Theoretical foundation of 3-S

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The incontrovertible connection between drug addiction and HIV infection, especially in the nation's inner cities, has highlighted the important role that substance abuse treatment can play as a front line defense in the war against AIDS. Indeed, there is considerable evidence supporting the efficacy of substance abuse treatment, specifically methadone maintenance programs, for reducing the number of HIV infections caused by needle sharing (see Gossop, Marsden, Stewart, & Treacy, 2002; Sorensen & Copeland, 2000). While these results are encouraging, the risk for HIV transmission in this client population remains high due to unsafe sexual practices and the use of drugs, such as cocaine or other stimulants that, even in the absence of the sharing of drug paraphernalia, increase impulsivity and therefore HIV risk (cf. Bux, Lamb, & Iguchi, 1995; Grella, Anglin, & Wugalter, 1995; Hudgins, McCusker, & Stoddard, 1995; Kosten, Rounsaville, & Kleber, 1987; Magura, Siddiqi, Freeman, & Lipton, 1991). As unsafe sexual practice and use of stimulants remains largely unaffected by interventions such as methadone maintenance, there has been a pressing need for theory-based psychotherapeutic interventions to augment conventional substance abuse treatment that will simultaneously treat addiction while also facilitating change in HIV risk behavior. For the most part, interventions that have been proposed, to date, are adaptations of risk reduction interventions developed originally to reduce HIV risk behavior among other high risk populations (e.g., gay/bisexual men) (e.g., Coates, 1990; Fisher & Fisher, 1992; Kelly, 1995), or are adaptations of interventions developed originally to treat substance abuse alone (e.g., Marlatt & Gordon, 1985; Monti, Abrams, Kadden, & Cooney, 1989) that have been modified to include risk reduction strategies. Few, if any, theory-based interventions have been developed to address simultaneously the linked problems of addiction and HIV risk behavior. The goal of this paper is to describe the development of a manual-guided treatment approach for reducing HIV risk and addictive behavior that is based on observations made by ourselves and others of the potentially important role of spiritual and religious beliefs in facilitating health-related behavior change (Avants, Warburton, & Margolin, 2001; Carter, 1998; Gorsuch, 1994; Green, Fullilove, & Fullilove, 1998; Kus, 1995; Mathew, Georgi, Wilson, & Mathew, 1996; Miller, 1999; Pardini, Plante, Sherman, & Stump, 2000; Tangenberg, 2001).

Despite the wide observance of religious practice in the United States (Gallup, 1996), and the long-held view of community-based treatment programs such as Alcoholics Anonymous that addiction is a spiritual, as well as a medical, disorder (Alcoholics Anonymous World Services, 1976), spirituality *per se* has not been a primary focus of investigation in the addiction literature (see Miller, 1998). There is, however, increasing interest in, and evidence for, the role of spiritual and religious beliefs in both recovery from addiction (Avants et al., 2001; Brizer, 1993; Goldfarb, Galanter, McDowell, H., & Dermatis, 1997; Green et al., 1998; Kendler, Gardner, & Prescott, 1997; Mathew et al., 1996; Pardini et al., 2000) and in HIV prevention efforts among drug users and their drug- and sexual-partners (Avants, Marcotte, Arnold, & Margolin, 2002; Des Jarlais et al., 1997). More generally, spiritual and religious beliefs and

practices have been shown to have an impact on a variety of health-related outcomes (Matthews et al., 1998; Weaver et al., 1998). While religious behavior (e.g., service attendance, prayer) and religious coping (placing trust in God, seeking comfort in religion), may affect these outcomes differently (Woods, Antoni, Ironson, & Kling, 1999), spiritual and religious faith, in general, appears to provide a buffer against the depressogenic effects of stressful life events (Kendler et al., 1997). By providing an effective coping strategy (see Pargament, 2001), faith may play a protective role in physical and mental health (Benson & Dusek, 1999; Ellison, 1991; Galanter, 1997).

