Theoretical foundation of 3-S+

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The Spiritual Self-Schema (3-S+) development program

> *Spiritual Self-Schema (3-S+) therapy is a manual-guided cognitive-behavioral therapeutic approach informed by Buddhist psychology, for helping individuals with HIV who are in treatment for addiction to use their own spiritual/religious beliefs to develop and activate a self-schema consistent with drug abstinence, HIV preventive behavior, and adherence to medical recommendations.*

Need for the intervention.

The health consequences of drug use in the nation's inner-cities are numerous and dire. Consequences of heroin and cocaine addiction to the individual, in addition to the significant psychological and interpersonal effects, include the potential for disability or premature death. Consequences to society, in addition to the high cost of crime and other drug-related activities, include the monetary costs of providing health care to a patient population that is typically not privately insured, costs that can be expected to increase as this patient population ages. The rapid spread of the human immunodeficiency virus (HIV) among injection drug users has added a potentially lethal dimension to the already serious health and social consequences of drug use, contributing further to the human suffering and social ills associated with addiction. The need for comprehensive interventions for HIV-positive drug users is urgent (Grella, Etheridge, Joshi, & Anglin, 2000). In many parts of the country, drug users represent the largest segment of current or newly reported cases of AIDS. In Connecticut, the association is particularly high, with 51% of AIDS cases linked to injection drug use. Of considerable concern is the finding that individuals infected with HIV continue to engage in behaviors that place others at risk for acquiring HIV, and that place the HIV-positive individual at risk for further health deterioration (Avants, Warburton, Hawkins, & Margolin, 2000; Kalichman, 1996). Data from the Supplemental HIV/AIDS Surveillance (SHAS) project revealed that 32% of persons with AIDS reported that their most recent sexual partner was HIV-negative; 51% reported engaging in unprotected sexual activity; and 55% reported injection drug use (Connecticut Department of Public Health, 1997). Data on the risk behavior of HIV-infected individuals who have not progressed to AIDS are not included in these reports, raising the possibility that the situation may be even more serious than these data suggest. Thus, there is compelling evidence concerning the need for effective interventions with this patient population that increase motivation to engage in harm reduction behavior and facilitate adaptive coping with HIV.

Rationale for developing a faith-based intervention

Faith and addiction. Despite the wide observance of religious practice in the United States (Gallup, 1996), the role that spiritual or religious faith plays in recovery from addictive disorders, has been the focus of relatively few empirical investigations (Miller,

1998). Those that have been conducted suggest that this may be a potentially important dimension of human experience to assess in relation to addiction treatment outcome (Goldfarb, Galanter, McDowell, H., & Dermatis, 1997). For example, a large-scale study of over 2,000 female twins examined the relationship between religiosity, psychopathology, and substance abuse (Kendler, Gardner, & Prescott, 1997) and found that while traditional religious beliefs may prevent initial abuse of substances, recovery from substance abuse appears to be facilitated by personal devotion (i.e., the perceived importance of religious and spiritual beliefs in daily life, spirituality as a source of comfort during adversity, and private prayer). Other smaller scale studies have come to similar conclusions (e.g., Brizer, 1993; Mathew, Georgi, Wilson, & Mathew, 1996). In a study of 237 recovering substance abusers, strength of religious faith and spirituality was also found to be associated with more adaptive coping, greater resilience to stress, an optimistic life orientation, greater perceived social support, and lower levels of anxiety (Avants, Warburton, & Margolin, 2001; Pardini, Plante, Sherman, & Stump, 2000). The specific aspects of religiosity and spirituality that influence recovery from addiction are at present unclear, but may importantly involve a shift from a punitive to a supportive conception of religiousness (Gorsuch, 1994). Despite the current lack of replicated research findings in this evolving field, many community-based treatment approaches, such as the 12-Step program of Alcoholics and Narcotics Anonymous, have long been based on the premise that addiction is a spiritual, as well as a medical, disorder (Alcoholics Anonymous World Services, 1976; Kus, 1995).

Faith and HIV risk behavior. Spiritual beliefs have also been linked to avoidance of HIV risk behaviors. Over one-third of a sample of HIV-negative injection drug users in New York City reported that "prayer" or "God's help" was responsible for helping them avoid engaging in behaviors that could lead to HIV infection (Des Jarlais et al., 1997). Because spiritual and religious faith appear to provide a buffer against the depressogenic effects of stressful life events (Kendler et al., 1997), and can play a protective role in physical and mental health (Benson & Dusek, 1999; Ellison, 1991; Galanter, 1997; Pargament, 2001), it may be an especially salient dimension of recovery for HIV-positive drug users in addiction treatment (Kaplan, Marks, Mertens, & Terry, 1997). These patients are faced with the stress of a chronic, and potentially fatal disease, as well as the daily challenges of becoming and remaining abstinent (cf. Jenkins, 1995; Tsevat et al., 1999; Woods & Ironson, 1999), and adhering to potentially complex medical regimens.

Faith and coping with HIV. It is clear from an extensive literature on coping with illness that maladaptive coping is associated with poor adjustment to HIV disease in various subpopulations of HIV-infected individuals (Billings, Folkman, Acree, & Moskowitz, 2000; Florence, Luetzen, & Alexius, 1994; Klein, Forehand, Armistead, & Wierson, 1994; Leiberich et al., 1997; Siegel, Gluhoski, & Karus, 1997). In general, HIV-infected patients have been found to use less effective coping strategies and to have fewer social supports than other medical populations (Grassi, Caloro, Zamorani, & Ramelli, 1997). The consequences of maladaptive coping include psychological distress (Blaney et al., 1997; DeGenova, Patton, Jurich, & MacDermid, 1994; Folkman, Chesney, Pollack, & Coates, 1993; Fukunishi, Hosaka, Negishi, & Moriya, 1997; Wolf, Balson, Morse, & Simon, 1991), increased HIV symptomatology (Moneyham et al., 1998;

Swindells et al., 1999; Thomason, Jones, McClure, & Bantley, 1996), nonadherence to antiretroviral medication therapy (Singh, Squier, Sivek, & Wagener, 1996), and continued high risk behavior (S. K. Avants, L. A. Warburton, & A. Margolin, 2001; Clement, 1992; Kalichman, Roffman, Picciano, & Bolan, 1997; Robins, Dew, Davidson, & Penkower, 1994; Robins, Dew, Kingsley, & Becker, 1997). One of the coping strategies, whose benefits have received empirical support, is seeking and receiving spiritual support (see Folkman, Chesney, Pollack, & Phillips, 1992). Religious behavior (e.g., service attendance, prayer) has been found to be associated with medical outcomes, and religious coping more generally (placing trust in God, seeking comfort in religion), with lower levels of psychological distress (Woods, Antoni, Ironson, & Kling, 1999). The relationship between adaptive coping and spirituality is particularly strong among African-Americans and women with HIV disease (Biggar et al., 1999; Demi, Moneyham, Sowell, & Cohen, 1997; Florence et al., 1994; Jenkins, 1995; Kaplan et al., 1997; Tangenberg, 2001). Thus, spirituality, and its links to adaptive coping, may be particularly relevant to address in inner-city settings, in which HIV disproportionately affects African-Americans (Centers for Disease Control and Prevention, 1999).

Integration of Buddhist psychology and Western psychotherapy

There is at present a considerable literature on the integration of spirituality and psychotherapy. Some authors provide a broad foundation for the integration of Western, theistic spirituality in the practice of psychotherapy (Richards & Bergin, 1997), and others describe more specific instances of this integration, such as a theistically-oriented cognitive-behavioral treatment (Probst, 1988). One reason for the relative paucity of research on interventions focusing on patients' spiritual and religious beliefs may be the inherent difficulty in defining and measuring spiritual faith in a manner that is respectful of the potential diversity of patients' personal belief systems (Gorsuch & Miller, 1999). We think that a cognitive model of self and a Buddhist model of spirituality, which emphasizes the role of cognitive processes, provide highly relevant theoretical frameworks within which this can be accomplished. A number of clinicians and theorists have written extensively on integrating Buddhist and Western psychological principles and practices for a range of psychological problems (see Rubin, 1996; Varela, Thompson, & Rosch, 1991; Watson, Batchelor, & Claxton, 1999). Many of these discussions focus on the potentially important role for "mindfulness" meditation in the conceptualization and implementation of treatment. For example, Rubin (1996) and Epstein (1995) discuss how Buddhist thought and mindfulness experience can enrich a Freudian, psychoanalytic framework in the practice of psychotherapy. Segal and his colleagues provide a systematic mindfulness-based cognitive therapy for the treatment of depression (Segal, Williams, & Teasdale, 2002). More broadly, Rosenbaum (1999) describes how psychotherapists can enrich their work, their interactions with their clients, and, indeed, their lives, through the incorporation of mindfulness principles and practices of Zen Buddhism. With respect to the addictions, Ash (1993) has proposed a Zen Buddhist interpretation of the Alcoholics Anonymous, "12-step" framework (Alcoholics Anonymous World Services, 1976). The interested reader is also referred to an issue of the journal of the Association for the Advancement of Behavioral Therapy (AABT) Cognitive and Behavioral Practice, Vol. 9(1), Winter 2002, entitled 'Integrating Buddhist philosophy with cognitive and behavioral practice' for examples of how Buddhist

concepts can be usefully integrated with cognitive behavioral therapy (CBT), including CBT treatment for addiction. In the development of 3-S^+ we tacitly built on prior work integrating Buddhist psychology and Western psychotherapy, and present a therapy incorporating concepts and theories of information processing that have been of considerable theoretical interest but whose clinical application has only recently begun to be explored (Strauman & Segal, 2001; Vieth et al., 2003).

Self-schema theory

A cognitive self-schema model may be usefully applied to the development and evaluation of a specifically spirituality-focused intervention, because the process of activating a spiritual/religious schema is unlikely to differ from general processes involved in activating any cognitive schema (see McIntosh, 1995). A cognitive schema, regardless of content domain, is posited to facilitate rapid identification of stimuli, memory for schema-relevant information, interpretation of ambiguous stimuli, and selection of strategies guiding response (Markus, 1977; Taylor & Crocker, 1981). Schemas, as cognitive organizing structures, are therefore amenable to empirical investigation. For example, a number of studies have provided evidence for faster cognitive processing of schema-relevant material than schema-irrelevant material (e.g., MacDonald & Kuiper, 1985; Markus, 1977), including more rapid endorsement of religious attributes by individuals with religious schemas relative to individuals without religious schemas (see McIntosh, 1995), and greater recall of schema-relevant information (e.g., Markus, Crane, Bernstein, & Saladi, 1982; Rogers, Kuiper, & Kirker, 1977; Swann & Read, 1981).

***Multiple Self-Representations*.** A view of the "self" as comprised of multiple self-representations has been advanced by many theorists in this country over the years, from the seminal work of James (James, 1890-1950) to contemporary cognitive and social psychologists' perspectives on the self as multifaceted and dynamic (Greenwald & Pratkanis, 1984; Kihlstrom & Cantor, 1984; Markus & Nurius, 1986; Markus & Wurf, 1984; McGuire, 1984; Singer & Salovey, 1991). In cognitive psychology, a self-schema is conceptualized as a highly automatized, hierarchically-organized, system of knowledge or beliefs about one's intentions and capacities that is stored in long-term memory (Singer & Salovey, 1991). It establishes selection criteria for regulating attention, provides focus and structure for encoding, storing and retrieving information, and has strong associative links to other components of the system, such as the emotions and physiology (Carver & Scheier, 1982, 1990). Which of our multiple self-representations is activated at any given time is posited to be the one that is most elaborate, most extensively rehearsed, and most frequently and easily accessible or available in a given context (Markus & Nurius, 1986). When a self-schema is activated, specific beliefs about the self are activated that, in turn, provide rapid access to a behavioral repertoire and to automatized scripts and action plans (Schank & Abelson, 1977) that facilitate efficient performance of the behavior selected (Ng, 2000). This process is adaptive in that it facilitates rapid processing of incoming information and rapid adjustment of the system to maintain homeostasis (Bargh & Chartrand, 1999; Hart, Field, Garfinkle, & Singer, 1997). However, it can also become maladaptive, as described below.

