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CE/CME Reflections by Inner-City Drug Users on a Buddhist-Based Spirituality-Focused Therapy: A Qualitative Study

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A manual-guided, spirituality-focused intervention—spiritual self-schema (3-S) therapy—for the treatment of addiction and HIV-risk behavior was developed as part of a Stage I behavioral therapies development project. It is theoretically grounded in cognitive and Buddhist psychologies and may be suitable for individuals of diverse faiths. The therapy development process began with focus groups to assess addicted clients' perceived need for a spirituality-focused intervention. The therapy was then codified in manual format, and a controlled clinical trial was conducted. Here the authors report on inner-city, methadone-maintained clients' personal experiences that were recorded in semistructured interviews following completion of the therapy. Findings from this qualitative study support the value of integrating spirituality-focused interventions into addiction treatment for the purpose of increasing motivation for drug abstinence and HIV prevention.

Keywords: spirituality, addiction, HIV prevention, Buddhism, meditation

It has been suggested that spiritual and religious faith may play a protective role in physical and mental health outcomes (Pargament, 1997). In the treatment of addiction, results of a number of studies suggest that perceived comfort and support from spiritual or religious beliefs are positively associated with recovery (Avants, Warburton, & Margolin, 2001; Brizer, 1993; Gorsuch, 1994; Kendler, Gardner, & Prescott, 1997; Mathew, Georgi, Wilson, & Mathew, 1996; Pardini, Plante, Sherman, & Stump, 2000). They may also contribute to HIV-preventive behavior in this at-risk population (Avants, Marcotte, Arnold, & Margolin, 2003; Des Jarlais et al., 1997). However, despite the interest in, and the growing evidence for, the role of spirituality in recovery from addiction and HIV prevention, there are few manual-guided spirituality-focused interventions that have been developed, subjected to empirical evaluation, and made available for use by community-based treatment programs (Marlatt, 2002; Miller, 1998).

One reason for this is the inherent difficulty in defining "spirituality" in a manner that is applicable to clients' diverse religious beliefs. Another is the challenge of integrating a personally meaningful spirituality within established psychological theoretical frameworks that facilitate evaluation of the therapy across clients, therapists, and sites. In this article, we describe the steps taken by our clinical research team to develop and evaluate one such intervention, beginning and ending with what we view as the guiding force behind this endeavor—our clients' personal experiences recorded in their own words.

Our first step was to conduct focus groups with clients in treatment for addiction in order to explore the perceived need for a spirituality-focused intervention in treatment facilities serving this population. We also hoped to gain a better understanding of the concept of spirituality from clients' perspectives and to explore how they viewed the relationships, if any, among spirituality, drug abstinence, and HIV prevention. Twenty-one HIV-positive methadone-maintained individuals, the preponderance of whom had a history of both illicit opiate and cocaine use, participated in the focus group study. In addition to the focus group participants, 26 methadone-maintained patients also answered questions concerning the perceived helpfulness of spirituality. Findings showed that a considerable majority of the sample expressed an interest in receiving such an intervention and reported that it would be helpful for reducing both drug craving and HIV-risk behavior, as well as for promoting other health-related behaviors. (Arnold, Avants, Margolin, & Marcotte, 2002). Our addicted clients' view of spirituality—which was characterized both as a source of strength and protection of self, as well as a source of altruism and protection of others—was consistent with these therapeutic goals

Having established a perceived need for the intervention among the target population of drug-addicted clients and a rationale for including spirituality in HIV prevention efforts, we embarked on a Stage I behavioral therapies development project to develop the therapy. A Stage I project is specifically devoted to codifying and

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developing treatment manuals; to addressing issues of internal validity, including assessment of therapist competence and adherence to the treatment manual; and to developing and testing assessment methods (Rounsaville, Carroll, & Onken, 2001). It precedes a formal test of the intervention in a Stage II randomized clinical trial. The product of our Stage I project was a manual-guided therapy: spiritual self-schema (3-S) therapy, theoretically guided by an information–motivation–behavioral model of HIV-preventive behavior (Fisher & Fisher, 1992), and a social–cognitive model of self-perception that views the self as composed of multiple self-representations, or self-schemas. Self-schemas are defined as hierarchically organized systems of knowledge and beliefs that underlie an individual's intentions and capacities (Singer & Salovey, 1991). Activation of a self-schema activates specific beliefs about the self and provides access to the behavioral repertoire associated with those beliefs through automatized event scripts and action plans.