Despite an apparent interest in spirituality in both the clinical and the research communities, there are few manual-guided spirituality-based interventions that can be subjected to rigorous evaluation using randomized clinical trial methodology. One reason for the relative paucity of such interventions may be the inherent difficulty in operationally defining, addressing, and measuring spiritual faith in a manner that is amenable to scientific investigation, while remaining sensitive to the potential diversity of clients' personal belief systems (Gorsuch & Miller, 1999; Koenig, McCullough, & Larson, 2001; Zinnbauer, Pargament, & Scott, 1999). In guiding our own thinking concerning the development and scientific study of an intervention that could potentially tap spiritual/religious faith as a resource for injection drug users in recovery from addiction, we have found it useful to draw on a number of different, but compatible, theoretical frameworks, specifically, self-regulation theory (see Carver & Scheier, 1982), self-schema theory (Markus & Nurius, 1986; Markus & Wurf, 1984) and self-discrepancy theory (Higgins, Bond, Klein, & Strauman, 1986). Conceptualizing an individual's spiritual and religious beliefs as a construct or cognitive schema that serves to reduce discrepancies between current and desired goals or reference states, permits an integration of the literature on the psychology of religion/spirituality with methodology more commonly used in contemporary cognitive and social psychology (see Ingram, 1989; Lipson, 1983; McIntosh, Silver, & Wortman, 1993; Ozorak, 1996; Pargament & DeRosa, 1985; Taylor & Fiske, 1982), and, as will be described in a later section, with Buddhist psychology.

The goal of this paper is to describe how self-schema theory may be usefully applied to the development of a manual-guided intervention for reducing illicit drug use and other HIV risk behaviors among inner-city injection drug users. The paper is organized as follows. First, we provide a brief overview of self-schema theory. Next, we describe evidence for the habitual activation of an addict self-schema in drug users, and the basis for a therapeutic goal of creating, elaborating, and making available for activation a competing non-addict self-schema. Lastly, we describe Spiritual Self-Schema (3-S) therapy, a cognitive therapeutic approach informed by Buddhist psychology, for helping the addicted individual develop and activate a self-schema for compassion that fosters drug abstinence and HIV preventive behavior.

We recognize that our discussion does not touch upon a host of theoretical issues that attend any attempt to integrate contemporary cognitive and Buddhist psychologies (see Rubin, 1996; Varela, Thompson, & Rosch, 1991; Watson, Batchelor, & Claxton, 1999). 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). A number of clinicians and theorists have also written extensively on integrating Buddhist and Western psychological principles and practices for a range of psychological problems. 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 primary difference between the current approach and those cited above is our use of an information processing, cognitive self-schema theoretical framework[1]. As has been noted previously (Kabat-Zinn, 2000), a number of Buddhist concepts and principles, such as "non-self", may be difficult for Westerners to grasp. By providing an example of an illusory self (e.g., addict) and labeling the 'non-self' or 'true self' as the 'spiritual self', drug abusing clients are able to use, and elaborate, their personal religious beliefs and practices within the treatment, and may be able to therapeutically assimilate a number of basic principles of Buddhist psychology. In this article we tacitly build 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., in submission). This may be viewed as a theoretical integration (Strickler & Gold, 1996) insofar as fundamental "behavioral" principles of Buddhism are used to provide content relative to which hitherto theoretical concepts of self-schema theory are interpreted, and endowed with potentially practical psychological import.

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.,

[1] Since the current article was accepted for publication a special series, entitled 'Integrating Buddhist philosophy with cognitive and behavioral practice' was published in the journal of the Association for the Advancement of Behavioral Therapy (AABT) Cognitive and Behavioral Practice, Vol. 9(1), Winter 2002. The interested reader is referred to this special issue for examples of how Buddhist concepts can be usefully integrated with cognitive behavioral therapy (CBT), including CBT treatment for addiction.

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). 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. If the individual is later asked what led to drug use 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 <u>one</u> trigger, in that <u>particular</u> situation, given the individual's <u>particular</u> state of mind <u>at that moment</u>, that set off the chain reaction. An intervention guided by self-schema theory would <u>not</u> 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 do not promote drug use and HIV risk behavior. To date, this general approach has formed the basis for two psychotherapeutic interventions -- Self-Reevaluation Therapy (SRT) (Avants et al., 1994) for the treatment of cocaine addiction, and Self-System (SST) therapy for the treatment of depression (Strauman et al., 2006) – and it subsequently provided a foundation for the development of the spirituality-focused intervention for the treatment of HIV risk and addictive behavior to be described in this paper -- Spiritual Self-Schema (3-S) therapy. At present, 3-S therapy is being delivered in an inner-city methadone maintenance program (MMP) as part of a National Institute on Drug Abuse (NIDA) funded Stage 1 behavioral therapies development. Primary outcomes include illicit drug use and drug- and sex-related HIV risk behavior; self-schema process measures include pre- and post-treatment reaction time and incidental memory for addict and spiritual self-schema-relevant attributes, number and type of attributes generated, and change in strength and frequency of schema activation over time.