The addict self-schema: When addictive behavior becomes "Second Nature"

In his description of habit, William James notes: "Habit diminishes the conscious attention with which our acts are performed" (p. 114) (James, 1890-1950). He gives the example of a discharged veteran, carrying home his dinner, whose drill formation training had become so automaticized that upon hearing the word 'attention' the man instantly brought his hands to his side "… losing his mutton and potatoes in the gutter. The drill had been thorough, and its effects had become embodied in the man's nervous structure" (p.120). From a self-schema perspective, the man's "soldier" schema was so elaborate and readily accessible that the word 'attention' automatically activated an action plan associated with drill-formation. Contemporary cognitive models of depression (Beck, 1976), and distress more generally (see Segal & Blatt, 1993), also posit a habitual, or automatic process whereby a habitually activated negative schema filters and processes incoming information such that negative affective states are perpetuated (Svartberg, Seltzer, Choi, & Stiles, 2001). One model that guided our own thinking concerning maladaptive self-schema activation in the addictions is self-discrepancy theory, which uses a self-regulation framework to describe how discrepancies between one's view of oneself and one's goals or standards can cause vulnerability to negative emotional states (Higgins, Klein, & Strauman, 1985; Strauman, 1989; Strauman & Higgins, 1988, 1993; Strauman et al., 2006). In a series of studies using an adaptation of the Selves Questionnaire developed by Higgins and his colleagues (Higgins, 1989), we found that among inner-city injection drug users, discrepancies between their self-identity as "addicts" and their personal ideals or societal standards for the type of person they desire to be, or feel they ought to be, may contribute to negative affect, and may influence the processing of incoming information such that drug use and other addiction-related behaviors are perpetuated. Specifically, our findings can be summarized as follows: (a) the working self-schema of addicted individuals is extremely negative (see also Fieldman, Woolfolk, & Allen, 1995; Tarquinio, Fischer, Gauchet, & Perarnaud, 2001), and includes such self-attributions as "selfish, aggressive, evil, impulsive, irresponsible, manipulative, and unmerciful;" (b) negative affective states (e.g., depression) are associated with activation of the addict self-schema; and (c) an important process involved in successful addiction treatment is "self-reevaluation" during which the "ideal" or "non-addict" self-schema is strengthened, and begins to replace the addict self-representation as the working (or "actual") self-schema in the individual's daily activities (Avants, 1993; Avants & Margolin, 1995; Avants, Margolin, Kosten, & Cooney, 1995; Avants, Margolin, Kosten, & Singer, 1993; Avants, Margolin, & McKee, 2000; Avants, Margolin, & Singer, 1994; Avants, 1996; Avants, Singer, & Margolin, 1993).

The habitually activated addict self-schema appears to provide rapid access to a rich network of beliefs, emotions, and behaviors associated with illicit drug use that has become highly elaborate, extensively rehearsed, and is readily available for activation. This rich cognitive network, which may be activated not only in drug-related contexts (e.g., exposure to drug cues), but in other contexts as well (e.g., sexual, social, and medical contexts), includes beliefs about the worthiness of the self and about the world's "fairness" (see Avants et al., 2003), as well as expectations concerning the effects of drugs on self. In addition, access to over-learned event scripts and action plans is facilitated, which sets into motion the rapid, automatic, and seemingly unconscious,

sequence of behaviors that lead to drug use as well as other behaviors that place the health of the addicted individual and others at risk.

Addicted individuals, and the clinicians who treat them, are familiar with the concept of a 'trigger,' as something that activates addictive behavior – a person, place, thing, feeling -- seemingly without conscious awareness, causing what clients and clinicians refer to as 'going on automatic pilot.' As with William James' retired soldier who snaps to attention without conscious awareness, addicted individuals may, in fact, be trying to maintain abstinence, but while engaged in an activity perhaps completely unrelated to drug use, something or other activates the addict self-schema and initiates a cascade of automatic drug-seeking behaviors (Tiffany, 1990). These "addict" scripts and action plans may eventually lead to obtaining and using drugs, as well as to other risky behaviors, such as needle sharing and unsafe sexual practices, and to failure to adhere to complex HIV medication regimens. If the individual is later asked what led to drug use or other risky behavior on that occasion, identifying the specific trigger may be like trying to find the beginning of an intricate spider's web -- so complex is the network of associations that he or she may never be able to identify what was the one trigger, in that particular situation, given the individual's particular state of mind at that moment, that set off the chain reaction. An intervention guided by self-schema theory would not approach the problem of automaticity by focusing on identifying the illusive trigger, as would, for example, relapse prevention therapy (e.g., Marlatt & Gordon, 1985). Rather, it would focus primarily on changing the automatic process itself by helping the client develop, strengthen, and activate a cognitive schema that is incompatible with an 'addict' self-schema, the activation of which would therefore lead to thoughts and behaviors that promote drug abstinence, HIV preventive behavior, and medication adherence.

It is a fundamental tenet of 3-S^+ that HIV-positive drug users will not change their personally and socially destructive behaviors unless they relinquish their core identification with the addict self-schema, with its drug-related thoughts, feelings, and behaviors, and choose instead to invoke, and fill their minds with a self-guide that is the antithesis of the addict self, and that is congruent with drug abstinence, HIV prevention, and medication adherence. But upon which sense of self should the addicted individual "stake his salvation?" Which sense of self is sufficiently powerful to compete with the addict self? For the addicted individual, replacement of the addict self-schema, with its ultimate goal of transforming and transcending ordinary human experience, is unlikely to occur, or be maintained, in the absence of a non-drug-related self-schema that is also sufficiently powerful to evoke a transformational and transcendent experience.

If habit is 'Second Nature,' what then shall we define as 'Original Nature?':

In the psychological, philosophical, and theological literatures, the spiritual self has been defined as the "Self of selves," the moral guide, and 'original or true nature.' We suggest that just as an addict self-schema is constructed and maintained to provide an exceedingly efficient, rapid, and automatized path that culminates in drug use, so too can a spiritual self-schema be constructed to provide an efficient, rapid, and automatized path to one's original, or spiritual, nature that culminates in protection of self and others. Thus, through elaboration, rehearsal, and frequent activation, a spiritual self-schema can

provide rapid access to automatized scripts and action plans for abstinence, HIV prevention, and medication adherence (cf. Spilka & McIntosh, 1996).

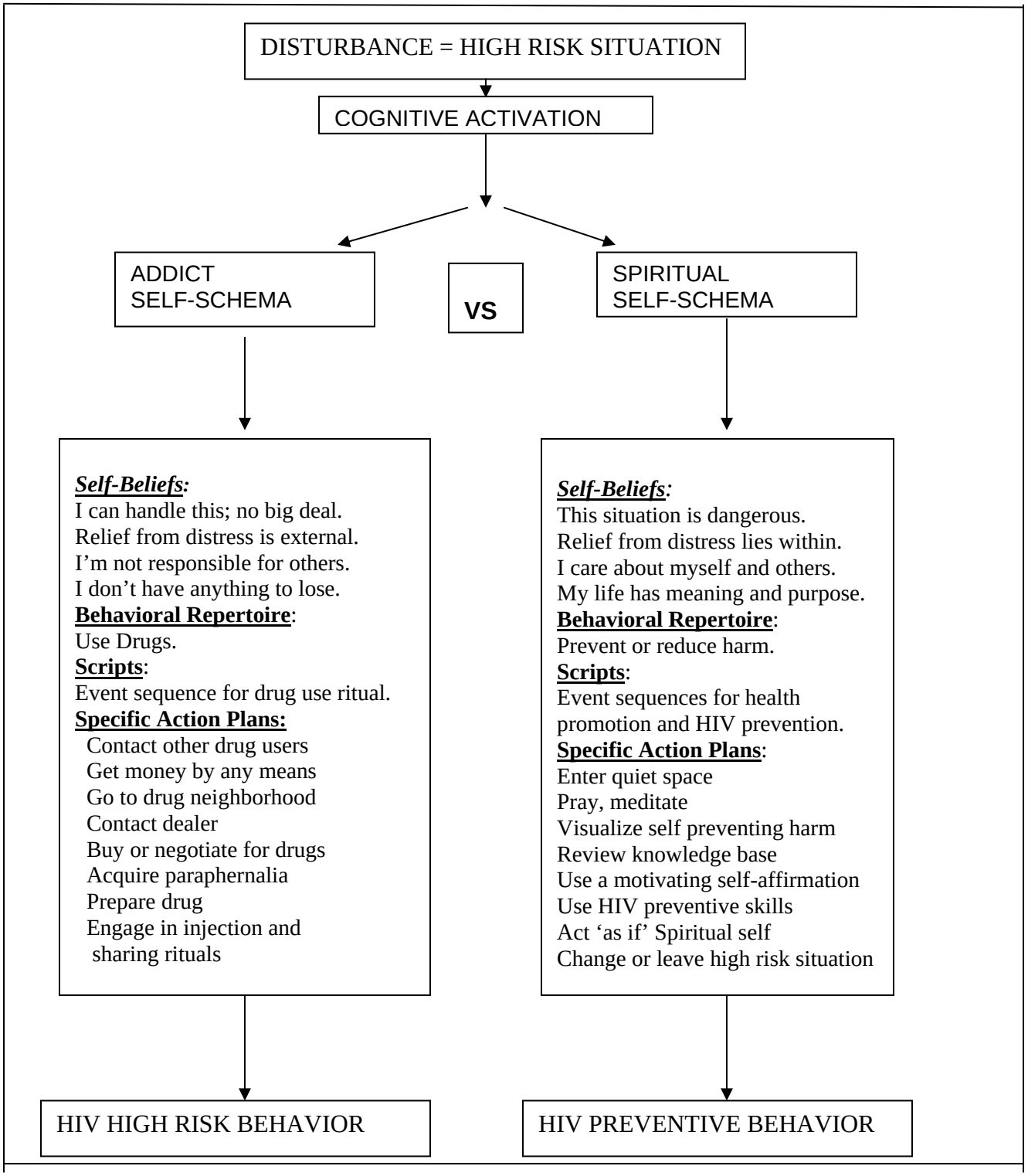
But what do we mean by spirituality? Although rooted in religious traditions, spirituality is not synonymous with religion. Contemporary interest in spirituality on the part of the mental health community has already generated an extensive literature containing a number of different definitions of spirituality (cf. Zinnbauer et al., 1999). It is clear that spirituality is a complex, wide-ranging, multidimensional concept, and the difficulty of creating a definition that encompasses all, or even many, of the seemingly relevant dimensions of this concept, that avoids possible contamination with psychological or other existing constructs, and is applicable across manifold populations and disorders, is well recognized (Larson, Swyers, & McCullough, 1998). In order to develop a spirituality focused therapy with the widest possible application with respect to potentially highly diverse client belief systems, we have chosen to characterize states of mind or behaviors that spirituality may be viewed as promoting, relative to the goal of reducing drug use and other HIV transmission behaviors and increasing adherence with medical regimens. Each client's own beliefs concerning spirituality and religiousness provide the basis for the achievement of these goals, for which the operative construct is not spirituality *per se*, but the client's spiritual self-schema. A study recently completed by our team suggests that this view of spirituality is compatible with the views of injection drug users who perceive their spirituality in terms of protector of self and others (Arnold, Avants, Margolin, & Marcotte, 2002).