The goal of 3-S therapy is to facilitate a shift in the client's habitual self-schema—that is, from the "addict" self-schema that, when activated, results in drug use and other high-risk behaviors, to a "spiritual" self-schema that is consistent with drug abstinence and HIV prevention. 3-S therapy does this by integrating modern cognitive–behavioral techniques with traditional Buddhist principles and practices (Avants & Margolin, 2004). We selected a nontheistic Buddhist framework, with its emphasis on changing unwholesome "habit patterns of the mind" that cause harm to self and others (Nanamoli & Bodhi, 2001), not only for its compatibility with cognitive–behavioral therapy but also for its potential applicability to people of diverse faiths. There are two versions of 3-S therapy, a 12-session version for clients who are HIV positive and an 8-session version for clients who are HIV negative or whose HIV status or unknown. Sessions are provided weekly, in a one-on-one format; there is also an adjunctive 12- or 8-session group therapy that provides clients with the opportunity for additional practice of concepts learned in individual therapy sessions. (More information about 3-S therapy is provided below in the "session content" section.)

In developing the therapy manual, we were particularly concerned about therapist "drift," which can occur in any psychotherapy clinical trial but which may be a particular liability when a spirituality-focused therapy is implemented by therapists of various backgrounds and faiths. Therefore, to reduce the potential for drift, we included detailed scripts for each session in the therapy manual. Therapist competence and adherence measures were also developed and made available in the manual, and a video training series was produced to ensure standardization of therapist training. An assessment battery was also developed.

In keeping with the goals of a Stage I behavioral therapies development project, in addition to treatment outcome measures related to drug use and HIV prevention, there were a number of measures evaluating the extent to which the intervention was delivered as intended. These included the following: (a) session attendance; (b) completion of at-home assignments; (c) observer ratings of therapist competence and adherence—sessions were videotaped and rated by trained observers; (d) client mastery of session content, assessed both by therapist ratings and by a post-treatment quiz; (e) client's perceived credibility of the treatment for the targeted problems; and (f) satisfaction with treatment for these problems. A preliminary uncontrolled study of the eight-session version of 3-S therapy was then conducted with a sample of clients in treatment for addiction. Twenty-nine methadone-maintained clients meeting criteria for opiate and cocaine dependence participated in this study. Findings were supportive of the intervention's efficacy. There was a decrease in drug use and other HIV-risk behaviors, as well as a shift from addict to spiritual self-schema. In addition, self-report of daily spiritual experiences and practices and the perceived influence of spirituality on behavior increased. We also found that a shift in self-schema was correlated with a change in drug use and other HIV-risk behaviors (Avants, Beitel, & Margolin, 2005).

The next step, Stage II, was to conduct a formal controlled evaluation of 3-S therapy in the target population. In this controlled study, 72 methadone-maintained clients, all of whom were long-term illicit opiate users, and 89% of whom also abused cocaine, received either standard care and the 8-week version of 3-S therapy or standard care alone. Clients were assessed pretreatment and at the end of the 8-week intervention. Results showed that completion of 3-S therapy predicted posttreatment HIV-preventive behavior, controlling for pretreatment behavior, demographics, and addiction severity measures.

Clients receiving 3-S therapy reported significantly greater increases in spiritual practices, expression of spiritual qualities, and motivation for HIV prevention, compared with a standard care control condition, and they were also less likely to have engaged in HIV-risk behavior (Margolin, Beitel, Schuman-Olivier, & Avants, 2006).

Before proceeding to the final step, a Stage III project devoted to technology transfer to diverse community settings, we return to our point of origination—with our clients' own experiences as recorded in their own words. We began our work by asking clients if they perceived a need for a spirituality-focused intervention and whether they thought it would be helpful to them in their recovery. Now, having received such an intervention, clients were asked to reflect on their experiences. What did they think of this therapy—what did they like and dislike about it? Could ethnically diverse clients from low socioeconomic backgrounds, often with limited education and the potential for drug- and HIV-related cognitive difficulties, engage in what could be viewed as a theoretically sophisticated intervention founded in cognitive psychological and Buddhist principles? Was such a therapy capable of addressing and meeting their personal spiritual needs? Were they able to sustain a commitment to completing at-home assignments (an important component of the therapy) that included the daily practice of meditation? These and other questions were the focus of the qualitative study to be presented here.

Method

Participants

Thirty-nine participants, all enrolled in an inner-city methadone maintenance program, participated in a posttreatment interview on completion of the 3-S therapy intervention; an additional 4 clients were eligible for this study but were unavailable for the interview. The sample included 24 women (62%) and 15 men (38%); the mean age was 43 (range = 28–54; SD = 6.39). The sample was ethnically diverse: 46% Caucasian, 31% African American, and 23% Hispanic. More than one third of the sample (38%) was HIV

positive. Most (69%) had completed high school or the equivalent; 80% were unemployed or disabled. The majority identified themselves as Christian (41% Catholic, 39% Protestant). All met the criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM–IV*; American Psychiatric Association, 1994) for opiate dependence, and 77% met criteria for cocaine abuse or dependence. The mean numbers of years using heroin and cocaine ($\pm SD$) were 18 (± 7.92) and 16 (± 8.37) years, respectively.