Goal of 3-S therapy: Elaborating and activating a cognitive schema that is incompatible with drug use and HIV risk behavior – the spiritual self-schema

In his writings on multiple self-representations, William James notes that each individual has a number of different self-representations from which to choose:

> *"I am often confronted by the necessity of standing by one of my empirical selves and relinquishing the rest….. the seeker of his truest, strongest, deepest self must review the list carefully, and pick out the one on which to stake his salvation." (pp. 309-310 James, 1890-1950).*

Contemporary cognitive theorists concur with James that invoking, and standing by, a possible self and "filling one's mind" with it through elaboration and rehearsal not only prevents activation of alternate self-schemas, allowing them to be relinquished, it also organizes and energizes behaviors that are congruent with the activated self-schema (cf. Cross & Markus, 1990). It is a fundamental tenet of 3-S that 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 and HIV prevention. 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 and HIV prevention (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. 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:

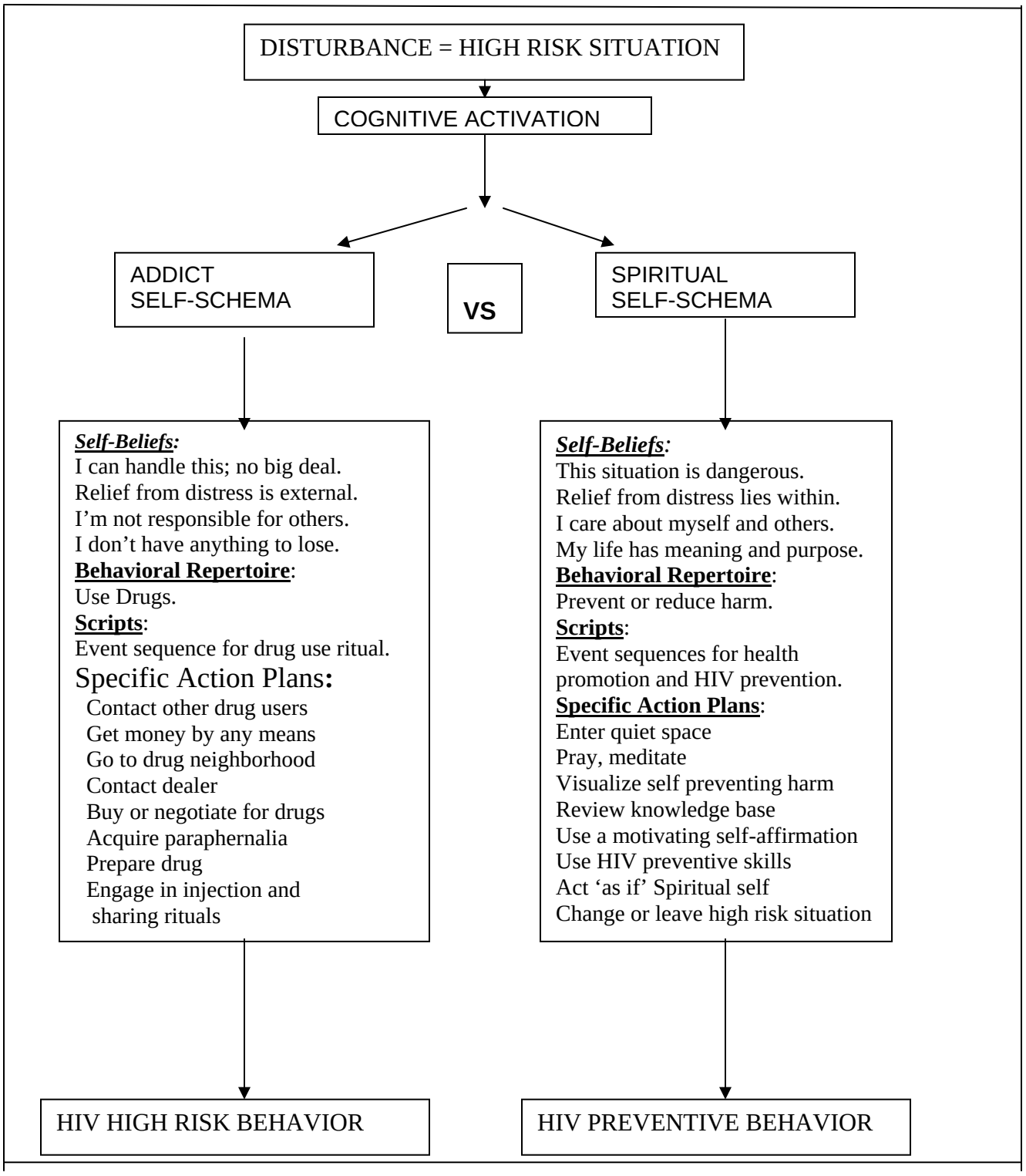
1) non-judgmental reflection on moment-to-moment experience in a way that engenders increased self-awareness and insight;