Thus, for purposes of the development and provision of 3-S^{+} therapy , we regard spirituality as characterized by:

1) reflection on moment-to-moment experience in a way that engenders increased self-awareness, serenity and insight;
2) a sense of inter-connectedness among living things that promotes the development of altruistic personal and social values that are incompatible with acts that harm oneself and others;
3) access to states of inner peace, which counteract harmful desires that lead to self-injurious, anti-social behaviors such as drug use, needle sharing, unsafe sexual practices, and non-adherence to potentially life-prolonging medical regimens.

The figure below depicts the hypothesized activation of the addict self-schema versus spiritual self-schema when an HIV-positive drug user is in a high risk situation.

The cognitive component of the system: Activation of two incompatible self-schema.



Spiritual Self Schema (3-S$^+$) therapy: A convergence of Buddhist principles and practices and cognitive-behavioral therapy (CBT)

Although strategies used in 3-S$^+$ therapy are not incompatible with the practices of most world religions, a Buddhist framework facilitates the convergence of spirituality and contemporary cognitive psychology (see also Varela et al., 1991), and is particularly appropriate in the development of a manual-guided intervention for individuals with HIV who are in treatment for addiction because it contains the fundamental assertion that craving is the cause of suffering and that ending suffering requires identifying and correcting faulty cognitions, specifically erroneous self-perceptions. We wish to note that it is not our goal to expound or explicate Buddhist doctrine. Rather, our goal is to show how Buddhist principles and practices can be integrated with contemporary cognitive self-schema and self-regulation theories and can be usefully applied to the treatment of HIV-positive drug users. Our discussion does not purport to reflect the richness and complexity of Buddhism as a religion, psychology, philosophy, or way of life.

A Buddhist perspective is particularly germane in the development of a harm reduction and health promotion intervention for use with HIV-positive addicted individuals with diverse spiritual/religious beliefs for a number of reasons. First, fundamental tenets of Buddhist doctrine – compassion and the avoidance or reduction of all harm to self and others -- are consistent with HIV prevention efforts in this patient population. Second, Buddhist doctrine offers a highly structured and clearly marked "Path" specifically to preventing all harm, and to the expression of compassion, altruism, and optimism – attributes that we hypothesize are essential for promoting drug abstinence, HIV preventive behavior, and medication adherence. Third, a "stage model" of spiritual development advocated in many Buddhism traditions is consistent with current thinking in addiction treatment with its emphasis on therapist sensitivity to the client's stage of treatment readiness (Miller & Rollnick, 1991; Prochaska & DiClemente, 1986). Fourth, strategies such as monitoring of automatic thoughts, thought stopping and refocusing, self-affirmation, and visualization, which in the West are immediately recognizable as contemporary cognitive therapeutic techniques (Beck, 1995; Meichenbaum, 1977) have, in fact, been in use for over 2,500 years, and are described in detail in the Pali Canon and Buddhist manuals for training the mind (e.g., the Visuddhimagga).

We are what we think. *'All the phenomena of existence have mind as their precursor, mind as their supreme leader, and of mind are they made'* (Dhammapada I). Buddhist texts provide specific step-by-step instructions for increasing awareness of the cognitive processes and 'habit energy' (i.e., 'habit patterns of the mind') that cause suffering, for becoming 'fully awake' and aware of one's 'true nature' -- which according to Buddhist doctrine, is wholly compassionate -- and for experiencing and expressing one's true nature unimpeded by those habit patterns of the mind that lead to craving and, thus, to suffering. 3-S$^+$ therapy is fully compatible with these Buddhist principles and practices. One goal of 3-S$^+$ therapy is to help addicted individuals become aware of the erroneous assumptions of the addict self-schema, and of its automatic activation via the elaborate network of addiction-related cognitions, emotions, and behaviors that lead to suffering (i.e., the harm caused to self and others by drug use and other risky behavior, including

medication non-adherence). Another fundamental goal is to help addicted individuals create, elaborate, and make more accessible for activation a cognitive self-schema powerful enough to replace the maladaptive addict self-schema, one that will provide rapid access to the experience and expression of the individual's true (i.e., spiritual) nature. In 3-S^+ therapy, the individual's spiritual nature is defined by the individual, in its particulars. However, in keeping with Buddhist precepts, it is deemed to be wholly compassionate, and thus incompatible with acts that harm self or others. We recognize that the definition of spiritual nature as being wholly compassionate may be regarded as constituting a non-empirical, "metaphysical" declaration; it is clearly stipulated as such for therapeutic reasons (Davidson & Harrington, 2002).

Although the word 'self' may seem incongruent with Buddhist teachings with its emphasis on the illusion of self (for a discussion of this issue, see Gaskins, 1999), we use the term 'spiritual self-schema' specifically to describe a cognitive structure that we hypothesize is created, elaborated, and maintained by devotees of all faiths (see also McIntosh, 1995; Ozorak, 1996), including practitioners of the highly disciplined Buddhist practice of mindfulness meditation, that facilitates rapid and habitual access to the experience and expression of thoughts, feelings, and behaviors associated with core spiritual beliefs. According to the Dalai Lama, the Tibetan Buddhist spiritual leader, through training one "can habituate [oneself] toward a certain disposition" (p.223), specifically a disposition that expresses compassion for oneself and others (Davidson & Harrington, 2002). A spiritual self-schema may be likened to a raft or vehicle (or in more contemporary cognitive terms – a rapid transportation system) that, according to Buddhist teachings, takes the seeker of Enlightenment to the other bank. Without it, the crossing would not be possible, but once the crossing is successfully made, the vehicle is no longer necessary.

The Four Noble Truths and the Noble Eightfold Path. The foundation of Buddhist teachings -- the Four Noble Truths about suffering and the Noble Eightfold Path leading to freedom from suffering -- provide an experiential framework for understanding and treating addictive behavior that can be fruitfully integrated with a cognitive self-schema approach. Buddhist teachings suggest specific techniques for "habituating oneself toward a compassionate disposition" that are consistent with contemporary cognitive-behavioral therapeutic approaches for modifying maladaptive self-beliefs and associated thoughts, feelings, and behaviors (cf. Ash, 1993; Groves & Farmer, 1994). Below we describe how The Four Noble Truths and Eightfold Path have guided the development of 3-S^+ therapy. We rely heavily on contemporary translations of the Pali canon (e.g., Abhidhammatha Sangaha, Dhammapada, Digha Nikaya, Visuddhimaggga, Samyutta Nikaya, Majjhima Nikaya) as well as commentaries on these and other Buddhist texts provided in a number of scholarly sources (e.g., Goddard, 1938; Guenther & Kawamura, 1975; Kalupahana, 1987; Lopez, 1995).

The Four Noble Truths: According to Buddhist teachings: (1) Suffering exists by virtue of our being born in bodily form, with feelings, perceptions, cognitions, and states of consciousness (i.e., the five aggregates of existence). (2) Suffering is caused by craving and desire that result from becoming attached to the five aggregates as if they were not transient, as if they had ego-identity, which they do not. (3) Suffering ends when craving and desire ends. (4) Craving and desire, and therefore suffering, end by following the Noble Eightfold Path. According to Buddhist scripture, one needs to become free of the bondage of 'habit energy' – of habit patterns of the mind. Human life is represented as a circular structure of habitual patterns – a binding chain – with each link (ignorance, volitional action, consciousness, psychophysical complex, the senses, contact, sensation, craving, clinging and attachment, becoming, birth, decay and death) causing, and being caused by, the next link in the chain of causality. In order to break out of this vicious cycle, delusion and craving must be abandoned; and tranquility and insight must be developed. Sensation and subsequent craving are crucial links in the chain of dependent origination because they provide opportunities for awareness; for example, how one handles a habitual craving response may determine whether the habitual process is perpetuated, or whether it is interrupted, and thereby potentially changed (Rosch, 1994; Varela et al., 1991). Buddhist teachings describe a path (referred to as the Middle Path because it is one of moderation) by which one can increase one's awareness and insight into habit patterns of the mind that cause suffering; a detailed roadmap based specifically on 'non-harming' is provided for changing these habit patterns that is consistent with the fundamental principles expounded by major world religions.

3-S$^+$ therapy's interpretation of the Four Noble Truths applied specifically to drug abstinence, HIV prevention, and medication adherence. In our use of a Buddhist framework in the development of 3-S$^+$ therapy, the addicted individual is viewed as suffering not only by virtue of having been born into the five aggregates of existence, as is the case for all sentient beings, but also by virtue of having become entangled in the illusion that drug use will relieve suffering. Suffering is also perpetuated because the addicted individual does not have a well-developed cognitive 'road map' to liberation from suffering, rather he or she has a road map leading to more suffering. 3-S$^+$ therapy therefore seeks to increase clients' awareness of the automatic activation of the addict self-schema, with its associated thoughts, feelings, and behaviors, that lead to drug use and further suffering. It also seeks to help addicted clients to develop a cognitive road map (the spiritual self-schema) by which they can become awakened to their "true nature," that is, at its core, wholly compassionate, altruistic and optimistic, and seeks, above all, to do no harm to self or others. As in the Buddhist practice of mindfulness, clients learn to make previously automatic schematic processes conscious, thus reducing their automaticity. They are taught to become aware of the automatic processes of the addict self-schema through non-judgmental observation of the activation of this schema. Subsequently, they learn how the "automatic" unconscious thoughts, words, emotions, and actions of the 'addict self-schema' not only increase their own suffering, but also place others at risk for physical, emotional, and spiritual harm. Once the addict self-schema is brought into awareness, clients are taught how to develop a spiritual self-schema, and to elaborate and strengthen it until it becomes a rich associative network of

scripts and action plans that can facilitate rapid access to a behavioral repertoire congruent with abstinence and harm reduction. This is accomplished through practices such as mindfulness, which requires detached observation of what, in Buddhist texts, are termed 'hindrances' that impede access to one's true nature. 3-S^+ therapy sessions serve not only as a vehicle for counseling addicted clients about the existence and consequences of self-schema activation, they also provide an opportunity for addicted individuals to practice in the presence of the therapist who can help them experience the activation of a spiritual self-schema. Thus, 3-S^+ is not solely a talk-therapy, but rather, in keeping with Buddhist principles and practices, is a highly practical and experiential therapy, that seeks to whet the client's appetite for increased awareness of his or her spiritual nature as the basis for behavior change.

The Noble Eightfold Path: The Buddha's Noble Eightfold Path follows:
1) Right Understanding (or view) (*samma-ditthi*);
2) Right Thinking (or intention) (*samma-sankappa*),
3) Right Speech (*samma-vaca*),
4) Right Behavior (*samma-kammanta),*
5) Right Livelihood (*samma-ajiva*),
6) Right Effort (*samma-vayama),*
7) Right Mindfulness (*samma-sati*),
8) Right Concentration (*samma-samadhi*).

In Buddhist traditions, the eight components of the Noble Eightfold path are classified as three types of training undertaken by one on the Path. These are:

1) training in morality/ethics (*sila*);
2) training in mastery of the mind (*samadhi*); and
3) training in wisdom (*panna).*

Training in '**morality'**, includes the following components of the Noble Eightfold Path -- Right Speech, Right Action, and Right Livelihood, and provides the foundation of the Path.

Training in '**mastery of the mind**' includes the components Right Effort, Right Mindfulness, and Right Concentration, and describes the cognitive skills and practice required for the Path.