The Intervention

Clients described in the present report had received either the weekly individual 3-S therapy sessions alone (46%) or both the individual and the group 3-S therapy sessions (54%).

Following is a brief overview of the intervention. [The treatment manuals can be downloaded free of charge under the "Training" link at the 3-S website: www.3-S.us.]

Session Content

The first individual session provides an orientation to the therapy. Clients are introduced to basic concepts, such as self-schemas as "auto pilots," and are informed that the goal of 3-S therapy is to replace the addict self with the spiritual self, which will guide them in preventing harm to themselves and others throughout their daily lives. The therapist also respectfully queries clients regarding their spiritual or religious beliefs. This allows clients to be introduced to the Buddha's Noble Eightfold Path (Nanamoli & Bodhi, 2001) in a manner that is consistent with their own faith. The Eightfold Path is traditionally organized around three trainings: Mastery of the Mind, Morality, and Wisdom. These three trainings provide the basic structure for 3-S therapy.

Once the client has been oriented to the therapy, the training in Mastery of the Mind begins. In these sessions, clients learn to become aware of how going on "auto pilot" (which, as clients enter treatment, is usually governed by their addict self-schema) becomes activated and causes harm in their daily lives. They then learn how to refocus on their spiritual path whenever the addict self intrudes and learn how to use techniques such as *anapanasati* meditation (awareness of the in and out breath) and mindfulness training to help make healthy lifestyle choices. For clients living with HIV, an additional session is included, which is specifically focused on using mindfulness to increase medication adherence.

The Training in Morality is next, with morality defined broadly as "doing no harm to self or others." In these sessions, clients become aware of how the addict self is associated with speech, action, and livelihood in ways that cause harm to self and others, and they work on developing cognitive scripts of compassion and empathy, as well as action plans for risk prevention. It should be noted that these 3-S sessions on morality are linked to a separate one-on-one educational session that provides clients with specific information and behavioral skills for preventing HIV, hepatitis, and other infectious diseases.

The final section is the Training in Wisdom, which emphasizes that the addict self is not the client's true nature but, rather, is a maladaptive and long-standing habit pattern of the mind that causes profound suffering. Clients learn that, with diligent practice, this habit pattern can be changed and their core spiritual nature revealed. They are taught that this can be accomplished by beginning to construct, activate, and maintain a spiritual self-schema—that is, a cognitive structure that facilitates expression of their spiritual nature (which, for therapeutic purposes, is assumed to be fundamentally compassionate and thus seeks to do no harm to self or others but is otherwise defined according to each client's own spiritual/religious beliefs). The ultimate goal of the therapy is the replacement of the addict self-schema by the spiritual self-schema as the habitually activated schema in daily life. Of course, constructing such a self-schema requires diligent practice, and maintaining it is the work of a lifetime. Therefore, 3-S therapy is not solely a "talk therapy" but is also an experiential therapy as well, in that clients are encouraged to activate the spiritual self frequently both during and between therapy sessions.

To help clients experience their spiritual self, each 3-S therapy session includes an experiential component that uses the metaphor of "going to the gym" to strengthen the client's spiritual muscles. Each week, the therapist assigns one or two spiritual qualities to be strengthened, both in and out of session. These qualities are taken from the 10 Buddhist *paramis*—generosity, morality, renunciation (i.e., giving-up drug use), wisdom, effort, tolerance, truth, strong determination, loving kindness, and equanimity—which are applicable to diverse religious faiths and systems of spiritual beliefs.

The final session of 3-S therapy focuses on transitioning clients to community resources that can help them continue to make progress on their spiritual path and to continue to develop and maintain their spiritual self-schema. In this session, clients are taught how to develop a three-tier support system. This approach stems from the Buddhist custom of seeking refuge in the triple gem—the Buddha, the Dhamma, and the Sangha—which is translated for 3-S clients as seeking refuge in their *own* spiritual teacher, the teachings or scriptures of their spiritual teacher, and a community (or fellowship) of individuals who, like themselves, are also trying to live a life in accordance with these teachings.[1]

Measures

Posttreatment questionnaire (PTQ). As shown in Table 1, the PTQ is a six-item self-report measure assessing, on 5-point scales (0 = *not at all*; 1 = *slightly*; 2 = *moderately*; 3 = *a lot*; 4 = *extremely*), the extent to which clients made certain changes in their lives as a result of having received 3-S therapy. Higher scores reflect more change. The PTQ was administered in a battery of questionnaires after the last session of 3-S therapy.