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, and unsafe sexual practices.

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 therapy in the treatment of addictive and HIV risk behavior

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 reducing addictive and HIV risk behavior 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, in this paper or in the delivery of 3-S therapy, to expound or explicate Buddhist doctrine. Not only would this be beyond the scope of both this paper and 3-S therapy, it would also go beyond the expertise of the authors. 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 addictive and HIV risk behavior. 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 intervention for use with 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 addicted client populations. Second, Buddhist doctrine offers a highly structured and clearly marked "Path" to preventing all harm, and to the expression of compassion, altruism, and optimism – attributes that we hypothesize are essential for changing HIV risk and addictive behavior. 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' 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). 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 individual's 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' as it is often used in Buddhist texts, as a convenient "manner of speaking" that can be employed by individuals of diverse faiths to refer to their 'spiritual nature,' in whatever way this is defined by their religious beliefs. 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 be 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 (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.' 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 wisely abandoned; and tranquility and insight must be wisely 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) by which awareness and insight are increased and suffering ends and provide a detailed roadmap based specifically on 'non-harming.'

3-S therapy's interpretation of the Four Noble Truths applied specifically to addictive and HIV risk behaviors. 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 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*), and 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: training in morality/ethics (*sila*); training in mastery of the mind (*samadhi*); and training in wisdom (*panna)*. Training in morality, includes the components Right Speech, Right Action, and Right Livelihood, and provides the foundation of the Path. 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. 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, its unsatisfactoriness, and its absence of self-identity). Thus, as each 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. However, it should be noted that to facilitate client understanding of the material, the order of presentation of the three trainings in the 3-S treatment manual is: 1) training in mastery of the mind, 2) training in morality, and 3) training wisdom.]

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., greed, anger, 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]. 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 therapy training in 'wisdom' in the treatment of addictive and HIV risk behavior: In 3-S therapy, 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 HIV risk behavior. Addictive and HIV 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 the 'spiritual self,' 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 – the spiritual self – 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 relief from suffering. The therapist's task is to acknowledge, rather than minimize or challenge, clients' suffering due to 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.

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 therapy training in 'morality/ethics' in the treatment of addictive and HIV risk behavior. In 3-S, the training in morality/ethics specifically focuses 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), 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. The need to abstain from all harmful behavior, including drug use, deceit, criminal activity, and other drug- and sex-related HIV risk behavior is unambiguously addressed by the 3-S therapist. However, drug use or any other HIV risk behavior that occurs during treatment (when occurring in the context of a sincere desire for abstinence) 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).