Training in '**wisdom**' includes the components Right View (also interpreted as right understanding) and Right Thinking (also interpreted as right intention) and, among other things, defines the 'rightness' of each of the path's components, in that, for example, concentration is 'right' only if it is concentration on the nature of "reality" [e.g., its impermanence (*anicca*) , its unsatisfactoriness (*dukkha*), and its absence of self-identity (*anatta*)].

As each of the three trainings defines and is defined by each of the others, the order of presentation can vary. To illustrate the convergence of 3-S^+ therapy and Buddhist

principles and practices, below we describe the three trainings in the order most commonly provided for the components of the Noble Eightfold Path. We then describe how these components have been applied to the treatment of addictive and HIV risk behavior in the 3-S$^+$ development program. It should be noted, however, that to facilitate client understanding of the material, the order of presentation of the three trainings in the 3-S$^+$ treatment manual is as follows:

Individual 3-S$^+$ Session 1: Introduction to 3-S$^+$ and the 3 "trainings"
Individual 3-S$^+$ Sessions 2-4: Training in mastery of the mind
Individual 3-S$^+$ Sessions 5-7: Training in morality/ethics
Individual 3-S$^+$ Sessions 8-11: Training in wisdom
Individual 3-S$^+$ Session 12: Termination and transition to community resources

Note: At-home assignments and adjunctive 3-S$^+$ group sessions are also available to provide opportunity for additional practice of the three 'trainings' taught in individual sessions.

Buddhist training in wisdom (*panna*): Right View/Understanding and Right Thinking/Intention.
Right understanding refers to the realization that suffering (causing harm to self and others) is the result of habit patterns of the mind (*sankharas* or, in 3-S therapy, self-schemas) that generate craving/clinging to pleasant sensations and hating/avoiding unpleasant sensations which are in fact impermanent; and, coming to the realization that changing these habit patterns of the mind will prevent/reduce suffering. One may gain this understanding to some extent through hearing/reading about it (*suta-maya panna*) and by intellectually understanding it (*cinta-maya panna*), but, above all, one must experience the truth of it for oneself (*bhavana-maya panna*). According to Buddhist teachings, personal experience is absolutely necessary; one must become personally aware of those thoughts, feelings, and behaviors that lie along the wrong path, and understanding their causes (e.g., craving, hatred, and delusion), and gain direct knowledge of what lies along the right path [e.g., the 10 spiritual perfections (*paramis)* of generosity, morality, renunciation, wisdom, effort, tolerance, truth, strong determination, loving kindness, and equanimity, and in 3-S$^+$, the additional qualities gratitude, courage, forgiveness, serenity]. According to Buddhist doctrine, one must be ready to develop 'operations of the mind' that abhor the wrong path of ignorance, and that instead conjoin with the path to enlightenment.

3-S$^+$ application of the TRAINING IN WISDOM' for individuals with HIV in treatment for addiction: Training in Wisdom begins in Session #1. Addiction is described as a 'habit pattern of the mind' -- a maladaptive attempt to reduce suffering that has, in fact, engendered further suffering – by leading to continued drug use and other behaviors that place the health of self and others at risk. Addictive and health-risk behaviors are viewed as constituents of this highly elaborate and automatic habit pattern of the mind, which we term the 'addict self-schema.' When the addict self-schema is activated, it blocks access to the experience and expression of one's true nature – which in 3-S$^+$ therapy is termed 'spiritual nature' and which, the client is told, is viewed as wholly compassionate and incompatible with causing harm to self or others. The client is

taught that habitually activated maladaptive schemas, such as the addict self-schema, have become so elaborate, so automated, and so frequently accessed that they chronically predominate, and a powerful illusion is created that the addict self is THE core self. The person's true nature is hidden not only from those people associated with the addicted individual, but also from the addicted individual him or herself. The goal of 3-S^+ therapy is to expose the addict self for what it truly is – the cause of suffering – and to begin activating and strengthening a spiritual self-schema that will provide rapid access to a path that leads to the experience of the spiritual nature and to relief from suffering. The therapist's task is to acknowledge, rather than minimize or challenge, clients' suffering due to HIV and addiction, to articulate support for clients' desire to incorporate their spiritual and religious beliefs into their recovery program, and to state clearly that the ultimate goal of 3-S^+ therapy is to help clients protect themselves and others from all harm. Spiritual ideals are identified and over the course of the therapy are integrated into the client's spiritual self-schema. At each session, therapist assigns one or two spiritual self attributes (e.g., from a list of 14 spiritual qualities, each of which is consistent with abstinence and harm reduction). The client then creates and rehearses scripts and action plans for each spiritual quality (i.e., client is encouraged to consider how someone with this spiritual attribute would think, feel, and behave in a specific stressful or high risk situation – one that the client is expected to encounter in the coming week). (Example: in the first session, the client and therapist engage in a role-play in which the therapist plays the role of a drug using friend who is tempting the client with an offer of free drugs, while the client refuses the offer by expressing various spiritual qualities. The therapist helps the client to identify the spiritual qualities demonstrated during the role-play and to differentiate them from qualities usually associated with the addict self-schema.)

Training in wisdom continues in Session 8, when clients learn how to replace the old habit pattern of mind (the addict self) with a new one (i.e., the spiritual self) which they can use to access their true spiritual nature. Buddhist texts state that 'one must concentrate one's whole mind in a resolution to resist them [old habit patterns] to the uttermost' (see *Surangama Sutra* in Goddard, 1938). In 3-S^+ therapy, 'filling the mind' is an important component of treatment because the over-learned and automatically-activated addict self-schema is unlikely to be replaced by a spiritual self-schema unless it too becomes over-learned and elaborated. Increasing automaticity of the spiritual self-schema requires the establishment of a network of linked cognitions, emotions, and behaviors in various sensory modalities. The client is therefore taught to activate the spiritual self-schema in various ways throughout the day. This is consistent with the notion of "filling the mind" as described by William James (Cross & Markus, 1990; James, 1890-1950) and with the concept of increasing the number of nodes in the associative network, as described by contemporary cognitive theorists (Cross & Markus, 1990; Singer & Salovey, 1991), such that the spiritual self-schema becomes more readily available for activation in an ever-widening range of contexts. An example of how 3-S+ therapy's 'mind-filling' strategy is used to complement a commonly-used cognitive strategy (i.e., self-affirmation) follows: With the therapist's help, the client composes a series of short affirmations (e.g., 'my spiritual nature is loving and kind' or 'God protects me and others from harm'). These affirmations would be repeated verbally throughout the day, cued, for example, by wearing a watch on the non-usual wrist. Affirmations

would also be expressed artistically (e.g., set to music, chant, rap, poetry, given color, texture, and shape). In addition, the client would be taught to search for manifestations of the self-affirmation in the external environment (e.g., listening for similar words or meaning in favorite songs, hymns, television shows, books, art work, relationships.) The goal is to increase attention, focus, and clarity of the spiritual self-schema. The use of techniques to focus and fill the mind are common in Buddhist practice, as well as in the practices of other world religions, and include the use of mantras (symbolic sound frequencies or repetitive prayers) and mandalas (e.g., visualization of a sacred world that the individual seeks to manifest and inhabit, or identification with artistic depictions of deities, saints, relics, or sacred events), and the use of objects, such as rosaries and bells, to cue action.

Training in Wisdom continues in Session 9 in which clients learns how to cope with the social stigma of HIV and addiction by understanding the Buddhist maxims: 'this is not me; this is not mine' and 'you are heir to your actions' (see *Digha Nikaya*), and by training their minds in forgiveness to avoid getting caught in the cycle of hatred that can activate the addict self and cause further harm to self and others.

In Session 10, clients renounce the addict self as their true self, and acknowledge their spiritual nature with the help of visualization techniques. In tantric Buddhism, visualization includes the use of mandalas or symbols that serve to externalize aspects of one's self, including one's cravings and aversions, in order to gain control over them, to see them as self-created illusions, and to forge an increasingly clear image of an ideal spiritual self (often the image of a Buddha or deity) in order to internalize its ideal qualities. In 3-S^+ therapy, clients are taught to visualize an image of their addict self being projected on a TV screen, and learn to control that image, gradually fading it until it can no longer be seen. They then project their idealized spiritual self on the screen, and practice sharpening the image until it has become three-dimensional and imbued with the thoughts, feelings, and behaviors that exemplify the ideal attribute of the spiritual self. Visualization exercises such as this provide the client with the opportunity for cognitive rehearsal of the attribute and its associated thoughts, feelings, and behaviors. Depending upon the client's interests and needs, the visualization can be audiotaped and provided for daily home use between sessions, and a log can be provided for recording each attribute, and its associated thoughts, feelings, and behaviors, as they are integrated into the schema, and for making a note of what, if any, obstacles (e.g., the five hindrances) to mental rehearsal were encountered. At the conclusion of the guided visualization, clients are instructed to take on the role of their spiritual self in their daily lives, as an actor might take on a role, and to act 'as if' they were a person with such an attribute during the coming week. For example, if a high risk situation is identified in session as upcoming during the week, the client might attempt to act as a 'compassionate' person would act in such a situation.

In the final session in training in wisdom -- Session 11 -- clients address grief and fear of death and dying by understanding how grief and fear activate the addict self and maintain the illusion of permanence which is the cause of their grief and fear. Clients learn to

meditate on each line of the serenity prayer in order to experience their own inner-peace, and to gain insight into, and accept with serenity, the law of impermanence (*anicca*).

Buddhist training in Morality/Ethics (*sila*): Right Speech, Right Behavior, and Right Livelihood

These steps, with their emphasis on refraining from engaging in speech, action, or livelihood that could cause harm to self or others, form the ethical foundation of the Buddha's Eightfold path. They center around the precepts to be followed by everyone on the path: (1) not to kill, but instead to practice kindness and harmlessness towards all animate life; (2) not to steal or covet what does not belong to one, but instead to practice charity and going without things oneself; 3) not to engage in sexual misconduct, but instead to practice purity of mind and sexual self-control; (4) not to lie, but instead to practice honesty and sincerity in thought, word and deed; and (5) not to partake of alcoholic drinks or drugs, or anything that weakens one's ability to control one's mental processes, but instead to practice abstinence and self-control.