Posttreatment interview (PTI). The PTI is a face-to-face semi-structured interview conducted during the posttreatment assessment that includes 19 primarily open-ended questions designed to elicit qualitative data from clients regarding their experiences in treatment (see Table 2). Prior to the interview, its purpose was explained, and clients were asked whether they would participate or not. Interviewers were members of our clinical research staff, with experience and training in interviewing clients for this and other studies; 3-S therapists did not interview their own clients. PTIs were videotaped, and clients' responses were then tran-

[1] Readers may be more familiar with the Sanskrit terms for these concepts (e.g., Dharma rather than Dhamma, Samgha rather than Sangha). Because our therapy is based on the Theraveda Buddhist tradition, whose source texts are in Pali, we have used Pali terms in the 3-S therapy manuals and in this article.

Table 1
Posttreatment Questionnaire

Question	*M* ± *SD*
1. How much closer to quitting drugs are you now than before you began the therapy?	2.92 ± 1.04
2. How much did your drug use decrease as a result of participating in this therapy?	2.61 ± 1.35
3. How much did your craving for drugs decrease as a result of participating in this therapy?	2.67 ± 1.11
4. How much did this therapy increase your experience and expression of spirituality in your daily life?	3.15 ± 0.63
5. How much of a shift from your addict self to your spiritual self did you experience while participating in this therapy?	3.00 ± 0.69
6. Since your participation in this therapy, how much has your motivation increased to prevent the transmission of HIV and other diseases?	3.18 ± 0.79

Note. The posttreatment questionnaire is a six-item self-report measure using 5-point scales ranging from 0 (*not at all*) to 4 (extremely).

scribed. The questions that clients were asked during the interview covered the following content domains:

Client Expectations of 3-S Therapy

The sample consisted of methadone-maintained opiate- and cocaine-addicted individuals who presented to 3-S therapy with long histories of drug use and previous treatment failures. For these reasons, it was important to assess—in their own words—what they had expected to get out of 3-S therapy.

Process

Beyond initial expectations, we sought to assess clients' actual experience of the treatment. We were particularly interested in the ways in which clients perceived 3-S therapy as distinct from "treatment as usual"; that is, their standard drug counseling. Because 3-S therapy is a novel treatment, we sought to assess the clients' views of both process and outcome. With this in mind, we formulated questions to shed light on what may have facilitated or hindered treatment processes. In terms of facilitating processes, we

Table 2
Semistructured Posttreatment Interview Questions

No.	Question
1.	If it were possible to do so, would you like to continue receiving spirituality therapy? (yes/no)
2.	If you received both individual and group therapy, which did you prefer? (1 = *individual,* 2 = *group,* 3 = *both equally,* 4 = *neither individual nor group*)
3.	What did you hope to accomplish when you enrolled in this therapy? Did you meet your goal? If so, how? Please be specific.
4.	How was spirituality therapy different from standard drug counseling?
5.	What aspects of this therapy did you like most?
6.	Which of the various techniques that you learned in the therapy did you find most helpful in your daily life?
7.	Please tell me about a good moment during the therapy. [Interviewer: Prompt for a narrative with a beginning, middle, and end. Assess what the client was thinking, feeling, experiencing.] Why was it good? In what ways was it notable, significant, special? How did it reflect progress? How did this moment move you forward?
8.	Did you experience a "shift" in your life during the treatment? If so, when? What was the experience like?
9.	What aspects of this therapy did you like least?
10.	What was your biggest challenge in the therapy?
11.	Please tell me about a difficult or hindering moment in therapy. [Interviewer: Prompt for a narrative with a beginning, middle, and end. Assess what the client was thinking, feeling, experiencing.] Why was it difficult or hindering? What made it so? How could it have unfolded differently (i.e., more helpfully)?
12.	How has this therapy experience changed you?
13.	Tell me something that happened outside of therapy that might serve as an indication that you made progress in the therapy.
14.	How did your relationships change as a consequence of this work?
15.	In what ways have others noticed your changes?
16.	What will be your biggest challenge as you continue the journey along your spiritual path?
17.	What skills did you learn in the therapy that can help you with this challenge?
18.	For how many minutes each day do you currently practice meditation on the in and out breath?____
19.	Do you plan to continue meditating daily? (yes/no)

asked about which aspects of 3-S therapy clients liked most and which clinical techniques were most helpful. We also asked clients to describe a "good moment" in the course of treatment to get a sense of what they found to be particularly healing. We also asked if and when they experienced a positive "shift" in their thoughts, feelings, and/or behavior as a consequence of treatment.

