and self-compassion, there are also some key differences. One way to identify these differences is to look at how each different current approach to treatment differs from the constructs that make up mindfulness and self-compassion. .

For example, when examining AA and Celebrate Recovery, one word springs to mind that separates these from mindfulness and self-compassion: *powerlessness.* The word "powerless" is found in the first step of AA and in the first principle of Celebrate Recovery. This makes it seems that an individual has no control over their own lives. This can easily be seen as a harsh-judgment made towards oneself, which can easily be misconstrued as an excuse not to be kind towards oneself. This can also lead the individual to over identify with being powerless, thus not keeping themselves in balance awareness. This is also seen in using the word *addict* or *alcoholic* in the 12-step

programs. Over identification with these words can definitely make a self-fulfilling prophecy. Using the label of *addict* or *alcoholic* can also break this feeling of common humanity with others who are not seen as addicts or alcoholics.

In another pair of current approaches, SMART Recovery and Harm Reduction, the individual is not labeled as *powerless* or as an *addict* or *alcoholic*, but both of these approaches go straight into problem-solving mode, which contradicts what a self-compassionate approach would take. The problem-solving mode stems from being self-critical, which is also seen in TC's and Synanon, and does not address the underlying feelings that accompany these self-criticisms.

The final approaches to discuss would be the faith-centered approaches. This is probably where the most apparent differences are seen. Although some of the current approaches have an aspect of spirituality involved, none of them are faith specific. Those within a faith-based program are practicing a particular faith, and to be involved with that program, the individual, too, must accept and practice that faith. Most faith-based approaches are rooted within Christianity, so if the individual is of another faith, they might be turned away or themselves turn away from these particular programs. Mindfulness and self-compassion do have some roots in Buddhist practices and philosophies, but one does not have to accept or practice Buddhism to practice mindfulness or self-compassion. An individual could keep their own faith and still practice mindfulness and self-compassion.

4.2 Compassion Program Recovery

In this section I describe a basic framework of how a compassion-based recovery program might look. The section starts with the initial phase of the program, continues

with a description of the heart of the proposed program, which can be inpatient or outpatient, and ends with a section that will conclude with the aftercare or continuing care phase of the program.

Phase 1: Detoxification & Classification

As in any recovery program, the first phase of the program must include a detoxification process. This phase would have to be done in a medical facility so the patient could be closely monitored and allowed to get the drug out of his or her body safely. This phase would probably mimic most detox programs, as the patient is usually either sleeping or eating during most of the time during this process. This can take anywhere from three to five days based upon the intensity of the detox.

Once the patient has detoxed, a series of assessments can begin by a counselor or therapist who is trained in self-compassion. This is where the patient will be classified into either outpatient treatment or inpatient treatment, based upon the same factors mentioned in Chapter 2, and the treatment plan will be presented to the patient.

Phase 2: Compassionate Treatment

Once the patient has been placed in either inpatient or outpatient care, the compassionate program recovery will begin. The length of stay in the program will be that of the Minnesota Model, 28-30 days inpatient or six to eight weeks of outpatient. The first week of the program (2 weeks for outpatient) for every patient will consist of classes that define and identify areas of self-compassion, much like the introductory session in the workshop designed by Neff and Germer (2011). These classes will use the

different approaches of CMT, MBSR, ACT, and DBT. This can be done in a multitude of ways. If group classes are used, individuals will be led to identify ways that they have been self-compassionate and ways that they have not led by therapists trained in self-compassion. Each afternoon of the first week (last hour for outpatient) will use different meditations to introduce the individuals to the practice of meditating.

For the remaining three weeks of the program (4-6 for outpatient) a different "face" of self-compassion will be covered each week. Because each individual will join the program at different times, some will be on their first "face" whereas others in the same class/group may be on their second or their third "face". These three weeks would be in the same order so that each patient would always get a week for each "face". Throughout the individual week, the patient will learn ways in which to strengthen that week's "face" in themselves as well as to identify how their substance abuse is hindering the practice of self-compassion. Also within the week, two of the days will be set aside to each focus on one different topic of the topics from the 8-week workshop by Neff and Germer (2011) so that all eight topics will be covered throughout the program. There will be at least one one-on-one session a week with the therapist during which the patient can set goals to attain for that week's "face" and they will discuss these goals and how they are doing in reaching their goals in the group sessions throughout the week. Each weekend for the individuals who are halfway through their program, a half-day retreat much like the retreat by Neff and Germer (2011) will take place for various mediations. There will always be common groups for sharing, and the treatment would end with a graduation when a patient has successfully completed all three "faces".

Phase 3: Continuing Care

Upon graduation from outpatient or inpatient care, the individual would be encouraged to attend the aftercare program. This would consist of coming in one night per week for an alumni type meeting (run by a therapist) to share with other patients who are currently in the program how self-compassion has worked in their lives, as well as the challenges they face with self-compassion A support type group (without a therapist) that is based on compassionate program recovery would also be held at the facility for the inpatients and outpatients who are in treatment on a weekend night to discuss openly the practice of self-compassion. The hope would be to build these support type groups independent of the facility to be available for all who want to come and discuss and practice self-compassion in their lives.