3-S$^+$ application of the TRAINING IN 'MORALITY/ETHICS' for individuals with HIV in treatment for addiction: In 3-S$^+$, three sessions are devoted specifically to training in morality/ethics – doing no harm to self or others. One session is devoted specifically to helping HIV-positive clients take personal responsibility for stopping the spread of HIV/AIDS, notifying partners of possible exposure, and becoming a community advocate for HIV-testing. Other sessions focus on helping the client to refrain from engaging in "addict speech" (e.g., lying, manipulating), "addict behavior" (e.g., drug use, needle sharing, irresponsible sexual behavior, nonadherence to medical regimens), or "addict livelihood" (e.g., dealing, pimping, prostitution, and other criminal activity). Individuals addicted to heroin and cocaine have described themselves as 'liars' and 'thieves,' who are willing to do or say anything to get drugs (Avants & Margolin, 1995). Early in 3-S$^+$ therapy, clients are therefore encouraged to identify any addict self-schema scripts that could potentially sabotage their recovery (e.g., scripts for non-engagement in the treatment process that lead to poor attendance and misrepresentation of adherence). In Buddhist teachings, the ability for honest, nonjudgmental, self-reflection of the 'wrong path' (and in 3-S$^+$ therapy, the ability to monitor addict self-schema activation and its consequences) is viewed as a necessary first step along the 'right path' (in 3-S$^+$ therapy, the development, elaboration, and habitual activation of the spiritual self-schema). Thus, in this phase of treatment, scripts and action plans associated with the addict self-schema are identified and monitored for the purpose of reducing their automaticity, and in preparation for elaborating and increasing the automaticity of the spiritual self-schema in the next phase of 3-S$^+$ therapy. Specifically, clients are asked to take the time thrice daily (mid-day, early evening, and upon retiring) to determine whether the addict self-schema is currently activated, and to identify thoughts, feelings, and behaviors currently being activated by this self-schema. The need to abstain from all harmful behavior, including drug use, other drug- and sex-related HIV risk behavior, and non-adherence to medical recommendations is unambiguously addressed by the 3-S therapist. However, drug use or any other behavior that places the health of self or others at risk, including medication non-adherence, that occurs during treatment (when occurring in the context of a sincere desire for change) is characterized

as evidence of automatic activation of the addict self-schema, not as a moral failing. The 3-S$^+$ therapist's approach to such behavior, termed 'addict self-intrusions' in 3-S$^+$ therapy, is not punitive, and the focus, as stated earlier, is not on identifying specifically what served to trigger the addict self-schema. Rather, the 3-S$^+$ therapist's approach is to model compassion, and to focus on facilitating a cognitive shift such that the spiritual self-schema becomes activated. Addict self-schema intrusions are therefore viewed as opportunities for clients to strengthen the spiritual self-schema in order to make this schema more available for activation in situations which, in the past, have activated an addict self-schema. Creating psychological distance between clients' core identity and their addictive behavior permits them to view this behavior from the perspective of their spiritual self – with compassion, without judgment, and with the goal of targeting and eliminating the addict self-schema, rather than targeting and punishing themselves. In this way, clients are taught to be their own therapists (Beck, 1995) and to examine and address their own behavior with compassion, but also responsibly (e.g., in the case of behaviors that transmit diseases to others, the therapist and the client act in accordance with any federal, state, or local reporting guidelines). During this phase of treatment, the therapist also needs to be sensitive to socioeconomic forces that may be maintaining the client's addict self-schema, and hence makes appropriate referrals for community services (e.g., housing, employment, medical).

Buddhist training in gaining mastery of the mind (*samadhi*): Right effort, right mindfulness, and right concentration.

As described in Buddhist texts …when individuals are driven by craving and desire, they will seem like an automatic machine that once started goes on by itself, but as soon as the automatic machine loses its motive power, not only its activities, but the machine itself ceases to exist. Mastery over the mind, through effort, mindfulness, and concentration, is a prerequisite to ceasing the activities of 'the automatic machine.' Right effort includes (a) the effort to Avoid, (b) the effort to Overcome, (c) the effort to Develop, and (d) the effort to Maintain. Clearly, the Buddhist path is not a passive one. One must work diligently to achieve relief from suffering, and must aspire to achieve the spiritual qualities, described earlier, at a level of specificity appropriate to the individual's stage of spiritual development. Through meditation, with its single-pointed focus on the impermanence of mental and physical phenomena, together with awareness of the five hindrances to insight (craving, aversion, sloth/torpor, restlessness, and doubt), one interrupts the automaticity of thoughts that lead to suffering, thus permitting the cognitive shift required for enlightenment. There are numerous Buddhist texts that provide detailed instructions for how to reduce the automaticity of maladaptive thoughts and thus facilitate this cognitive shift (e.g., the Visuddhimaggga); these techniques are highly similar to strategies currently in common use by cognitive therapists (Beck, 1995; Meichenbaum, 1977).

3-S$^+$ application of the TRAINING IN 'MASTERY OF THE MIND' for individuals with HIV in treatment for addiction: In 3-S$^+$, the 'right effort' required to 'avoid and overcome' pertains to the fading of the addict self through continued diligent self-monitoring of addict self-schema activation (as described above). The effort required to 'develop and maintain' pertains to the creation, elaboration, and maintenance

of the spiritual self-schema. Each 3-S^+ therapy session includes practice in meditation on the in- and out-breath (*anapanasati*) as well as mindfulness training – see #4 and #5 below, with three sessions devoted specifically to other aspects of training in 'mastery of the mind'. The following cognitive/Buddhist strategies are used:

1. Schema interruption techniques: To prevent going on 'automatic pilot,' clients are taught the following techniques: (a) Thought-stopping: interrupting the addict self-schema by stopping the flow of maladaptive thoughts (e.g., mentally shouting 'stop' when they first become aware of a thought associated with the addict self-schema); (b) Observe and name: Slowing down the action by mentally naming specific thoughts, feelings, and behaviors as they arise in consciousness; (c) Changing routines: creating interruptions to other well-learned scripts and action plans that are unrelated to the addict self-schema (e.g., the automatized action plan for looking at one's watch) to serve as cues for monitoring the addict self-schema (e.g., by moving a wrist watch to the non-usual wrist, the interrupted 'time checking' action sequence can serve as a cue to monitor and interrupt the addict self-schema each time the client checks the time); (d) Cues-to-action: Cues, such as bells used in many religious traditions to alert the faithful to some action, can also be used to monitor and interrupt the addict self-schema (e.g., setting an hourly alarm to interrupt the addict self-schema; or using the sound of telephone ringing as a cue to identify the currently activate self-schema).

3. Cognitive refocusing: Once the addict self-schema has been interrupted, the client is taught to refocus immediately in order to activate a schema that is incompatible with drug use – the spiritual self-schema. Early in treatment, the client may choose to use a prayer or mantra, or write their own self-affirmations, as a form of protection from addict self-schema activation. If so, these should be practiced in session, written on index cards, and placed in convenient locations in the client's home environment. The singing of hymns, chanting, or listening to inspirational music may also help the refocusing process, as can meaningful visual stimulation.

3. Meditation. Concentrating the mind is a prerequisite for the cognitive shift necessary for the habitual activation of a new self-schema that is compatible with abstinence, HIV preventive behavior, and medication adherence. The client is therefore taught how to meditate [specifically developing a single-pointed focus on sensations around the nostrils caused by the in- and out-breath (*anapanasati*)]. The need for daily practice is emphasized.

4. Mindfulness. Clients are taught a variety of mindfulness techniques throughout the therapy for the purpose of interrupting the automaticity of the addict self, and thus reducing its activation. Mindfulness is also used specifically to increase adherence to medical recommendations; in Session 4, clients develop 'medication mindfulness rituals' to help them increase their adherence to complex HIV-related medication regimens.

5. Transcending physical discomfort (including drug craving, symptoms of HIV, and medication side-effects). The fundamentals of attentiveness, as described variously in Buddhist and cognitive psychology literatures, involve training oneself to become aware of sensations as they arise in the body and feeling states as they arise in the mind in order to gain insight into their impermanent nature. Clients are taught how to control craving and other unpleasant physical sensations by increasing their awareness of the impermanence of these sensations. Through systematic examination of the craving (or

other unpleasant) sensation, also learn how automatic reactions (e.g., self-medication) occur, and are able to interrupt the automaticity of these reactions.

3-S$^+$ Case Report

Delivery of 3-S$^+$ therapy, in its initial formulation, to a 49 year-old HIV-positive, African-American male with a 20-year history of intravenous heroin and cocaine use has been reported (Marcotte et al., 2003). As treatment progressed, this client reported that his spiritual self was becoming stronger than his addict self, and that this shift was helping him to abstain from illicit drug use. At treatment completion, urine analysis verified that the client was indeed abstinent from both heroin and cocaine. When asked what he had found most helpful, he stated "Most effective to me is the daily log [i.e., the 3 times daily self-schema check-in], when you have to stop and think about the spiritual self. Knowing the difference, slowing down and distinguishing the difference between the addict self and spiritual self and making a real effort to stay in your spiritual self….To me, that's the most important thing, stopping and thinking about it. The addict runs on automatic…so when you interrupt that process and think about it…[there are] things you don't want to lose like your relationship or getting kicked off the [methadone] program…it isn't worth it."

As stated in The Middle Length Discourses of the Buddha (Majjhima-Nikaya)… 'once contemplation of the body is practiced, developed, often repeated, has become one's habit, one's foundation, is firmly established, strengthened and well perfected, one gains mastery over discontent, fear and anxiety, hunger and thirst, cold and heat, and pain and sharp words'. Clearly this is a lifetime's work. 3-S$^+$ therapy seeks to help the HIV-positive client begin the process of developing and elaborating a self-schema that is compatible with drug abstinence, HIV preventive behavior, and medication adherence, that can replace the habitually activated addict self-schema. The client described in the case report (Marcotte et al., 2003) was similar to other inner-city drug users who have received 3-S therapy in more recent systematic evaluations (see Avants, Beitel, & Margolin, 2005; Margolin, Beitel, et al., 2006; Beitel, et al., 2007; Margolin, Schuman-Olivier, et al., 2007), in that he was able to view his spiritual self as an agent of protection from harm and from doing harm to others, such as sharing needles or having unsafe sex (see also Marcotte, Avants, & Margolin, 2003).

Conclusion

Scholars and clinicians over the years have sought to describe and harness that component of human nature that has the power to transcend suffering. With the call to integrate spiritual beliefs in addiction treatment (Miller, 1998), we offer 3-S$^+$ therapy as a potentially promising approach that integrates contemporary cognitive-behavioral techniques with a spiritual path, here using a Buddhist framework, that can readily be adapted to incorporate individual religious beliefs and practices, and that can target health-related behaviors, including HIV prevention and medication adherence, in the treatment of individuals with HIV who are in treatment for addiction.

Target population and common problems

Target population

Several versions of 3-S and 3-S^{+} therapy will be available. The current version specifically targets individuals with HIV who are in treatment for addiction. Users of heroin and cocaine were the focus in the development of this manual, due to the prevalence of HIV and other infectious diseases in this patient population; however, the manual is readily adapted for use with any addicted population.

Common problems

Poor adherence. Adherence is a common problem when working with substance abusing populations regardless of the type of intervention being offered. 3-S^{+} therapy addressed this potential problem with the client at the outset by framing poor adherence as an expected intrusion of the addict self. Clients predict ways in which the addict self will attempt to sabotage recovery (e.g., missing sessions, non-completion of at-home practice assignments, duplicity concerning drug abstinence, and so forth).

Cognitive impairment. Cognitive impairment may be temporary, as in the case of recently abstinent substance abusers, or long-term, as may be the case for some chronic drug users and those with HIV/AIDS. 3-S^{+} addresses this issue by reviewing material covered in the previous session prior to presenting new material, and by summarizing new material at the completion of each session.

Psychiatric disorders. Substance abusers frequently present with a number of Axis I and II psychiatric disorders. A careful assessment should therefore be conducted to ensure that 3-S^{+} therapy, with its focus on multiple self-representations, is not counter-indicated. If the 3-S^{+} is not deemed to be counter-indicated, care should be taken to ensure that the dually-diagnosed client is receiving the appropriate clinical care in addition to 3-S+ therapy, and that the client is referred to appropriate care in the event of deterioration during treatment.

Hospitalization. HIV/AIDS-related hospitalizations may interrupt a 12-week course of 3-S^{+} therapy. Clients with extended hospitalizations who have received fewer than four 3-S^{+} sessions, should begin again with Session 1.