Given the ethical imperative to "do no harm," it was important to assess both hindering and facilitating processes. We therefore asked clients to identify those aspects of 3-S therapy that they liked least, to describe a "difficult" moment in treatment, and to describe their greatest challenge with the therapy.

Outcome

We asked clients to indicate whether they had made positive changes as a consequence of their participation in 3-S therapy. If clients indicated that they had made positive changes, they were then asked to describe these changes in some detail. They were also asked to describe an event that occurred outside of the therapy context that indicated that these changes had indeed taken place. We also asked them to indicate whether others had noticed their changes. Finally, clients were asked whether they noticed any changes in their personal relationships with others as a consequence of the therapy.

Life After 3-S Therapy

Addicted clients often remark that "quitting is easy; it's staying quit that's hard." Therefore, clients were asked to describe their biggest challenge in the future. They were also asked to list the 3-S therapeutic skills that they had acquired in therapy that would be most useful as they confront this challenge.

Procedure

PTI coding. Using a grounded theory approach, we used standard, qualitative procedures to code the data (Strauss & Corbin, 1998). Two coders, working independently, read a transcript of clients' unedited answers to each question and identified phenomena in the text that were deemed responsive to the question and thus, in the opinion of the coder, should be regarded as relevant data for inclusion in the analysis. Phenomena included all phrases or statements conveying meaningful ideas, events, objects, and actions. If both coders selected the same phrase or statement in the answer to a given question, then it was counted as an agreement. Overall, percent agreement between coders averaged 89% (± 6 *SD*) for this first step. Disagreements were resolved through discussion and consensus.

The coders next worked together to partition the total set of phenomena generated by the identification procedure for each question into mutually disjoint subsets based on similarity of the selected data. For example, such a subset might include the phrases "the meditation" and "the breathing technique." Last, the coders worked together to generate a conceptual label for each of the distinct subsets that resulted from the partition procedure—in this instance, "meditation." Some participants may have mentioned a phrase more than once in his or her response to a given question; for example, "I liked the meditation . . . . The meditation was enjoyable." In these cases, the concept was coded once per question to control for the influence of particularly long or repetitive responses. This method allowed us to study the number of clients who mentioned a particular concept regardless of the number of times that they mentioned it in response to a particular question.

The conceptual labels that emerged from this process are presented in the Results section. As a principle guiding the selection of conceptual labels to present in the Results section, we stipulated that at least 25% ($n \geq 10$) of the participants had to have mentioned the conceptual label in a response to a given question. The only exception to this principle was for the questions under the *Hindering Aspects of Treatment* heading. None of the conceptual labels generated in response to these questions satisfied the 25% cutoff criterion; nevertheless, we thought it best to be more liberally inclusive regarding this question; therefore, the next most frequent conceptual labels are presented under this heading.

Quotes provided in the Results section underwent only minor editing to remove hesitation vocalizations, such as "um" and "you know."

Results

Treatment Modality

Twenty-one clients received 3-S therapy in both individual and group modality, and 18 received 3-S individual therapy sessions only, without the adjunctive group. As reported previously (Avants et al., 2005), receipt of the adjunctive group therapy had a small but significant effect on retention, but this does not affect outcome in any of the dimensions of interest. In the present study, of the 21 clients who received both individual and group therapy sessions, when asked which treatment modality they preferred (individual or group), 43% ($n = 9$) of the clients reported liking the individual and group sessions equally, 43% ($n = 9$) preferred the group sessions, and 14% ($n = 3$) preferred the individual sessions.

In light of this finding, we used chi-square analyses to identify any differences between clients who received individual therapy only and clients who received both group and individual modality with respect to the number and type of PTI categories generated. Given the large number of tests conducted ($N = 30$), some significant findings were anticipated simply due to chance. However, only one test produced a significant result; a greater proportion of clients in the individual 3-S therapy-only condition reported "none" when asked to describe a difficult moment in treatment, compared with clients in the individual-plus-group condition (11 of 18 vs. 6 of 21, respectively), $\chi^2(1) = 4.17$, $p < .05$.

Gender, Ethnicity, and HIV Status

Potential differences in category frequency by gender, ethnicity, and HIV status were also assessed with chi-square analyses. Neither gender ($n_{\text{men}} = 15$, $n_{\text{women}} = 24$) nor HIV status ($n_{\text{positive}} = 15$, $n_{\text{negative}} = 24$) were statistically significant at the .05 level. The only statistically significant finding for ethnicity was that Hispanics ($n = 9$) responded "none" when queried about least helpful aspects of treatment at a higher proportion than either Whites ($n = 18$) or African Americans ($n = 12$), $\chi^2(2) = 7.64$, $p = .025$. Of course, given the small *n*s involved, there was little power to detect differences in these analyses.