4.3 Testing the Effectiveness of Compassion Program Recovery

In this section, I will offer a suggested design on how one might test the effectiveness of a compassion based recovery program. As mentioned in the section on self-compassion, increasing self-compassion can facilitate emotional intelligence and has been negatively correlated with rumination and thought suppression (Neff, 2003b), as well as shown to influence affect and behavior (Adams & Leary 2007). So in theory, increasing self-compassion in those with chemical dependencies would allow them to cope better with the feelings caused by their dependency and reduce rumination while positively influencing their affect and behavior.

The first thing to do is find a traditional inpatient and outpatient treatment. The patients would be randomly assigned either to attend the traditional Minnesota Model treatment or the compassion-based treatment. All individuals would be given the self-

compassion scale at the beginning of their treatments. Individuals would go through their treatments so that half of the inpatients would receive the Minnesota Model and the other half the compassion based treatment for either inpatient or outpatient. At the end of the treatment, their self-compassion would be measured again with the self-compassion scale. Other data will involve tracking who has not completed the program, as well as rates of relapse. The numbers would be analyzed to see if self-compassion was significantly raised and follow-ups can be done at three and six month points. It should be added that at anytime one of the treatments is shown to significantly render better results, all individuals would be given the option to switch over his or her treatment. Many of the scales that were used to measure the effectiveness of the Neff and Germer (2011) study could and would also be used to measure the effectiveness of this program.

This is a very basic design of how this study might look. There will be critics for this compassion based recovery program. Some might say that not enough research has been done on mindfulness and self-compassion, especially in the realm of chemical dependency, to propose such a program, a valid concern. There is also the chance that the patients themselves might not accept this "alternative" type of program, especially with men, another concern. There may also be some critics who feel that the self-compassion approach does not address the problems that might be involved with what it means to be chemically dependent. These points are all very valid, as mindfulness and self-compassion are still relatively new constructs in psychology. The one thing that can be said to address these critics is that raising self-compassion in these individuals will most likely not make their problems and dependencies any worse, and maybe the raising of their self-compassion is what they needed for themselves all along.

In this chapter an attempt was made to bring together mindfulness and self-compassion together with the current approaches to the treatment of chemical dependency. The similarities and differences were discussed, as well as basic frameworks for a new treatment approach and a method to test this approach. As mentioned before, there definitely needs to be more research in all these areas, but the hope would be to keep the best practices of each to ensure that the individual is receiving the most adequate treatment that is available.

Chapter 5 Conclusion

This report has covered many areas of chemical dependency. In the first chapter, I presented some of the current trends on chemical use and the common characteristics of those whom are chemically dependent. In the second chapter, I wrote on the current approaches to chemical dependence treatment, including the traditional approaches, secular approaches, and faith-based approaches. In the third chapter, I defined mindfulness and self-compassion. I also spoke of the best practices to increase mindfulness and self-compassion as well as some empirical findings to support their practice. In the fourth chapter, I compared the current treatment approaches to self-compassion, identifying similarities and differences. I also gave a basic framework on how a compassion-based recovery program might look, and some basic guidelines on how the effectiveness of such a program might be tested.

The intent of this report is to show how self-compassion should be implemented in the practice of treating the chemically dependent. Self-compassion is a new construct in the field of psychology and still needs to be examined in many areas. My proposal is that one of these areas is that of chemical dependence. In my experience with treatment centers and treatment programs I have come across many cases of chemical dependency. I have seen firsthand what chemical dependence does to an individual and also to those who care about the individual. I have seen these individuals try so hard to quit something that he or she think that they cannot, and be baffled with why not. There are many

therapies and self-help groups that want the individual to do steps, and to talk, and to practice different techniques to help him or her alleviate their chemical dependence. I have seen so many people fail miserably, and become hopeless in their chemical dependence.

Take a look back at the three "faces" of self-compassion. The first one is self-kindness. In my experience, most of the individuals that come into treatment and recovery hate themselves. He or she has hurt so many people and themselves with their addiction that they cannot even look in the mirror, much less be kind to themselves. If he or she can learn and practice self-kindness, this will allow them to have a feeling of worth to move further and start the process of recovery by accepting themselves for who they are on the inside and loving that person. The second face is common humanity. It has been my experience that most individuals enter treatment so isolated by their addiction that some even cease to feel human anymore. If he or she accepts that they are part of a common whole and start working as such, this connection can alleviate this need to isolate and hide which is a precursor to substance use. The third face is mindfulness. It has been my experience that individuals who enter treatment and recovery are so disconnected from their emotions and in such shame and guilt over their past, it is impossible to even think about a balance awareness. These individuals call themselves drunks, bums, drug addicts, junkies, and losers. If the individual could be taught that this is not him or her and to stop identifying with these labels, a new person could be born. There needs to be something positive, bright, and new for these individuals.

Novelist Ayn Rand once wrote, "Do not let your fire go out, spark by irreplaceable spark, in the hopeless swamps of the approximate, the not-quite, the not-yet, the not-at-all. Do not let the hero in your soul perish, in lonely frustration for the life you deserved, but have never been able to reach. Check the road and the nature of your

battle. The world you desired can be won. It exists, it is real, it is possible, it is yours." This battle is one that can be won, but a new road to victory has to be built. This road can run right through self-compassion.

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