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 ten spiritual perfections (*paramis*), 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 therapy training in 'mastery of the mind' in the treatment of addictive and HIV risk behavior. In 3-S therapy, the effort to 'avoid and overcome' refers to the fading of the addict self through continued diligent self-monitoring of addict self-schema activation. The effort to 'develop and maintain' refers to the creation, elaboration, and maintenance of the spiritual self-schema. The following cognitive/Buddhist strategies are used:

1. Schema identification: In the first phase of treatment, clients are asked to take the time thrice daily (mid-day, early evening, and upon retiring) to identify which self-schema is currently activated, and to identify thoughts, feelings, and behaviors currently being activated by this self-schema. A log may be used for monitoring and recording this information.

2. 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) Item-naming: 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.

4. 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 and HIV preventive behavior. 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 (*ananapanasati*)]. The need for daily practice is emphasized.

5. Transcending craving. 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. Here the 3-S therapist's task is to teach the client how to control craving by helping the client become aware of the experience of craving as it arises and passes away. Through systematic examination of the craving experience, in a variety of sense modalities, the client learns how to interrupt its automaticity, and is able to perceive it as an impermanent state that can be controlled and transcended. This is accomplished with the use of a guided imagery exercise in which the powerful, usually ineffable, experience of craving, described by most clients as "that overwhelming feeling that makes me use drugs," is captured and dissected, then each of its sensory components is carefully identified and labeled, and finally a memory of a personally meaningful spiritual experience is used to transcend it.

6. Elaborating the spiritual self-schema. The following strategies are used to elaborate and strengthen the spiritual self-schema in order to make it more available for activation:

(a) Increasing schema-congruent attributes. Spiritual ideals are identified and integrated into the client's spiritual self-schema. At each session, clients and therapist select an attribute (e.g., from the list of spiritual perfections (*paramis*) described earlier, each of which is consistent with abstinence and harm reduction), and identifies thoughts, feelings, and behaviors associated with that attribute (e.g., the selection of the attribute 'loving kindness,' which is consistent with a capacity for selfless love and altruism, might be associated with the thought 'I believe my behavior can affect my partner's health and well-being;' with the feeling of caring for the partner's well-being; and with behaviors such as drug abstinence, not sharing needles, and condom use).

(b) Spiritual self-schema scripts and action plans (cf. Beck, 1995; Kelly, 1955). In session, the client 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.) Brief affirmations are also developed (e.g., I care about myself and others), and written on index cards which are placed in specific locations in the client's environment that will cue the spiritual self-schema scripts and action plans.

(c) Visualization and self-control: mental rehearsal. 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

that is reflected in the scripts and action plans of (b) above. 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.

(d) Acting 'as if': behavioral rehearsal. At the conclusion of the guided visualization, clients are instructed to take on the role of their spiritual self, 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, in an upcoming high risk situation identified in session, a client might attempt to act as a 'compassionate' person would act in such a situation. A log can be used for recording progress and noting any obstacles to behavioral rehearsal that were encountered.

E. Mind-full-ness (i.e., filling the mind). According to Buddhist teachings, once the disciple has learned to detach from 'sensual objects and demeritorous things' he or she enters the stages of 'verbal thought' and 'rumination' that are free from the five hindrances. However, because human beings are prone to yield to temptation and allurements, the teachings state that in order to free oneself from their bondage and their intoxication, 'one must concentrate one's whole mind in a resolution to resist them to the uttermost' (see *Surangama Sutra* in Goddard, 1938). 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. 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. 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.

A case report describing the delivery of 3-S therapy to a 49 year-old HIV-positive, African-American male with a 20-year history of intravenous heroin and cocaine use is provided elsewhere (Marcotte et al., 2003). We note here that, 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 client begin the process of developing and elaborating a self-schema that is incompatible with drug use and other HIV risk behavior 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 addictive and HIV risk behavior in the treatment of clients suffering from addiction.

Target population, common problems, compatibility with other treatments

Target population

Several versions of 3-S therapy will be available. The current version specifically targets drug users. 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 be conducted prior to beginning 3-S therapy 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.

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

The 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

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 and harm prevention.