PTQ Findings

Table 1 presents mean scores (± *SD*s) on the six PTQ items assessing perceived changes as a result of the therapy. As shown, clients reported moderate or greater gains in addiction-related outcomes, spirituality, and motivation for HIV prevention.

PTI Findings

Clients clearly enjoyed participating in 3-S therapy. Nearly all (97%) of the clients indicated that they would like to continue receiving the treatment after the study ended.

Expectations and Goals

Clients were asked to reflect upon what they hoped to accomplish when they began 3-S therapy. The largest category of stated goals was to improve daily functioning (44%). Thirty-six percent of the sample hoped to learn concepts that would foster functional improvement. Reducing drug use (28%) was the third most commonly stated goal.

One client explained that she "was looking for help, because they were giving me medication for depression, and it wasn't helping. And it's weird because . . . something as simple as breathing in and out . . . it helps a lot. It does help." Another client described his expectations and experiences with 3-S therapy in the following way:

> I thought it was going to help me with my cocaine use. But it helped me with much more than that. It had the ability to change the way I think which to me is enormous, that's big—to actually change the way someone thinks is pretty special.

Overall Comparison of 3-S Therapy to Standard Drug Counseling

Clients were asked to indicate the ways in which 3-S therapy differed from their standard drug counseling. Thirty-six percent of the sample reported that this treatment was different from drug counseling because it offered more variety. The second most commonly stated difference was that 3-S therapy promoted self-awareness (31%), whereas standard drug counseling was experienced at times as "lecturing." Finally, 28% of the sample mentioned that 3-S therapy focused on spirituality and/or religion in contrast to treatment as usual. One of our clients was particularly impressed with the variety that 3-S therapy offered:

> Drug counseling . . . It becomes redundant . . . It's a routine. You know what they're going to say. With the spirituality, every week is different . . . something different for you to concentrate on . . . a different part of your life, even a different part of your breathing is working. With the spirituality, something is always different, and it was more fascinating." He went on to share that this variety helped him to stay engaged in the treatment: "It held my attention. My attention span was a lot longer than it would be with a drug therapist."

Facilitating Aspects of Treatment

Aspects of 3-S therapy liked most. Clients were asked which aspects of the 3-S therapy they liked the most. The most frequent response was the meditation (44%). Thirty-six percent of the sample reported that they liked the various concepts (*paramis*, spiritual nature, mindfulness) learned in the therapy that would foster functional improvement.

One client explained, "I'm learning new techniques like meditation. It helped me look at life and myself in a better way." For another client, the concepts seemed to resonate deeply, and proved to be quite motivating: "I guess I liked learning that everyone has a spiritual nature and that being an addict is just a pattern that you learn. Knowing that I can still change, that it can be done."

Techniques of therapy experienced as most helpful. Clients were asked which specific techniques they experienced as most helpful while in therapy. Sixty-two percent of the sample stated that the meditation was the most helpful technique. Of his experience with meditation, one client commented, "When I relax, it takes my mind off things, using the anchor, breathing in, breathing out, clearing your mind." Another acknowledged the power of meditation to change his outlook: "The morning meditation. That can totally change how your day goes."

Good moments in therapy. Clients were asked to describe in detail a good moment they experienced during therapy. Once again the most frequent response was the meditation (33%). One client, who had struggled for many years with anger issues explained:

> I like the beginning, the meditation part, 5 minutes. That puts me relaxed, calm. I can come in angry, have something on my mind, after that meditation, it's like I'm in the room. I don't have nothing else in my mind but in the room.

Another client experienced the feeling of success, of doing something properly when she meditated:

> Closing my eyes when we first started and doing the in and out breath. It relaxed me and got me set up for therapy. When I first felt it, it hit my nose, it was exciting. I felt the air.

Life-shifting experience. Clients were asked whether they had experienced a shift in their life during the therapy and when the shift occurred. Forty-nine percent of the sample reported that the therapy improved their interpersonal/intrapersonal functioning. The majority of the sample (50%) stated that the shift occurred in the middle of therapy; 33% stated that the shift occurred early in the therapy.

While shifts ranged from great to small, some of them were quite compelling: "I made a change. I started caring about myself; I didn't want to die. I was on the road to kill myself, so yeah, there was a shift in my thoughts." Clients were also able to pinpoint when in the course of the therapy things began to change for them: "About a month into treatment. I started believing I really wanted to follow through with it. I just felt hopeful that I don't have to be miserable all the time. I can't remember when I haven't felt like that." Another client specified, "Yes, probably about the third week. It was a feeling of enjoyment or self fulfillment."