Compatibility with other treatments

3-S$^+$ therapy is readily integrated into substance abuse treatment programs (e.g., methadone maintenance), and can be used in conjunction with case management, pharmacotherapy, and alternative or complementary therapies. 3-S$^+$ is consistent with a number of self-help programs and psychotherapeutic approaches currently in wide use in the addictions and with spirituality-based treatment approaches to addiction treatment (Kus, 1995). For example, 3-S$^+$ is congruent with the fundamental philosophy of AA which espouses respect for each individual's unique spiritual path in recovery from addiction (Alcoholics Anonymous World Services, 1976). 3-S$^+$ differs from AA, as traditionally practiced, in that it views the individual, rather than a "Higher Power," as the agent of change, albeit through access to a cognitive self-schema that may include the belief in a deity or 'Higher Power.' Referral to AA/NA 12-step meetings is an important component of 3-S$^+$ therapy termination and transition to community-based services, as is attendance at the place of worship of the client's religious affiliation, if any, and participation in spiritual and religious rituals and practices relevant to the client's beliefs. 3-S$^+$ therapy is also consistent with a social-learning approach to addiction treatment that is exemplified in relapse prevention (Marlatt & Gordon, 1985) and coping skills training (Monti et al., 1989; Monti, Rohsenow, Michalec, Martin, & Abrams, 1997). However, 3-S$^+$ therapy places greater emphasis on recovery as a construction of the client's cognitions, and less emphasis on the need to identify specific environmental or emotional triggers. The client-centered approach (Rogers, 1951) used in 3-S$^+$ therapy is also consistent with a motivational enhancement therapeutic (MET) style (Miller & Rollnick, 1991), which emphasizes the communication of respect and empathy. However, unlike MET, 3-S$^+$ therapists teach and model methods for change. Similarities and differences between 3-S$^+$ therapy and 12-Step Facilitation (Nowinski, Baker, & Carroll, 1992), Cognitive-Behavioral Coping Skills Therapy (CBT) (Kadden et al., 1992), and Motivational Enhancement Therapy (MET) (Miller, Zweben, DiClemente, & Rychtarik, 1994) approaches as formulated in treatment manuals used in the large-scale multisite psychotherapy study for the treatment of alcoholism (Project Match Research Group, 1997) are described in the table below.

Comparison between 3-S^{+} therapy and other approaches to addiction treatment

12-Step Facilitation	Relapse Prevention	Motivational Enhancement	Spiritual Self-schema
Treatment Goals: Acceptance of loss of control over drug use; Surrender to a Higher Power; and active fellowship in AA/NA	Treatment Goals: Master skills necessary to identify and avoid or cope with high risk situations in order to maintain abstinence	Treatment Goals: Enhance intrinsic motivation for initiating and maintaining abstinence from drugs of abuse (e.g., based on the negative effects of drug use).	Treatment Goals: Cognitive shift from habitual activation of Addict Self-schema to activation of a Spiritual self-schema that is congruent with abstinence, HIV preventive behavior, and medication adherence
Assumptions: May or may not be abstinent (in denial); behavior sustained by progressive illness and loss of control; client's faith in a Higher Power is more important than personal will power.	Assumptions: Abstinence initiated and motivated to prevent relapse; slips triggered by internal and external high risk situations; client can examine antecedents and consequences of past use and can learn skills to prevent future relapse.	Assumptions: May or may not be abstinent; behavior sustained by an approach avoidance conflict; client solely responsible for, and capable of, changing behavior; discrepancies identified to shift the balance in favor of change, client's own strategies are elicited.	Assumptions: Motivated for harm prevention; behavior sustained by habitual activation of Addict self-schema; slips viewed as intrusions of Addict self; client has access to a spiritual nature that is congruent with drug abstinence, HIV prevention, and medication adherence.
Core content areas: 4 core topics, 6 electives, termination: ▪ Introduction ▪ Acceptance ▪ Surrender ▪ Getting Active ▪ Termination	Core content areas: 8 core sessions plus 4 electives: ▪ Intro to coping skills. ▪ Coping with craving ▪ Thoughts about drugs ▪ Problem solving ▪ Drug refusal skills ▪ Lapses ▪ SIDs ▪ Termination	Core content areas: Extensive assessment battery plus 4 core sessions: ▪ Assessment/feedback ▪ Cost-benefit analysis ▪ Support/encourage choices ▪ Termination	Core content areas: 8-fold path (guided by Buddhist psychology) in 12 sessions: • Right Understanding • Right Intention • Right Speech • Right Behavior • Right Livelihood • Right Effort • Right Mindfulness • Right Concentration
Core techniques: ▪ Spiritual beliefs ▪ Pragmatism ▪ Coaching ▪ Modeling ▪ 12 steps of AA/NA ▪ Fellowship in AA/NA	Core techniques: • Didactic approach to skills training • Modeling by counselors • Directed practice • Role playing • Feedback • Assigned homework	Core techniques: • No instruction, modeling, practice, or homework • Inclusion of S.O. • Empathic listening • Perceptions explored, not labeled or corrected.	Core techniques: • Coaching, modeling, homework assigned • Non-judgmental observer of automatic processes • CBT: thought-stopping, refocusing, elaborating, strengthening, & activating spiritual schema (e.g., through guided imagery)
Therapeutic style: Confront, educate, support, advise	Therapeutic style: Directive Didactic	Therapeutic style: Non-directive Empathic	Therapeutic style: (Rogerian) Genuine, warmth, caring, acceptance, empathy

Respect for client's spiritual/religious beliefs

Compatibility between client's personal spiritual/religious beliefs and 3-S$^+$ therapy's conceptualization of spiritual self

The 3-S$^+$ therapist's task is to establish respect for the client's personal spiritual and religious beliefs while communicating (a) the concept of a compassionate spiritual self, and (b) the goal of 3-S$^+$ therapy to develop and strengthen a spiritual self-schema that, like a vehicle or path, provides a means of rapid access to the spiritual self even in high risk situations. It is therefore important to determine: (a) whether the client's own spiritual and religious beliefs are compatible with the concept of a compassionate spiritual self-representation; (b) whether the source of this compassion is perceived as internal or external to the client; and (c) whether the client currently adheres to any specific religious practices or rituals that may be usefully incorporated into subsequent 3-S$^+$ phases that focus on strengthening the spiritual self-schema (cf. Miller, 1999). It is also important to determine whether the client's religious or spiritual beliefs facilitate adaptive coping in recovery from addiction, or in living with HIV, or whether they reflect internalized stigma (e.g., does the client view addiction, or HIV, as a punishment from God?). Images of a stern, punitive deity may inadvertently activate the client's 'ought' self-schema (i.e., parental or societal standards of behavior) which, when discrepant with current behavior, may lead to anxiety (Higgins, 1989), and negative health outcomes (see Fetzer Institute, 1999). Use of an assessment instrument, such as the Brief Multidimensional Measure of Religiousness/Spirituality (Fetzer Institute, 1999), administered pre-treatment, can help the therapist identify beliefs that are compatible and incompatible with the goals of 3-S$^+$ therapy.

Treatment readiness and Treatment Duration

Treatment readiness

The importance of identifying an individual's stage of readiness for change is acknowledged not only in contemporary approaches to addiction (e.g., Miller & Rollnick, 1991) but also in Buddhist practice, in which the teacher seeks to match specific doctrine and practices to the disciple's current level of understanding and stage of enlightenment. 3-S^+ therapy, as described here, may be unsuitable for individuals at the precontemplation level of behavior change (Prochaska & DiClemente, 1986). The addicted individual entering 3-S^+ therapy needs, at a minimum, to be open to experiencing a cognitive shift [what in Buddhist doctrine has been termed a 'turning-about' (see *Lankavatara Sutra* in Goddard, 1938)]. The client should therefore have already completed a detoxification program, if appropriate, and be medically stabilized prior to beginning 3-S^+ therapy. Although the cognitive shift is anticipated to occur gradually over the course of treatment, the client should enter 3-S^+ therapy with: (a) a willingness to examine and disrupt the highly elaborate and automatized process (i.e., the addict self-schema) that leads to drug-use and further suffering, and (b) an interest in developing and activating a spiritual self-schema for rapidly accessing thoughts, feelings, and behaviors compatible with compassion, harm prevention, and health promotion.

Recommended treatment duration

As described in this manual, 3-S+ is delivered over the course of 12 weeks, in once weekly, 60-minute individual treatment sessions. Twelve 60-minute manual-guided group sessions are also available that can be delivered adjunctive to the individual sessions. These group sessions are not stand-alone sessions, but rather provide additional opportunity for clients to practice skills learned in individual sessions. In settings where shorter or longer treatment episodes are desirable, the 3-S^+ treatment manual is readily adapted by providing more or less didactic material at each session, by providing more or less opportunity for repetition and practice at each session, and by providing increased or decreased opportunity for therapist-client discussion of material.

Recommended therapist characteristics, style, tasks, and training

Provider characteristics, therapeutic style, and therapeutic tasks:

3-S$^+$ therapy is designed to be provided by therapists with experience providing cognitive-behavioral therapy (CBT) to HIV-positive drug abusers who have an interest in integrating spirituality into their treatment. Using a client-centered therapeutic style (Rogers, 1951), which is highly congruent with Buddhist psychology (Hayashi, Kuno, Osawa, & Shimizu, 1992), 3-S$^+$ therapists have as a goal to reflect an accurate, empathic understanding of their client's private world, and to communicate their compassion and unconditional positive regard for the client. Specific therapeutic tasks follow:

1. 3-S$^+$ therapists have their own daily practice that promotes mindfulness (i.e., meditation, reflective prayer, contemplative practice), and are willing to spend a few minutes prior to each session to center themselves and to practice *metta* (loving-kindness) meditation towards the client (see separate section on *metta* meditation).

2. 3-S$^+$ therapists have personal spiritual/religious beliefs that are compatible with the 3-S$^+$ development program.

3. 3-S$^+$ therapists show respect for client's spiritual and religious beliefs, and refrain from proselytizing their own religious beliefs. They collaborate with the client to define and elaborate a spiritual self-schema that is a reflection of, and serves to activate, a fundamentally altruistic "Buddha Nature," "Universal Mind Essence," or "Higher Power" that is incompatible with illicit drug use and HIV risk behavior. Buddhist texts provide the example of a poor man who spends his daily life in poverty searching for food, unaware that there is a magic gem sown into the hem of his garment. Someone tells him where to look, and he finds the gem that has been there all along and immediately wants for nothing (*Sarangama Sutra* as translated in Goddard, 1938). In 3-S therapy, the "magic gem" is the client's own spiritual strength, in whatever way it is experienced by each client; the task of therapists working with addicted individuals is not to change the nature of the gem, but to help clients locate and use it in their recovery.

4. 3-S$^+$ therapists use a nonjudgmental therapeutic style and teach clients to increase awareness of self-schema activation by becoming a nonjudgmental observer of their own thoughts, emotions, and behavior.

5. 3-S$^+$ therapists help clients to accurately identify their 'working' self-schema, to identify and divert addict self-schema intrusions, to refocus on and activate their spiritual self-schema; and to 'fill the mind' with an awareness of their spiritual self, or true nature.

6. 3-S$^+$ therapists openly address issues that may be especially relevant to individuals with HIV, including HIV disclosure and partner notification, HIV medication

adherence and transmission of medication-resistant virus, coping with stigma, and transforming grief and fear of death and dying. 3-S^+ therapists therefore need to have experience working with HIV-positive clients, be familiar with federal and state disclosure guidelines, and be current with regard to HIV/AIDS treatment regimens.

7. 3-S^+ therapists: (a) provide demonstrations of the influence of meditation and visualization on physiological and psychological states; (b) help clients to use mindfulness, visualization, and meditation to interrupt intrusive addiction-related thoughts, and to elaborate and strengthen thoughts, feelings, and behaviors associated with the spiritual self-schema; (c) demonstrate the ability of prayer/meditation, mantras and mandalas, to observe, dissect, and transcend the experience of drug craving and other negative affective states; (d) encourage clients to attend services at their chosen places of worship, and to use daily prayer/meditation to facilitate coping with stressful life events.