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 and HIV preventive behavior
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 abstinence and HIV prevention.
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 8 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

Recommended treatment duration

For purposes of evaluation, 3-S is being delivered in hour-long individual treatment sessions once weekly for 8 weeks. The additional benefit of providing an hour-long supportive group intervention in addition to the individual sessions is also being investigated. This group provides the opportunity for clients to practice skills learned in individual sessions. The treatment duration of eight weeks was selected primarily to facilitate technology transfer to community drug treatment facilities operating under managed care systems that mandate the cost-efficiency of brief interventions. However, in settings where longer treatment episodes are possible, the 3-S treatment manual is readily adapted by providing less didactic material at each session, by providing more opportunity for repetition and practice at each session, and/or by providing increased 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 an interest in integrating spirituality into the treatment of addictive and HIV risk behaviors, and who have experience providing cognitive therapy, including the use of guided-visualization and meditative strategies. 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: (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.

7. 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 the clients' use of drugs, if any, during treatment, 3-S therapists model for the clients how to view their behavior through the filter of their 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.

8. The 3-S therapist has an understanding of the relationships between the Four Noble Truths, the Eightfold path, and the 10 paramis (perfections/spiritual qualities required for the Path).

9. 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. Specifically, clients with the following characteristics will need the verbal expression of the material by the therapist to be accommodated accordingly: a) English as a second language; b) minimal education and/or reading ability; c) physical impairments such as limited eyesight, hearing, or attention span (e.g., slow down the presentation); and d) clients that have medical conditions (e.g., chronic pain that causes them to have difficulty being still).

10. The therapist understands and is able to integrate the Noble Eightfold Path of the Buddhist tradition with each client's unique spiritual beliefs and religious affiliations, if any. 3-S therapy utilizes non-sectarian and non-theistic Buddhist principles, principally from the Theravada tradition. This is understood clearly by 3-S therapists and conveyed without reservation to the client. There is no intent to "convert" the client to Buddhism. The value of using a Buddhist framework is that it is applicable to all people in all strata of society who simply wish to be free from suffering (i.e., craving).

Training

3-S therapists are masters' level or higher clinicians with prior experience and competence in the delivery of cognitive behavioral therapeutic techniques to individuals in treatment for addiction. 3-S training workshops therefore include only the principles and practices specific to 3-S therapy. Prior to certification, 3-S therapists undergo training, successfully pass (>80%) a quiz on 3-S principles and practices, and provide 'mock' 3-S sessions to the clinical supervisor who plays the role of client. These 'mock' sessions are videotaped and rated for competence and adherence using scales provided in this manual. These videotaped sessions, along with their ratings, are reviewed by future trainees as examples of (in)competence and/or (non)adherence. Upon satisfactory completion of the training, the 3-S therapist, with close supervision, is assigned his or her first case. Additional cases are then assigned based on therapist's ongoing competence and adherence to the manual.

Assessment approaches

Treatment Outcome

The following treatment outcomes can be readily assessed in community-based treatment facilities: (a) illicit drug use (by self report and urine toxicology); (b) alcohol use (by self-report and breathalyzer); (c) HIV risk behavior such as sharing of drug paraphernalia and unsafe sexual practices (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). Dispassionate scrutiny of the addict self exposes its impermanence, and, over time, reduces its automaticity. This process is begun pre-treatment by asking clients to generate a list of attributes that describe their 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). Clients are also asked to list attributes of the spiritual self. At this stage in recovery, the spiritual self-representation is unlikely to be well-defined, and the client is likely to use more attributes to describe the addict self than the spiritual self. In addition to providing a baseline for post-treatment comparisons, completion of a self-schema assessment serves as a way to begin to help the client articulate and elaborate the spiritual self-schema. The assessment also provides the therapist with an opportunity to determine the client's understanding of 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, scales are available (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, 'Who am I' refrigerator, magnet.)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 -- emphasizing that addict self intrusions are to be expected; and that awareness of them indicates progress			
8. Identify early warning signals for addict self intrusion and writes them 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 addict self interruption techniques: thought stopping, observe and name, changing routine (writes routine changes on Worksheet in client workbook)			
12. Explain how to refocus on spiritual path			
13. Help client create a meaningful self-affirmation for refocusing on spiritual path (written in client workbook)			
14. Encourage client to write self-affirmation on index cards and place in different areas around house/car.			
15. Explain saying 'all the world is medicine'			
16. Provide client with opportunity to handle and comment on beautiful natural objects (e.g., shells, rocks, leaves)			
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: '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 #5: '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 #6: '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 #7: '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 #8: 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:			