Hindering Aspects of Treatment

Aspects of 3-S therapy liked least. Clients were asked which aspects of the 3-S therapy they liked the least. The most frequent response (51%) was that there were no aspects of therapy that they liked the least. As one client stated, in response to this question:

> That's hard; I liked everything. I can't think of nothing that's, you know [difficult about the therapy]. I'm serious, I really like this group.

> I've been in several studies since I've been in the program and this one's touched me more.

The next most frequently stated response ($n = 3$) was that the 8-week treatment duration was too short.

Biggest challenge in treatment. Clients were asked what their biggest challenge in therapy was. There was a wide variety in the responses to this question. It was interesting, however, that 21% ($n = 8$) reported that the cultivation of mindfulness was their biggest challenge in treatment and 18% ($n = 7$) reported that doing the at-home assignments was their biggest challenge.

Difficult/hindering moment in treatment. Clients were asked to describe in detail a difficult or hindering moment they experienced during therapy. The most frequent response was that there were no difficult or hindering moments during therapy (44%). One client said, "I can't think of none. That's why I was—I really liked the study, it really worked," and another explained, "No. I was always comfortable here." The next most frequent response (15%; $n = 6$) was that it was sometimes difficult to share personal information (e.g., concerning HIV-risk behavior).

Outcome

Change as a result of experience in therapy. Clients were asked how they were changed by their experience with 3-S therapy. The majority of the sample (62%) reported that their interpersonal/intrapersonal functioning had improved as a result of therapy. Twenty-six percent stated that they became more mindful. Clients spoke very explicitly of their increases in mindfulness: "[Therapy made] me more mindful. It helps me to think about what I'm doing first before I do it. Think of the consequences, what I can lose. Things are coming around. I just had to be patient."

One client stated the outcome very succinctly: "I feel more whole." Another commented that she felt "more in control and peaceful." In terms of behavioral change, one client explained, "Instead of cursing, I talk. My actions, my behaviors, my speech changed. I was changing before, but this helped even more. I don't abuse pills anymore. It helped me calm myself down. I think before I react."

Examples of change outside of therapy. Clients were asked to describe an event that occurred outside therapy that would serve as an indication of progress made in therapy. Thirty-eight percent of the sample reported that the therapy improved their interpersonal/intrapersonal functioning. Generally, clients reported changes such as becoming more "generous and caring toward people I am close to." There were also very specific examples of change:

> I had an incident with a person that took something from me. Instead of me cutting them loose, or doing things that I would normally do, I sat down and I talked to them, and the talk, it went well. They opened up more, I opened up more, and it never happened again. I was calmer, this taught me calmness.

Relationship changes as consequence of therapy. Clients were asked whether their relationships had changed as a consequence of the therapy. The majority of the sample (69%) stated that their relationships improved and that overall functioning within self and with others improved. One client who reported a history of difficulties with his significant other had this to say about the interpersonal changes that he made as a consequence of training in 3-S:

> We used to argue so much, argue and fight so much, and then when I started learning how to just sit down, evaluate the situations. Because I'm like a very self-centered person, a very selfish person, and being in the study, I learned the world don't revolve around me. There's other people in this world. And I started thinking about her feelings, and like I said, this program taught me how to compromise with my relationship with her. I got to give a little, and we need to discuss things. Our relationship is a whole lot better. I can say the 8 weeks that I've been in this program our relationship has gotten, I'd say 85% better than what it was.

Changes noticed by others. Clients were asked in what ways others had noticed their changes. Seventy-three percent stated that others had noticed their improved interpersonal and intrapersonal functioning. One client summed it up in the following way: "Everybody said I looked better, my attitude is more positive and everybody says it's that spirituality thing you're doing and everybody says it and I'm not just trying to be nice. I'm being sincere." Another client simply said, "my mom feels like she has her daughter back."

Life After 3-S

Biggest challenge in future. Clients were asked what their biggest challenge would be as they continue their journey along their spiritual path. The majority of the sample (44%) reported that their biggest challenge would be to continue improving their interpersonal/intrapersonal skills. The second most frequent response (33%) was the challenge to continue with the work of therapy, to make the commitment to continue with what was learned in therapy. One client recognized that "getting really truthful with myself . . . to be honest with myself" would continue to be a challenge for her. Another client was preparing "to use this therapy, to use everything I learned, to continue using it. Be aware of the addict mind, thoughts and behaviors and try to stop it." The theme of continuing to foster awareness emerged in another client's response as well: "First becoming aware, aware of these changes, and all these different techniques to help me put these changes into effect." Furthermore, she explained that 3-S therapy motivated her to sustain her effort: "The motivation, [the therapist] was very good at what he did, I remain motivated."