8. 3-S^+ therapists seek at all times to interact with, and thus activate, the client's spiritual self-schema, in order to elaborate and strengthen this self-schema, and to provide the client with direct feedback concerning the interpersonal consequences of role-playing a selected spiritual self attribute. Therefore, 3-S^+ therapists refrain from interacting with the client's addict self-schema in a manner that serves to strengthen it. For example, family members, friends, employers, and even counselors, who have a history with the client that may have been chaotic and unpredictable, may treat the client with suspicion, increasing the client's defensiveness, and thereby keeping the addict self-schema activated in their interactions with the client. Therefore, when addressing clients' use of drugs, if any, during treatment, 3-S^+ therapists model for clients how to view their behavior through the filter of the spiritual self -- which is benevolent rather than punitive -- and how to observe their own behavior, without judgment, with the goal of interrupting its automaticity, and creating an opportunity for behavior change. In substance abuse treatment settings, it is therefore desirable for someone other than the 3-S^+ therapist to collect urine samples, monitor drug use, and record program infractions.

9. The 3-S^+ therapist has an understanding of the relationships between the Four Noble Truths, the Eightfold path, and the 14 spiritual qualities (the 10 *parami* and 4 additional attributes of the spiritual self).

10. During the initial sessions the therapist determines a rhythm and balance of presenting the information to the client in a manner that is understandable by the client based upon the general cognitive and verbal abilities of the client. For example, clients with the following characteristics will most likely require the verbal expression of the material to be modified by the therapist: a) English as a second language; b) minimal education and/or reading ability; c) physical impairments such as limited eyesight, hearing, or attention span (i.e., may require the rate of presentation of new material to be modified); and d) clients that have medical conditions (e.g., chronic pain that causes them to have difficulty being still).

11. The 3-S^+ therapist understands and is able to integrate the Noble Eightfold Path of the Buddhist tradition with each client's spiritual beliefs and religious affiliations.

3-S^{+} therapy utilizes non-sectarian Buddhist principles, principally from the Theravada tradition. However, there is no intent to "convert" the client to Buddhism. For example, most inner-city clients will probably belong to, or have previous experience with, a Christian religious denomination or tradition, and this is entirely compatible with the approach adopted in 3-S^{+} in which Buddhism constitutes a non-theistic "foundation" for the elaboration of clients' own religious or spiritual belief system. Thus, ideally, the Christian client will leave 3-S^{+} therapy feeling that he or she has become a "better Christian".

Training

A set of DVDs that provides over 17 hours of training in the delivery of 3-S is available free of charge. This training series assumes that 3-S^{+} therapists are clinicians with prior experience and competence in the delivery of cognitive behavioral therapeutic techniques to individuals with HIV who are in treatment for addiction. It therefore covers only those principles and practices that are specific to 3-S^{+} therapy. The video training series provides step-by-step instructions, and includes opportunities for trainees to practice. Following completion of the video training series, it is recommended that 3-S therapists practice delivering 3-S therapy in 'mock" therapy sessions. These sessions can either be delivered directly to a supervisor, or can be videotaped and then rated by a supervisor, using the Therapist Competence and Adherence Rating Scales. Upon satisfactory completion of the "mock" therapy sessions, and successful completion of a quiz covering relevant theory, principles, and practices, therapists may begin providing 3-S therapy to clients with ongoing supervision.

Assessment approaches

Treatment Outcome

The following treatment outcomes can be readily assessed in community-based treatment facilities: (a) motivation for HIV prevention; (b) HIV risk behavior such as sharing of drug paraphernalia and unsafe sexual practices; (c) illicit drug use (by self report and urine screens); (d) alcohol use (by self-report and breathalyzer); (e) HIV-medication adherence (by self-report).

Treatment Process

Self-schema assessment

The first step in becoming aware of the 'wrong path' is to take inventory of the addict self (cf. Alcoholics Anonymous World Services, 1976). This process is begun in Session 1 by asking clients to generate a list of attributes that describes the addict self. As stated earlier, our research has shown that cocaine and heroin dependent clients use a preponderance of negative attributes, such as 'selfish, evil, uncaring,' to describe the addict self (see Avants & Margolin, 1995). In addition to providing a baseline for post-treatment comparisons, completion of a self-schema assessment serves to help clients understand the self-schema concept.

Therapist Adherence and Competence and Client Mastery

Determining the benefits of a psychotherapy requires ongoing evaluation of the skill level of the therapists delivering the therapy. The therapist needs to deliver the treatment competently and adhere closely to the treatment manual. It is also important to determine the extent to which clients understood the key concepts of the therapy as it was delivered by the therapist. This will require audio- or videotaping treatment sessions, an option not available in many community treatment settings. However, for those settings wishing to assess therapist skills and client understanding of material, therapist adherence and competence scales are available for each individual session (see following pages).

Treatment predictors

Client's spiritual/religious beliefs and practices

Clients with an interest in pursuing a spiritual path in their recovery from addiction are anticipated to benefit from 3-S^{+} therapy more than those who are not. Assessing motivation for 3-S^{+} therapy is therefore important. The Multidimensional Measurement of Religiousness/Spirituality for use in Health Research (Fetzer Institute/National Institute on Aging Working Group, Dearborn, MI, 1999) provides 3-S^{+} therapists with important information that can be used not only to integrate the therapeutic goals of 3-S with the client's personal beliefs and practices, but also to determine whether 3-S^{+} therapy provides a good client-treatment match.

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #1: Introduction to 3-S model and Noble Eightfold Path Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client Mastery
1. Review client's commitment to a spiritual path (sign commitment in Client Workbook)			
2. Emphasize that 3-S^{+} therapy is for people of all faiths			
3. Act as client's "coach" - describe therapist role as client's "coach" and discuss expectations for therapy			
4. Describe the addict self as habit pattern of mind, or "automatic pilot" that causes suffering (including causing harms such as HIV and other diseases)			
5. Help client describe his/her own addict self – specifically, how the client views her/himself when s/he is thinking about and craving drugs, copping and using drugs.			
6. Help client acknowledge his/her addict self's capacity to cause harm to him/herself or others			
7. Emphasize that addict self is not client's true nature			
8. Emphasize that client's true spiritual nature provides relief from suffering – it does no harm to self or others			
9. Describe client's spiritual nature as always present, but hidden from view by habitual activation of addict self			
10. Describe 3-S therapy as "training" for the spiritual self (i.e., to help client strengthen his/her spiritual muscles so that spiritual self replaces addict self as the habitually activated self-schema)			
11. Describe 3-S method for replacing the addict self (become aware, interrupt it, refocus on spiritual self)			
12. Describe the 10 spiritual qualities as client's own spiritual muscles that exist but need to be strengthened			
13. Reflect back to client the spiritual qualities (muscles) used by client during role-play			
14. Describe purpose and expectations re: client workbook			
15. Emphasize the need to become aware of addict self activation by interrupting self at least three times daily			
16. Help client identify/use a cue to interrupt the addict self (e.g., ringing of telephone) and write cue in the client's workbook			
17. Assign at-home practice [e.g., assign spiritual quality 'strong determination' and 3 x daily check-in.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #2: Training in 'Mastery of the Mind' Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client Mastery
1. Review client's commitment to a spiritual path			
2. Review previous session			
3. Review client's at-home practice since last session (if assignment not done, modify cue, identify examples of spiritual quality during week, encourage practice)			
4. Act as client's "coach"			
5. Provide rationale for today's topic – training mind for spiritual path requires effort, mindfulness, and concentration			
6. Describe 'monkey mind' as the uncontrolled wandering mind that jumps around without client's awareness			
7. Explain that taking back control from the addict self's monkey mind requires effort – which means practice			
8. Emphasize that mindfulness means becoming aware of the monkey mind and knowing when the addict self is turned 'on' or in danger of being turned 'on'			
9. Emphasize that meditation is a tool for concentrating the mind on the spiritual path (thus keeping the monkey mind under control)			
10. Provide rationale for meditating on the breath			
11. Demonstrate meditation on in and out breath			
12. Determine client's ability to perceive changing sensations caused by in and out breath (and, if necessary, expand the area of concentration (to include entire nose)			
13. Refer to the object of meditation (in and out breath) as the client's 'anchor' (turning attention to the anchor prevents being swept away by strong currents of craving)			
14. Help client identify an upcoming stressor suitable for practicing use of anchor.			
15. Lead client in a guided visualization for using the meditation anchor to cope with the identified stressor			
16. Help client identify a suitable place for daily meditation			
17. Assign at-home practice [e.g., assign spiritual quality 'effort' and daily meditation, plus previous week's task.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #3: 'Mastery of the Mind' (cont) Addict self intrusions Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path			
2. Provide rationale for meditating on the breath			
3. Demonstrate meditation on in and out breath (5 mins)			
4. Review previous session			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach"			
7. Provide rationale for today's topic – identify- interrupt-refocus -- emphasizing that addict self intrusions are to be expected; and that awareness of them indicates progress			
8. "Break the habit' by identifying the component parts of the addict self intrusion – the feelings, thoughts, behaviors – write on Worksheet in client workbook			
9. Frame non-adherence to treatment recommendations as evidence of addict self intrusion.			
10. Encourage client to predict addict self's attempts to sabotage spiritual progress (e.g., by missing sessions, lying about drug use)and writes these on Worksheet in client workbook			
11. Explain and demonstrate addict self interruption techniques: check-ins, changing routine, thought stopping, observe and name (show on Worksheet in client workbook)			
12. Explain how to refocus on spiritual path – affirmation/prayer, song/hymn, picture/jewelry, meditation on 'anchor' (show on Worksheet)			
13. Help client create a meaningful prayer or self-affirmation for refocusing on spiritual path (write in client workbook)			
14. Encourage and help client to write self-affirmation on index cards and place in different areas around house/car.			
15. Explain saying 'the whole earth is medicine' and connect it to session topic			
16. Provide client with opportunity to handle and comment on beautiful natural objects (e.g., shells, rocks, leaves) and encourage client to do this at home			
17. Assign at-home practice [e.g., assign spiritual quality 'equanimity', and use of self-affirmation. Plus previous tasks.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #4: 'Mastery of the Mind' (cont) Medication mindfulness Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path			
2. Provide rationale for meditating on the breath			
3. Demonstrate meditation on in and out breath (5 mins)			
4. Review previous session			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach"			
7. Provide rationale for today's topic -- emphasizing that following medical regimens for HIV requires mastery of the mind – effort, mindfulness, and concentration			
8. Discuss the stress of being a patient in health care systems as trigger for addict self			
9. Provide instruction about effect of HIV on immune system (determine if client knows his/her viral load ;CD4 count)			
10. Explain need for strict medication adherence and emergence of medication resistant virus due to non-adherence that can be transmitted to self and others.			
11. Review client's current medical regimen and assess adherence			
12. Emphasize that an undetectable viral load does <u>not</u> mean HIV can't be transmitted			
13. Suggest that taking medications becomes one of the 3xdaily check-ins			
14. Teach client medication mindfulness ritual (if no HAART; use multivitamin)			
15. Discuss coping with side-effects by activating spiritual self (e.g., making offering; gratitude for medications that may prolong life; 'this too shall pass')			
16. Review medical appointment etiquette			
17. Assign at-home practice (e.g., assign spiritual quality 'gratitude', and daily use of medication mindfulness rituals. Plus previous tasks).			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #5: 'Morality' Preventing harm to self and others Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path			
2. Provide rationale for meditating on the breath			
3. Demonstrate meditation on in and out breath (5 mins)			
4. Review previous session			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach"			
7. Provide rationale for today's topic -- explaining that morality – doing no harm to self or others -- is the foundation of a spiritual path			
8. Explain that activation of the automatic addict self leads to medical harms, like HIV, hepatitis, and STDs.			
9. Explain why knowing how to prevent HIV, hepatitis, and other STDs is necessary when on a spiritual path			
10. Help client integrate motivation to prevent HIV and other diseases with his/her own spiritual/ religious beliefs - discuss spiritual self's "protective power"			
11. Explain why the spiritual self (because of it's motivation to do no harm) can help client learn and retain HIV info and skills better than the addict self.			
12. Explain difference between mindless reaction when in high risk situation and mindful action (interrupt a reaction to desire/craving long enough to be safe and do no harm; e.g., stopping to put on a condom)			
13. Provide rationale for experiential exercise – 'this too shall pass' -- the impermanence of craving and desire; how if you observe it, without reacting, it passes away.			
14. Provide visualization adequate to induce craving			
15. Help client experience the rising and passing away of sensations created by craving			
16. Ensure that any induced craving has diminished before client leaves session (e.g., using breath 'anchor')			
17. Assign at-home practice [e.g., assign spiritual quality 'morality', attend HIV harm reduction session, and observe impermanence of craving. Plus previous tasks.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #6: 'Morality' (Cont): Everyday Ethics Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path			
2. Provide rationale for meditating on the breath			
3. Demonstrate meditation on in and out breath (5 mins)			
4. Review previous session			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach"			
7. Provide rationale for today's topic -- 'addict' speech (lying), action (sharing needles), and livelihood (dealing/prostitution)run counter to everyday ethics			
8. Explain 'first you harm yourself, then you harm others' – e.g., anger hurts the angry person before the target of the anger – lose the balance of your mind			
9. Explain letting go of guilt -- learning from the past, but then moving forward so you can live in present			
10. Emphasize that each moment provides a new beginning.			
11. Explain that compassion and tolerance begin by knowing that all beings want to be happy and free of suffering			
12. Explain that all religious traditions agree that we should treat each other with loving kindness (provide example from client's own tradition)			
13. Explain how to use the meditation 'anchor' to stay calm even if others are expressing anger towards us			
14. Explain the power of repetitive thoughts -- we come to believe and act upon what we tell ourselves repeatedly			
15. Explain the need to train ourselves to have thoughts of loving kindness and compassion, rather than addict thoughts, so that we can remain on a spiritual path			
16. Demonstrate and provide rationale for metta meditation with practice of repetitive thought 'may all beings be happy'			
17. Assign at-home practice [e.g., assign two new spiritual qualities ('loving kindness' and 'tolerance'), and daily use of metta statements. Plus previous tasks.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #7: 'Morality' (cont) Stopping the spread of HIV Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path			
2. Provide rationale for meditating on the breath			
3. Demonstrate meditation on in and out breath (5 mins)			
4. Review previous session			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach"			
7. Provide rationale for today's topic -- emphasizing that the moral foundation of a spiritual path includes accepting social responsibility to stop the spread of HIV/AIDS			
8. Increase client awareness that addict self contributes to the spread of HIV			
9. Encourage client to share his/her personal story of becoming infected with HIV			
10. Express gratitude to client for sharing his/her personal story of HIV infection			
11. Assess extent to which client has disclosed HIV-serostatus to others and client's perceived barriers to disclosure			
12. Encourage client to make a commitment that no-one will get HIV from him/her			
13. Describe the spiritual self as having the courage to make a contribution to stopping the spread of HIV/AIDS			
14. Explain 'window period' and why early and frequent HIV testing is important			
15. Encourage client to speak to everyone in social network to get tested, regardless of whether client has engaged in high risk behaviors with these individuals			
16. Help client disclose his/her own serostatus to drug and sexual partners			
17. Assign at-home practice [e.g., assign spiritual quality 'courage'; and assignment to encourage at least one person to get tested. Plus previous tasks.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #8: 'Wisdom' Filling the Mind with the Spiritual Self Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path			
2. Provide rationale for meditating on the breath			
3. Demonstrate meditation on in and out breath (5 mins)			
4. Review previous session			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach"			
7. Provide rationale for today's topic -- explain that wisdom means understanding one's true spiritual nature and being committed to remaining on one's spiritual path.			
8. Explain that wisdom includes knowing that the addict self is not one's true nature, but rather a habitual way of thinking about oneself that leads to harmful behavior.			
9. Explain that a habitual unwholesome way of thinking (like the addict self) can be changed if we become aware of it and create a new wholesome habit to take its place.			
10. Explain how addict self fades away if mind is completely filled with the spiritual self and true nature is expressed in every thought, word, and deed			
11. Emphasize the importance of remaining mindful of when addict self is activated or about to be activated			
12. Help the client write a detailed plan for filling the mind – using Worksheet in client workbook			
13. Help client identify specific multi-sensory spiritual cues – sight, sound, taste, smell, touch			
14. Help the client incorporate new 3-S skills (e.g., meditation) in daily plan			
15. Help client incorporate practices of his/her spiritual/religious tradition (e.g., reading bible, singing hymns, lighting candles, receiving communion)			
16. Emphasize the necessity for commitment to the plan.			
17. Assign at-home practice [e.g., assign new spiritual quality 'wisdom' and use of daily plan for filling the mind with spiritual self. Plus previous tasks.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #9: 'Wisdom' (cont) Coping with Stigma Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path			
2. Provide rationale for meditating on the breath			
3. Demonstrate meditation on in and out breath (5 mins)			
4. Review previous session			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach"			
7. Provide rationale for today's topic -- emphasizing that training in wisdom also includes right view and right thinking in the context of other people's opinion of us			
8. Define social stigma in the context of both HIV and addiction			
9. Explain internalized stigma and assess client's internalization of personally experienced stigma (e.g., experience of shame)			
10. Explain self-fulfilling prophecy in the context of addict self responding to stigma with high risk behavior			
11. Teach client to activate Spiritual self to respond to stigma by reciting 'this is not me; this is not mine; I am my spiritual nature'			
12. Teach client to take responsibility for any harm the client has caused others, to apologize, make amends, and ask for forgiveness			
13. Help client understand that s/he has no control over other's response to his/her request for forgiveness; i.e., be prepared to accept a 'no' answer			
14. Assess client's prior response to being target of social stigma (e.g., with hatred, anger, drug use)			
15. Emphasize that one needs to train one's mind to forgive to prevent getting caught up in cycle of hate			
16. Encourage client to replace the word 'try' with the word 'train' – being on a spiritual path means being willing to train one's mind			
17. Assign at-home practice [e.g., assign spiritual quality 'forgiveness', and ask for and offer forgiveness. Plus previous tasks.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #10: 'Wisdom' Renunciation of the Addict Self Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path			
2. Provide rationale for meditating on the breath			
3. Demonstrate meditation on in and out breath (5 mins)			
4. Review previous session			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach"			
7. Provide rationale for today's topic -- explain that wisdom also means abandoning false views of oneself – this means giving up (renouncing) the addict self			
8. Explain that addict self separates client from his/her true nature – using the 5 enemies – craving, aversion, laziness, agitation, and doubt.			
9. Describe fully the need to give up addict speech, thoughts, emotions, and actions, and addict self identity			
10. Explain how generosity is related to renunciation – give up something that is bad for you in the long run and generously give to yourself that which is wholesome			
11. Explain the '5 friends' – faith, energy, awareness, concentration, and wisdom. These will help you give up the addict self and overcome the '5 enemies.'			
12. Help client to identify specific strategies for renouncing the addict self during the coming week			
13. Provide rationale for visualization strategy (e.g., used by athletes, actors)			
14. Explain acting 'as if' – (fake it 'till you make it)			
15. Lead client through a guided visualization exercise -- fading image of addict self on TV screen, refocusing on a new spiritual image, recognizing this new image as oneself, and finally taking on the role of spiritual self			
16. Encourage client to continue acting 'as if' s/he is spiritual self after session ends and throughout week			
17. Assign at-home practice [e.g., assign two new spiritual qualities 'renunciation' and 'generosity' and act 'as if' spiritual self. Plus previous tasks.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #11: 'Wisdom' (cont) Serenity & Insight Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path			
2. Provide rationale for meditating on the breath			
3. Demonstrate meditation on in and out breath (5 mins)			
4. Review previous session			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach"			
7. Provide rationale for today's topic -- emphasizing that training in wisdom includes the other two trainings – mastery of the mind and morality			
8. Define suffering: We suffer because we cling to what is actually impermanent			
9. Explain the law of impermanence: Everything that is born, dies			
10. Describe stages of grief: denial, anger, bargaining, depression, acceptance, hope			
11. Connect early stages of grief with activation of the addict self			
12. Assess the client's stage of grief with regard to HIV diagnosis, loss of health, loss of life			
13. Explain the first line of the serenity prayer: serenity is a characteristic of client's true spiritual nature; it is always there, it is just obstructed by ignorance			
14. Explain the second line of the serenity prayer: We cannot change the fact that everything that is born ultimately dies; nothing is permanent			
15. Explain the third line of the serenity prayer: One can change one's thoughts and actions to be consistent with one's spiritual nature			
16. Explain the fourth line of the serenity prayer: knowing the difference brings serenity and insight, ends any fear of death and dying			
17. Assign at-home practice [e.g., assign spiritual quality 'serenity', and daily meditation on serenity prayer. Plus previous tasks.]			
18.Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			

3-S^{+} THERAPIST RATINGS SCALES (and client 'mastery' of concepts)

Session #12: Termination: Maintaining the path with Truth Date:_____
Therapist(s): _____ Rater _____ Date rated _____
Rate therapists on the following scales:

Adherence to manual:

0	1	2	3	4
not at all	a little	somewhat	considerably	extensively

Therapist Competence and Client Mastery:

0	1	2	3	4
unacceptable	below average	average	very good	excellent

TO WHAT EXTENT DID THERAPIST:	Adherence	Competence	Client mastery
1. Review client's commitment to a spiritual path.			
2. Provide rationale for meditating on the breath.			
3. Demonstrate meditation on in and out breath (5 mins).			
4. Review previous session.			
5. Review client's at-home practice since last session (if assignment not done, modify cues, identify examples of spiritual quality during week, encourage practice)			
6. Act as client's "coach".			
7. Provide rationale for today's topic -- This final session will review steps already taken on spiritual path and discuss maintenance using the quality of Truth.			
8. Emphasize that the spiritual path is a lifetime journey. Client has taken a few very important steps, but needs to continue.			
9. Review the three trainings – mastery of the mind, morality, and wisdom – and discuss how client will continue these now that 3-S sessions are ending.			
10. Emphasize continued use of mindfulness to remain vigilant for addict self intrusions and meditation to strengthen single-pointed focus on spiritual path.			
11. Discuss how to handle addict self intrusions and how to continue strengthening the 10 spiritual muscles.			
12. Emphasize that the spiritual path needs to be well-maintained so that it remains readily accessible in daily life.			
13. Explain how the spiritual path is maintained with Truth – being honest with self, others, environment.			
14. Help client identify support system – using Worksheet to identify sources of spiritual support.			
15. Help client locate one or two specific community resources (e.g., using local newspaper)			
16. Ask for commitment to follow-up on one of the community resources during the coming week			
17. Assign at-home practice [e.g., assign new spiritual quality 'truth' and contact at least one community resource. Plus previous tasks.]			
18. Emphasize the need for at-home practice to train the spiritual self and strengthen spiritual muscles			
19. Summarize the session briefly			
20. Demonstrate, and provide rationale for, 3-S stretch			
21. Adhere strictly to the manual for this session – including adherence to time constraints for each segment			
22. Interact with client's spiritual self (e.g., by modeling and reflecting compassion)			
Other:			