Skills to help with future challenge. Clients were asked what skills they had acquired in 3-S therapy that could help them with their future challenge to continue along their spiritual path. Meditation (36%) was most frequently stated. When asked about meditation practice, every client reported that they had developed a daily meditation practice [averaging 26 ($\pm$17) min/day], and all clients indicated that they planned to continue meditating daily in the future as well. Twenty-eight percent also stated that their improved functional skills would help them with their future challenge. One client explained that it was "[t]he meditation skills, keeping things in balance, treating people the way you like to be treated. It's okay that these feelings come up and there's a way to stop it. I learned a lot." Another client noted that the meditation and the 3-S philosophy would be helpful to her in the future: "The meditation. That people deserve to be happy and free. My breathing, taking time out for myself, treat myself to something good sometimes."

Discussion

In this article, we described the systematic process of developing and evaluating a manual-guided spirituality-focused intervention that could be subjected to empirical evaluation. We began this process by asking inner-city addicted clients about the perceived need for and usefulness of a spirituality-focused intervention for the treatment of addiction and HIV-risk behavior, and we ended it by asking clients to reflect on their experience in the subsequently developed intervention. We believe that our report suggests that it is indeed feasible to develop a manual-guided, spirituality-focused intervention for the treatment of addiction, based on Buddhist principles, that can be delivered to and accepted by predominantly Christian clients and subjected to rigorous empirical evaluation.

Clearly 3-S therapy was well liked. Almost all (97%) of clients indicated that they would like to continue receiving 3-S therapy even after the study ended. Anecdotally, we note that this is the most popular treatment that our research team has offered in 15 years of substance abuse treatment research. Any concerns about the complexity of the therapy, which was founded in cognitive and Buddhist psychological principles, or about the heavy demands made by the therapy, with its emphasis on at-home practice, were allayed by clients' own reports. Clients' mastery of the concepts covered in the therapy was indicated by their experience of a cognitive shift from addict to spiritual self-schema during the course of the therapy. They also demonstrated that they were able to engage in the meditation and other mindfulness practices on their own, between sessions, and all reported that they planned to continue their daily practice. Indeed, meditation practice was identified by clients as one of the most popular components of the intervention, cited as the most liked and most useful technique in the therapy and as providing the best moments in treatment.

Most clients reported making significant changes in their lives as a consequence of the therapy. The majority specifically cited improvement in daily functioning and were able to give clear examples, outside of the therapy context, in support of these changes. Most noted that their relationships had also improved as a result of the therapy. After completion of the therapy, clients anticipated a variety of challenges. However, they hoped to sustain the gains in daily functioning that they had made and to continue the work of spiritual development begun in the therapy. Many indicated that their new mindfulness practices would help them to sustain their gains.

Limitations

This study had several limitations that should be taken into consideration in the interpretation of findings. Although clients were not interviewed by the therapists who provided the therapy, they were interviewed by members of the 3-S research team, creating the potential for demand characteristics that could have influenced the clients' responses. The timing of the interview could also have had an influence. Clients were interviewed shortly after the intervention ended, when their enthusiasm for the intervention may well have been at its peak, and we have no data from a long-term follow-up interview to disconfirm this. In addition, the sample size was relatively small, and the majority of clients were Christian; for this reason and the reasons mentioned earlier, the generalizabilty of our findings to other patient populations is attended with some degree of uncertainty. Further studies with larger samples, with greater religious diversity, in a variety of treatment contexts, would be needed to address this issue.

Call for Future Research

Despite these limitations, which in part attend any clinical research study conducted at a single site, these qualitative data, taken together with results from our controlled study, suggest the feasibility and utility of providing a manual-guided spirituality-focused intervention to clients in treatment for addiction. However, given that 3-S therapy was developed and evaluated specifically in the context of an inner-city methadone-maintenance program, the next step, as noted earlier, is to determine generalizability of the therapy to other treatment settings. Toward this end, as noted previously, all 3-S therapy manuals, as well as the therapist training program are available free of charge on our Web site (www.3-S.us), and we invite evaluation of 3-S therapy by other clinical research teams. Although 3-S therapy is designed to be an integrated, holistic intervention, providing a context facilitating clients' cognitive shift from addict to spiritual self-schema, another possible direction for future research involves the "dismantling" of the intervention to examine the unique contribution of various components of the therapy to clinical outcome. For example, such research could investigate the efficacy of specific mindfulness practices that were popular with our clients (e.g., *anapanasati* meditation), delivered with and without the theoretical context provided by self-schema theory.

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